NATIONAL Spine & Pain CENTERS

www.treatingpain.com

TODAY'S DATE:	ACCOUNT #:

PATIENT INFORMATION

LAST NAME:
FIRST NAME:
ADDRESS:
CITY: STATE: ZIP:
HOME PHONE #: MAY WE LEAVE A MESSAGE? Y N
CELL PHONE #: MAY WE LEAVE A MESSAGE? Y N
EMAIL*:
PREFERRED METHOD TO CONTACT YOU:
DATE OF BIRTH:
SOCIAL SECURITY #:
SEX (PLEASE CIRCLE): MALE FEMALE
HOW DID YOU HEAR ABOUT US:
PREFERRED LANGUAGE:
RACE:

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:
BILLING ADDRESS:
CITY: STATE: ZIP:
PHONE #:
ID #: GROUP #:
SECONDARY INSURANCE COMPANY:
BILLING ADDRESS:
CITY: STATE: ZIP:
PHONE #:
ID #:

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME:	PHONE #: RELATION TO YOU:

IF INSURANCE IS NOT IN YOUR NAME, PLEASE COMPLETE:

NAME OF POLICY HOLDER:	PATIENT'S EMPLOYER:
DATE OF BIRTH:	EMPLOYER ADDRESS:
SOCIAL SECURITY #:	WORK #:
POLICY HOLDER EMPLOYER:	CITY: STATE: ZIP:
EMPLOYER ADDRESS:	MAY WE CONTACT YOU AT WORK? Y N
CITY: STATE: ZIP:	MAY WE LEAVE A MESSAGE? Y N

REFERRING PHYSICIAN AND PRIMARY CARE PHYSICIAN INFORMATION:

REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
PHONE #:	PHONE #:
FAX #:	FAX #:

IF WORKERS COMPENSATION OR LEGAL CLAIM, PLEASE COMPLETE:

COMPANY NAME:	ADJUSTER NAME:
MAILING ADDRESS:	PHONE #: FAX #:
CITY: STATE: ZIP:	NURSE CASE MANAGER:
CLAIM #:	PHONE #: FAX #:
DATE OF INJURY:	INJURY YOU ARE BEING TREATED FOR:
EMPLOYER AT TIME OF INJURY:	

Assignment of Benefit Consent for Treatment do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not by my insurance. I authorize this office to release all information necessary to secure payment, transit and process claims electronically or through my other reasonable and customary means: including, but not limited to Medicare. I hereby voluntarily consent to my treatment at this office and authorize such treatment, examination, medications, anesthesia, surgical operations, and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physicians. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to the patient concerning the results which may be obtained by such treatments and procedures hereby affirmed by the signature of the undersigned.

Patient's Signature:_____ Date:_____

Assignment of Benefits

Name of Insured (print):

Date of Birth:

Item dispensed:

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare Beneficiary, be made either to me or on my behalf to the organization listed below for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my Insurance Carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my Insurance Company or other entity, if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

General Patient and Patient Family Responsibilities:

In certain circumstances, insurance company may send a check for services provided by M&M Orthopedics directly to the patient. In such cases, the patient agrees to endorse and send such- a check to M&M Orthopedics. If the patient deposits such a check into a Personal account, the patient agrees to send M&M Orthopedics a check for the equivalent amount.

If the patient receives from an insurance company, Medicare or Medicaid, an Explanation of Benefits (EOB), the patient agrees to send a copy of the EOB, by U.S. Mail directly to:

Organization: *Interventional Pain Center, PLLC*
2153 Valleygate Dr., Ste. 102
Fayetteville, NC 28304

Signature of Patient or Parent/Guardian:_____ Date: _____

Name of person signing (print): _____

Relationship to patient: _____

*Fit/Surgery/Scan Date*_____

Patient Name:

Social Security:

PATIENT FINANCIAL RESPONSIBILITY

This letter is to inform you of your financial responsibility when being seen by Interventional Pain Center. Interventional Pain Center charges are for the professional services of our physicians, supplies, and/or medications used during your treatment. If you have any questions regarding your financial responsibility you may call us at (910) 323-7246.

