



Dear Patient,

Welcome to Pain and Spine Specialists of Connecticut, an affiliate of National Spine and Pain Centers. To help facilitate your care, please complete the enclosed paperwork and bring with you to your appointment along with your insurance card(s) and a photo ID. If you have had a MRI or CT scan, please bring in the CD provided to you by the imaging facility.

Please be advised that we do not prescribe any medications at the first visit. If you are currently prescribed medication(s) by another physician, please notify their office that they will need to provide you with medications for up to two weeks after your initial consult.

If you are scheduled for a procedure, please arrange for a driver to bring you to and from the appointment unless other arrangements have been discussed. If you are scheduled to take Valium for your procedure, please pick up the medication at your pharmacy the day before your appointment. Please take one Valium 30 minutes prior to your scheduled appointment time. When you arrive, we will advise you when to take the remaining medication.

If you have any questions or concerns, please call Barbara at 203-743-7246 extension 40303.

Thank you.

67 Sandpit Road, Suite 308 Danbury, CT 06810
131 Kent Road, Building A New Milford, CT 06776
1320 West Main Street, Building 2 Waterbury, CT 06706

TODAY'S DATE:		ACCOUNT #:	
PATIENT INFORMATION		INSURANCE INFORMATION	
LAST NAME:		PRIMARY INSURANCE COMPANY:	
FIRST NAME:		BILLING ADDRESS:	
ADDRESS:		CITY:	STATE: ZIP:
CITY:	STATE:	ZIP:	PHONE #:
HOME PHONE #:	MAY WE LEAVE A MESSAGE? Y N		ID #: GROUP #:
CELL PHONE #:	MAY WE LEAVE A MESSAGE? Y N		
EMAIL*:		SECONDARY INSURANCE COMPANY:	
PREFERRED METHOD TO CONTACT YOU:		BILLING ADDRESS:	
DATE OF BIRTH:		CITY:	STATE: ZIP:
SOCIAL SECURITY #:		PHONE #:	
SEX (PLEASE CIRCLE): MALE FEMALE		ID #:	
HOW DID YOU HEAR ABOUT US:			
PREFERRED LANGUAGE:			
RACE:			

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME:	PHONE #:	RELATION TO YOU:
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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:	



FINANCIAL POLICY

The practitioners and staff of Pain and Spine Specialists of CT are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. Please read the following financial policy and sign. If you have any questions or concerns, please ask our staff.

INSURANCE

You, as the responsible party, are responsible for providing us with up to date insurance information. We will keep a copy of your insurance card(s) on file. Kindly report any changes in your insurance coverage immediately by telephone or upon your arrival to your appointment. If your insurance changes and you do not notify our office, you may be responsible in full for any charges incurred.

REFERRALS

If your insurance plan requires referrals from your PCP to come to our office, YOU are responsible for obtaining the referral. If you do not obtain a referral you may not be seen or you may be billed for the full amount of services rendered. Please check with your insurance company if you are not sure.

COPAYS

Copays must be paid at time of service. Please come prepared to pay the specialist copay at each visitor you may not be seen.

DEDUCTIBLES and COINSURANCES

We will submit your bills to your insurance carrier(s) for processing. All balances will be billed to you and payment is expected upon receipt. If you fail to pay any balance within 90 days, you may not be seen in the office until said balance is settled. If you require a payment plan, please contact our billing office at 203-730-0743.

MEDICARE

Medicare patients are responsible for their annual deductible, coinsurance and any non-covered services in which you agree to pay (Advanced Beneficiary Notice). We will bill your secondary insurance as appropriate to be processed in accordance with your plan. Any balances due after insurance processing will be your responsibility and will be due upon receipt. If you fail to pay any balance within 90 days, you may not be seen in the office until said balance is settled.

MOTOR VEHICLE ACCIDENT

If your charges are related to a MVA and you have med pay or PIP coverage, we will bill your auto insurance carrier. Any balances not covered by your carrier are your responsibility. We will not suspend collection of your balance until a third party claim is settled.

WORKERS COMPENSATION

If you have a work related injury, we will submit all claims to your workers compensation carrier. If your case settles, and you receive a set aside account for medical expenses, you will be billed at the current WC rates that will be due at each visit.

PATIENTS WITHOUT INSURANCE

If you do not have insurance, you may be offered a discounted rate. Payments are due upon arrival to your appointment, there are no exceptions.

LATE CANCELLATION/NO SHOW FEES

We require 24 hours notice for cancelling an appointment. If you do not give adequate notice or fail to show for your appointment, we reserve the right to charge a \$75.00 fee for a missed appointment and \$200.00 for a missed procedure. The fee must be paid prior to rescheduling the missed appointment.

RETURNED CHECKS

All returned checks are subject to a \$25.00 service fee.

PAST DUE ACCOUNTS

We expect that you will pay your account balance in a timely manner. Any account with a balance over 90 days past due will be referred to an outside collection agency and you will be responsible for any related collection costs.