INSURANCE/THIRD PARTY PAYORS

We will file your insurance for you as a courtesy service. All co-payments, deductibles and other amounts not covered by insurance are your responsibility. You should be prepared to pay these amounts at the time of your first appointment.

HMO's. PPO's

At the present time we do participate in many managed care companies. Please call our office to confirm those with us. Patients who belong to an HMO must go through their primary care physicians. Our physicians are specialists, and we are not able to contact these companies for needed referral numbers. This MUST be done by your primary care physician's office. This number must be called in to us before you can be seen. If we do not participate with your insurance company, payment is expected at the time of your visit.

SELF PAYMENT

If you do not have insurance or if we are unable to verify your insurance, you are considered self-pay. Payment is due, in full, at the time services are rendered.

MEDICARE AND MEDICAID

We accept assignment on Medicare and Medicaid. We do not file supplemental Medicare policies. Many supplemental insurance companies are automatically filed through an electronic filing system with Medicare. If you supplemental insurance is not one of those, you will be responsible for filing this. You will be responsible for any co-insurance amounts and deductibles specified by Medicare and Medicaid. If you have both Medicare and Medicaid, you will not be responsible for any co-insurance or deductible amounts. There are a few procedures not covered by Medicare. We will have the patients sign an Advanced Beneficiary Notice and the patient will be responsible for paying these procedures.

WORKERS' COMPENSATION

Workers' Compensation laws differ from state to state. Terms of payment will be worked out through your carrier or employer. All services must be pre-certified by your workers' compensation adjuster prior to services being rendered. If you are involved in a situation where your insurance company declines payment and you go into litigation, you are considered a self-pay patient and all charges will be due on the date that this information is received by our office.

DELINQUENT ACCOUNTS

All accounts over 90 days old will be turned over to a collections agency.

I have read and understand this letter. I realize that I am responsible for payment of my bill. If I need to make arrangements other than as stated above, I understand that I must contact the Billing department at Interventional Pain Center before my appointment time.

ACKNOWLEGEMENT OF PRIVACY PRACTICES

I hereby acknowledge the opportunity to review and obtain a copy of Fayetteville Pain Center's notice of privacy practices.

Signature: _____

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

I hereby authorize NSPC to disclose my individually identifiable protected health information (PHI) as described here to the person/organization named below.

Section A. Complete all sections

Patient Name:	Birth Date:	Social Security No.:
Patient Address:		
Name and Address of person (s) or organization (s) to whom this information will be sent:		

This authorization will expire on the following: (Fill in the Date or the Event but not both.). If I do not indicate a date, this will expire one (1) year from the date of my signature below.

Date:_____ Event:_____

Purpose of disclosure:

Description of information to be released:

Medical record from (insert date) _____ to (insert date) _____

Check the appropriate boxes:

☐ Entire Record	☐ Medication Reports	☐ Other: _____
☐ History and Physical	☐ Radiology Reports	
☐ Operative Reports	☐ Nursing Notes	
☐ Consultation Reports	☐ Physician Progress Notes	
☐ Laboratory Reports	☐ Physician Orders	

The following information will not be released unless you specifically authorize its disclosure by *initialing* the relevant line(s) below:

_____ I specifically authorize the release of information pertaining to mental health treatment

_____ I specifically authorize the release of information pertaining to alcohol and/or drug abuse

_____ I specifically authorize the release of information pertaining to confidential HIV(AIDS) related information

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the release of the protected health information as stated.

Signature of Patient or Representative Authorized by Law*:	Date:
Print Name of Patient or Representative Authorized by Law:	Relationship to Patient:

Section C: Office use only. Complete all sections.

Received by: _____ Date form received: _____

Delivery method: ☐ FAXED ☐ MAILED ☐ IN PERSON

Privacy Officer or Designee's signature authorizing release: _____

*REPRESENTATIVE AUTHORIZED BY LAW MUST SUBMIT COPIES OF LEGAL DOCUMENT SUPPORTING HIS OR HER AUTHORITY TO ACT ON THE PATIENT'S BEHALF.

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*Office use * Provider _____

Appt time _____ Entered _____

Vitals _____

_____

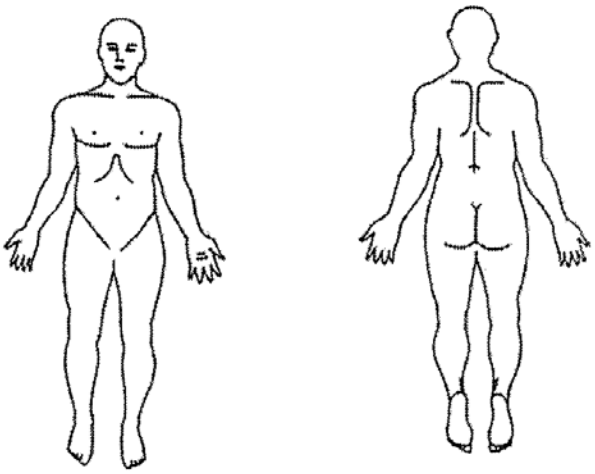
PAIN COMPREHENSIVE QUESTIONNAIRE

Patient Name _____ DOB _____ Date _____

Referring Physician _____ Primary Care Physicians _____

Chief Complaint (main problem seeking treatment) _____ Side ☐ right ☐ left

On the Diagram, shade in or circle the area where you feel pain:



R L **L R**

Preferred Pharmacy Name/Address:

_____

Preferred Pharmacy Phone:

_____

Are you pregnant or possibly pregnant?

☐Yes ☐No ☐N/A

---- (0 = no pain 10 = unbearable pain) ----

Pain level today

0 1 2 3 4 5 6 7 8 9 10

Over the last 4 weeks, please identify your pain levels below:

Severe pain level (on a bad day)

0 1 2 3 4 5 6 7 8 9 10

Average pain level (on an average day)

0 1 2 3 4 5 6 7 8 9 10

Allergies _____

Email _____

The onset of your pain was:

☐Motor vehicle accident

Date of Accident _____

Were you wearing a seatbelt: ☐Yes ☐No

Position during the accident:

☐Driver ☐Passenger in front seat ☐Passenger in back seat

☐Falling from a height

☐Injury at work

Date of injury _____

What injury occurred? _____

☐Insidious onset ☐Lifting an object ☐Playing a sport ☐Slipping and falling ☐Trauma ☐Tripping/uneven surface

Your pain occurs: ☐Constantly ☐Intermittent ☐Worse after activity ☐Worse at the end of the day ☐Worse during activity ☐Worse during cold seasons ☐Worse during the day ☐Worse during the night ☐Worse in the morning

Describe your pain: ☐aching ☐burning ☐cramp-like ☐dull ☐in a glove distribution ☐in a stocking distribution ☐pins & needles-like ☐sharp ☐shooting ☐stabbing

Your pain has been occurring for: _____ ☐days ☐weeks ☐months ☐years

Symptoms	Associated with your pain	**Symptoms**	Associated with your pain
Arm numbness		Insomnia	
Awakens you from sleep		Leg numbness	
Changes in bladder function		Perineal numbness	
Changes in bowel function		Sexual Dysfunction	
Changes in temperature in the affected area		Shoulder numbness	
Depression		Suicidal ideation	
Finger numbness		Sweating in affected area	
Flushing in affected area		Toe numbness	
Hand numbness		Hand numbness	

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PAIN COMPREHESIVE QUESTIONNAIRE

What activities aggravate/relieve your symptoms?

ACTIVITIES	AGGRAVATES YOUR PAIN	RELIEVES YOUR PAIN
All Movements		
Bending Forward		
Exercise		
Lifting Objects		
Lying Flat		
Rest		
Rotating the neck		
Sitting		
Standing for long periods		
Walking long distances		

What treatments have you used to treat the symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
ACTIVITY MODIFICATION			
ACUPUNCTURE			
BRACE			
What type of Brace?	☐Back Brace ☐Neck Brace ☐Cervical traction ☐TENS unit ☐Ankle Brace (R or L) ☐Wrist Brace (R or L) ☐Knee Brace (R or L)		
How long have you had the product?			
Are you obtaining relief?			
Are your products in good condition?			
CHIROPRACTIC MANIPULATION			
HEAT TREATMENT			
ICE TREATMENT			
PHYSICAL THERAPY			
PILATES			
WEIGHT REDUCTION			
YOGA			
MEDICATIONS	**Check mark all medication that apply below**		