Please call our billing office at 203-730-0743 if you have any questions.

I have read, understand and agree to the financial policies of Pain and Spine Specialists of CT.

Patient signature _____ Date _____

Print name _____



ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE & DESIGNATION OF DISCLOSURE

I acknowledge that I have received a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth NSPC's privacy practices and my rights regarding privacy of my protected health information.

Patient Signature _____ Date _____

Print Name _____ Date of Birth _____

METHOD OF COMMUNICATION

I wish to be contacted in the following manner:

- Home Phone # _____
OK to leave message with detailed information? Yes No Leave message with call back number only Yes No
- Cell Phone # _____
OK to leave message with detailed information? Yes No Leave message with call back number only Yes No
- Work Phone # _____
OK to leave message with detailed information? Yes No Leave message with call back number only Yes No

ACCESS TO MY INFORMATION

Please list the names below of anyone who may need to speak to us regarding your appointments and medications. Please include anyone who may pick up prescriptions on your behalf.

PASS may release my health information to the following people:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

The following person(s) are NOT authorized to receive or discuss my health information:

Name _____ Relationship _____

Name _____ Relationship _____

AUDIO/VIDEO ACKNOWLEDGEMENT

Please be advised, that in order to better enable us to assure compliance with HIPAA privacy and security laws and regulations, and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited.

We reserve the right to terminate any patient as permitted under State law if the patient or anyone accompanying the patient is found to be in violation of this policy. We appreciate your understanding and cooperation.

Patient signature _____ Date _____



ADVANCED DIRECTIVE

PASS is dedicated to providing comprehensive care to patients and following federal guidelines regarding important public health issues. Please answer the following question.

Are you able to name a surrogate decision maker in the event the you are incapacitated?

If yes, please indicate below.

Name _____ Relationship _____

Phone number _____

If no, please check the box below.

I do not wish or am unable to name a surrogate decision maker.

Patient signature _____ Date _____

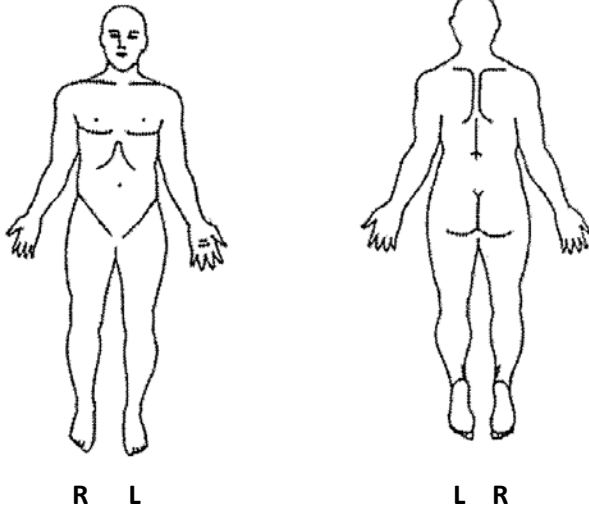
PAIN COMPREHENSIVE QUESTIONNAIRE

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:



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 a 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		Sexual Dysfunction	
Changes in bowel function		Shoulder numbness	
Changes in temperature in the affected area		Suicidal ideation	
Depression		Sweating in affected area	
Finger numbness		Toe numbness	
Flushing in affected area		Hand numbness	



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PAIN COMPREHENSIVE 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			
BRACE			
What type of Brace?	<input type="checkbox"/> Back Brace <input type="checkbox"/> Neck Brace <input type="checkbox"/> Cervical traction <input type="checkbox"/> TENS unit <input type="checkbox"/> Ankle Brace (R or L) <input type="checkbox"/> Wrist Brace (R or L) <input type="checkbox"/> Knee Brace (R or L)		
How long have you had the product?			
Are you obtaining relief?			
Are your products in good condition?			
CHIROPRACTIC MANIPULATION			
PHYSICAL THERAPY			
PILATES			
WEIGHT REDUCTION			
YOGA			
HEAT TREATMENT			
ICE TREATMENT			
ACUPUNCTURE			
MEDICATIONS	Check mark all medication that apply below		

Opioids	NSAIDs/Tylenol	Muscle Relaxants
<input type="checkbox"/> Tramadol	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Soma
<input type="checkbox"/> Demerol	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Lorzone
<input type="checkbox"/> Codeine	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Flexeril
<input type="checkbox"/> Fentanyl (Duragesic)	<input type="checkbox"/> Naproxen	<input type="checkbox"/> Baclofen
<input type="checkbox"/> Hydromorphone (Dilaudid,)	<input type="checkbox"/> Daypro	<input type="checkbox"/> Zanaflex
<input type="checkbox"/> Hydrocodone (Vicodin)	<input type="checkbox"/> Indocin	<input type="checkbox"/> Robaxin
<input type="checkbox"/> Oxycodone (Percocet, Oxycontin)	<input type="checkbox"/> Feldene	<input type="checkbox"/> Skelaxin
<input type="checkbox"/> Oxymorphone (Opana)	<input type="checkbox"/> Voltaren	<input type="checkbox"/> Valium (Diazepam)