Opioids		NSAIDs/Tylenol		Muscle Relaxants
☐ Tramadol	☐ Methadone	☐ Tylenol	☐ Lodine	☐ Soma
☐ Demerol	☐ Morphine	☐ Aspirin	☐ Orudis	☐ Lorzone
☐ Codeine	☐ Nucynta	☐ Ibuprofen	☐ Relafen	☐ Flexeril
☐ Fentanyl (Duragesic)	☐ Butrans	☐ Naproxen	☐ Celebrex	☐ Baclofen
☐ Hydromorphone (Dilaudid,)	☐ Suboxone	☐ Daypro	☐ Toradol	☐ Zanaflex
☐ Hydrocodone (Vicodin)		☐ Indocin		☐ Robaxin
☐ Oxycodone (Percocet, Oxycontin)		☐ Feldene		☐ Skelaxin
☐ Oxymorphone (Opana)		☐ Voltaren		☐ Valium (Diazepam)

Antidepressants		Other	
☐ Elavil (Amitriptyline)	☐ Paxil	☐ Neurontin (Gabapentin)	☐ Lyrica
☐ Pamelor (Nortriptyline)	☐ Prozac	☐ Tegretol	☐ Ativan
☐ Desipramine	☐ Serzone	☐ Dilantin	☐ Xanax
☐ Impramine (Tofranil)	☐ Cymbalta	☐ Topamax	☐ Imitrex
☐ Zoloft	☐ Savella	☐ Depakote	☐ Ergotamine
		☐ Klonopin	☐ Mexillitine

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PAIN COMPREHESIVE QUESTIONNAIRE

Do you have any adverse effects since starting any treatment?

☐Constipation ☐Drowsiness ☐Mental slowness ☐Other

What procedures have you had to treat the pain?

PROCEDURE	Mark if applicable
No Procedure	
Epidural Steroid Injection	
Facet Joint Injection	
Medial Branch Block Trial	
Peripheral Nerve Injection	
Rhizotomy	
Fusion, anterior	
Fusion, posterior	
Fusion, combined anterior and posterior	
Laminectomy	
Microdiscectomy	
Other	

What imaging studies have you had for the pain?

☐Bone scan

☐CT Scan

☐EMG

☐ MRI

☐ Radiographs

How has the pain limited you? (check mark all that apply)

Activities	Limit Pain	Activities	Limit Pain
No limitations		Inability to attend school	
Attending school on a limited basis		Inability to perform daily activities (ADL's)	
Difficulty getting up from chair		Inability to work	
Difficulty sitting		Requiring constant assistance	
Difficulty standing		Requiring occasional assistance	
Difficulty walking		Working on a limited basis	
Difficulty with daily activities (ADL's)		Working light duty	
Difficulty with recreational sports		Other	
Functional limitations			

Who have you seen for this problem? ☐Chiropractor ☐Emergency Room ☐General Surgeon ☐ Internist

☐Orthopedic Doctor ☐Pediatrician ☐Primary care ☐ Therapist ☐Trainer ☐Urgent Care Center ☐Walk in clinic

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INTAKE AND HISTORIES

***** PLEASE COMPLETE THE REMAINDER OF THIS PAPERWORK ON THE PATIENT PORTAL *****

https://nspc.ema.md **Contact our office at 855-836-7246 for a username and password**

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ **None**
- ☐ Other_____

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy ☐Right ☐Left ☐Both
- ☐ Breast: Lumpectomy ☐Right ☐Left ☐Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Tonsillectomy
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**
- ☐ Other_____

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INTAKE AND HISTORIES

Interventional Pain History (please check all that apply):

- ☐ Epidural Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Facet Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Medial Branch Block- Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Rhizotomy- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Intrathecal Pump
- ☐ Spinal Cord Stimulator
- ☐ **None**
- ☐ Other_____

Musculoskeletal History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **None**
- ☐ Other_____

Musculoskeletal Surgery (please check all that apply):