Antidepressants	Other
<input type="checkbox"/> Elavil (Amitriptyline)	<input type="checkbox"/> Neurontin (Gabapentin) <input type="checkbox"/> Lyrica
<input type="checkbox"/> Pamelor (Nortriptyline)	<input type="checkbox"/> Tegretol <input type="checkbox"/> Ativan
<input type="checkbox"/> Desipramine	<input type="checkbox"/> Dilantin <input type="checkbox"/> Xanax
<input type="checkbox"/> Imipramine (Tofranil)	<input type="checkbox"/> Topamax <input type="checkbox"/> Imitrex
<input type="checkbox"/> Zoloft	<input type="checkbox"/> Depakote <input type="checkbox"/> Ergotamine
	<input type="checkbox"/> Klonopin <input type="checkbox"/> Mexillitine



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PAIN COMPREHENSIVE 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

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

INTAKE AND HISTORIES

Past Medical History (please check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia, Chronic | <input type="checkbox"/> Diabetes, Non-Insulin Dependent | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Obesity, Morbid |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> PBPH |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes, Insulin Dependent | <input type="checkbox"/> Leukemia | <input type="checkbox"/> None |
| | | <input type="checkbox"/> Other _____ |

Past Surgical History (please check all that apply):

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

INTAKE AND HISTORIES

Past Orthopedic History (please check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Ankle Fracture
<input type="checkbox"/> Ankylosing Spondylitis
<input type="checkbox"/> Bursitis
<input type="checkbox"/> DISH
<input type="checkbox"/> Epidural Injections, Spine
<input type="checkbox"/> Fracture
<input type="checkbox"/> Gout
<input type="checkbox"/> Hip Fracture
<input type="checkbox"/> HNP, Cervical
<input type="checkbox"/> HNP, Lumbar
<input type="checkbox"/> Metastatic Bone Disease | <input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Osteopenia
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Primary Bone Sarcoma
<input type="checkbox"/> Psoriatic Arthritis
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Ricketts
<input type="checkbox"/> RSD
<input type="checkbox"/> Sciatica
<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Spine Fracture | <input type="checkbox"/> Soft Tissue Sarcoma
<input type="checkbox"/> Spinal Stenosis, Cervical
<input type="checkbox"/> Spinal Stenosis, Lumbar
<input type="checkbox"/> Vertebral Body
Compression Fracture
<input type="checkbox"/> Vitamin D Deficiency
<input type="checkbox"/> Wrist Fracture
<input type="checkbox"/> None
<input type="checkbox"/> Other _____ |
|--|--|---|

Past Orthopedic Surgery (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Ankle Fracture ORIF
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Carpal Tunnel Decompression
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Cervical Spine Surgery: ACDF
<input type="checkbox"/> Cervical Spine Surgery: Disc Replacement
<input type="checkbox"/> Distal Radius ORIF
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Intermedullary Nailing Femur
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Intermedullary Nailing Tibia
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Joint Replacement: Hip
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Joint Replacement: Knee
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Joint Replacement: Shoulder
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Knee Arthroscopy
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Kyphoplasty/Vertebroplasty
<input type="checkbox"/> Lumbar Spine Surgery: Decompression
<input type="checkbox"/> Lumbar Spine Surgery: Decompression & Fusion
<input type="checkbox"/> Lumbar Spine Surgery: Disc Replacement
<input type="checkbox"/> Rotator Cuff Repair
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Other _____
<input type="checkbox"/> None |
|--|--|

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

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 "Deceased" 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						

INTAKE AND HISTORIES

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								

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			Pain w/ breathing		
Joint swelling			Palpitations		
Difficulty Walking			Ankle Swelling		
Muscle Pain			Labored breathing w/exertion		
Weakness			Nausea		
Numbness			Vomiting		
Tingling			Diarrhea		
Fever			Constipation		
Weight Gain			Heartburn		
Rash			Ulcers		
Chest Pain			Blood in Stool		
Incontinence			Urinary Incontinence		
Shortness of Breath			Urinary hesitancy		
Suicidal thoughts			Urinary retention		
Weight loss			Blood in urine		
Chills			Genital pain		
Fatigue			Excessive bruising		
Discoloration			Excessive bleeding		
Scarring			Cancer		
Environmental Allergies			Excessive thirst		
Immunosuppression			Heat/Cold intolerance		
HIV/AIDS			Diabetes		
Blurred Vision			Thyroid Disease		
Double Vision			Joint Stiffness		
Glaucoma			Dizziness		
Eye pain			Fainting		
ringing in the Ears			Headaches		
Loss of hearing			Tremor		
Nose bleeds			Seizure		
Hoarseness			Memory Loss		
Difficulty Swallowing			Depression		
Cough			Anxiety		
Wheezing			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			HIV/ADS		
Premedicate Prior to Procedure			Diabetes		
Hepatitis B or C					