- ☐ Achilles Tendon Repair
- ☐ ACL Reconstruction
- ☐ Ankle Fracture ORIF ☐Right ☐Left ☐Both
- ☐ Bunion Correction
- ☐ Carpal Tunnel Decompression ☐Right ☐Left ☐Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ CMC Arthroplasty
- ☐ Distal Radius ORIF ☐Right ☐Left ☐Both
- ☐ Ganglion Cyst Excision
- ☐ Intramedullary Nailing Femur ☐Right ☐Left ☐Both
- ☐ Intramedullary Nailing Tibia ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Hip ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Knee ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Shoulder ☐Right ☐Left ☐Both
- ☐ Knee Arthroscopy ☐Right ☐Left ☐Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
- ☐ Reverse Total Shoulder Replacement
- ☐ Revision of Total Hip Arthroplasty
- ☐ Revision of Total Knee Arthroplasty
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ Rotator Cuff Repair ☐Right ☐Left ☐Both
- ☐ Shoulder Arthroscopy
- ☐ **None**
- ☐ Other_____

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INTAKE AND HISTORIES

Medications (please list all current medications or check option, which applies):

- Complete the information below regarding all medications you are currently taking, have discontinued, or modified.
- Be certain to list both prescription and non-prescription medication, including any herbals or supplements you take.

☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)

☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option, which applies):

☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)

☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

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INTAKE AND HISTORIES

Social History (please check all that apply):

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - o # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

Drug Use
- ☐ Drug Use
- ☐ IV Drug Use
  - o _____

Family History:

Please check appropriate box "Alive" or "Decease" and list ages for the following Blood Family Members. If Parents or Grandparents are deceased, please write in Age and Cause of Death, if known.

	Alive	Age (if known)	Deceased	Age at Death	If deceased, cause of death	Unknown Status
Father						
Mother						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

	Number Alive	Age (if known)	Number Deceased	Age at Death	If deceased, cause of death	Unknown Status
Brothers						
Sisters						
Sons						
Daughters						

Family History (continued):

Please mark YES or NO if a Blood Family Member has ever had any of these conditions. If you mark YES, please mark the box under the relationship of the person to you

				Relationship of Person to you				
	YES	NO	DO NOT KNOW	Father	Mother	Grandparent	Brother /Sister	Son/ Daughter
Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Stroke/TIA								
Alcohol Abuse								
Drug Abuse								
Psychiatric Illness								
Seizures								
Depression/Suicide								
Osteoarthritis								
Osteoporosis								
Scoliosis								
Other Conditions								

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INTAKE AND HISTORIES

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	Symptom	Yes	No
Joint pains			Wheezing		
Joint swelling			Pain w/ breathing		
Difficulty Walking			Palpitations		
Muscle Pain			Ankle Swelling		
Pain Radiating down to leg(s)			Labored breathing w/exertion		
Weakness			Nausea/ Vomiting		
Numbness			Diarrhea		
Tingling			Constipation		
Fever			Heartburn		
Weight Gain			Ulcers		
Rash			Blood in Stool		
Chest Pain			Urinary Incontinence		
Incontinence			Urinary hesitancy		
Shortness of Breath			Urinary retention		
Suicidal thoughts			Blood in urine		
Weight loss			Genital pain		
Chills			Excessive bruising		
Fatigue			Excessive bleeding		
Discoloration			Cancer		
Scarring			Excessive thirst		
Environmental Allergies			Heat/Cold intolerance		
Immunosuppression			Diabetes		
HIV/AIDS			Thyroid Disease		
Blurred Vision			Joint Stiffness		
Double Vision			Dizziness		
Glaucoma			Fainting		
Eye pain			Headaches		
Ringing in the Ears			Tremor		
Loss of hearing			Seizure		
Nose bleeds			Memory Loss		
Hoarseness			Depression		
Difficulty Swallowing			Anxiety		
Cough			Hallucinations		

Other Medical Conditions* (check yes or no for the following):

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Symptom	Yes	No	Symptom	Yes	No
Blood Thinners			Rheumatoid Arthritis		
Pacemaker			Hepatitis B or C		
Defibrillator			Pregnancy or planning a pregnancy		
Premedicate Prior to Procedure			HIV/ADS		
Hepatitis B or C			Diabetes		