Interventional Spine and Pain Center
2345 Murfreesboro Highway, Manchester, TN 37355
905 S. Church Street, Murfreesboro, TN 37130
Phone (931) 728-5607 *** Fax (931) 728-8354

Welcome To Our Practice!

Welcome

Thank you for scheduling an appointment with Interventional Spine and Pain Center. This letter confirms your appointment and provides valuable information for your visits with us. We are committed to providing you with the best possible medical care in a friendly atmosphere. Please do not hesitate to ask us any questions you may have. Your appointment is scheduled for _____ at _____ with _____.

Office Hours

Pain Management:

Manchester Office:

Monday	Tuesday	Wednesday	Thursday	Friday
7:00 – 5:30	7:00 – 5:30	Closed	7:00 – 5:30	7:00 – 5:30

Murfreesboro Office:

Monday	Tuesday	Wednesday	Thursday	Friday
8:00 – 5:00	8:00 – 5:00	8:00 – 5:00	8:00 – 5:00	8:00 – 5:00

Addiction Clinic: <u>Only open on Wednesdays and Saturdays in Manchester</u>

Emergencies: For life-threatening situations, call 911 or go to the nearest Emergency Room. If you have an urgent problem during working hours, please call our office at (931)728-5607 and a message will be given to a nurse. After hours, please leave a message on our answering machine. Your call will be returned on the next business day.

First Visit

Please come **30 minutes** <u>before</u> your appointment time and bring with you:

* Insurance card(s) – **It is your responsibility to inform our office of ANY insurance changes PRIOR to your visit.**
* Driver's license or photo I.D.
* ALL medicine bottles **(must have with you or appointment will be rescheduled)**
* **Completed** patient information and clinical history forms (included with this letter)
* Co-payment (if required by your plan)

Appointments

Please make any follow-up appointments as you leave.

* Call in advance to make or reschedule office visit appointments.
* As a courtesy to other patients and staff, please call the office as soon as possible if you are going to be late or are unable to keep your appointment.
* If you will be late, you will need to reschedule your appointment for the next available day and time.
* A $25.00 fee will be assessed for missed appointments which were not cancelled.
* Due to the large time allotment required, RFTC and RACZ appointments require 24 hours notice to cancel; otherwise, a $100.00 fee will be assessed.

Prescriptions

All prescriptions and refills should be obtained during your appointment. We do not call in refills. **Please bring all medications and bottles prescribed by us to your appointment or your appointment will be rescheduled.**

Financial Policy

* You are financially responsible for all charges incurred.
* Payment of any co-pays, deductibles and co-insurance is expected at time of service.
* We will file your insurance as a courtesy to you. Any remaining balance after 60 days will become your obligation.
* We accept: *Cash, Check, Visa, Mastercard, and Discover*
* Please see our "Policies and Procedures" for our complete financial policy.

Insurance

Prior to your appointment, please check your insurance information so you will be informed about referrals, co-payments, and any deductible required at the time of the visit. We accept Medicare as well as most other insurers.

* If your insurance requires a referral from your primary care physician, a written referral or authorization number must be in our office prior to your visit.
* Your health insurance contract is between you and your insurance company. Any concerns regarding your coverage or co-payments should be directed to your carrier.
* **It is your responsibility to inform our office of ANY insurance changes PRIOR to your visit.**

What We Need From You

* To arrive on time for scheduled appointments and cancel the appointment, when necessary, with a phone call.
* To inform the Medical Practice staff of any pertinent changes in insurance, demographic information, employment or other care/service givers.
* To notify the Medical Practice of any change in your health status.
* To follow the recommended treatment plan and inform the Medical Practice of any physical or mental impairment requiring special accommodations
* To ask questions if directions and procedures are not understood.
* To provide payment for services requested and delivered by the Medical Practice not covered by insurance within 90 days of date of service.

What You Should Expect From Us

* To be treated with respect and dignity.
* Professional, timely and appropriate services.
* To be informed of your care needs in order to make appropriate decisions.
* That teaching materials will be provided in a manner you can understand.
* To be informed of the Medical Practice billing process
* To have your records kept confidential except when consent has been given or to co-ordinate health care services for you.
* To communicate your complaints to the Medical Practice Manager and expect to receive follow-up without negative repercussions or changes in services.
* To receive care without discrimination due to race, religion, age, sex, disability or ethnic origin.

HIPAA Notice of Privacy Practices

Interventional Spine and Pain Center
2345 Murfreesboro Hwy, Manchester, TN 37355
905 South Church Street, Murfreesboro, TN 37130
931-728-5607 (office) 931-728-8354 (fax)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, ou Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry ou treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It als describes your rights to access and control your protected health information. "Protected Health Information" i information about you, including demographic information, that may identify you and that relates to your past, present o future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of ou office that are involved in your care and treatment for the purpose of providing health care services to you, to pay you health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healt care and any related services. This includes the coordination or management of your health care with a third party. Fo example, your protected health information may be provided to a physician to whom you have been referred to ensure tha the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. Fo example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed t the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support th business activities of your physician's practice. These activities include, but are not limited to, quality assessmen employee review, training of medical students, licensing, fundraising, and conducting or arranging for other busines activities. For example, we may disclose your protected health information to medical school students that see patients a our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name an indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. W may use or disclose your protected health information, as necessary, to contact you to remind you of your appointmen and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. I we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt ou of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. Thes situations include: as required by law, public health issues as required by law, communicable diseases, health oversigh abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funera directors, organ donation, research, criminal activity, military activity and national security, workers' compensatio inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your reques Under the law, we must also disclose your protected health information when required by the Secretary of the Departmen of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Diane Cothern, Practice Manager	931-728.5607	dcothern@manchesterpain.net
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

INTERVENTIONAL SPINE AND PAIN CENTER
Restoring Function...Improving Quality of Life

Patient Information Update

Name: _____ Date:_____

Date Of Birth: _____ SSN: _____

Current Address: _____

City, State, Zip: _____

How long at current address? ___ yrs ___ mos

Gender: M F Race: _____ Ethnicity: _____

Email address: _____@_____

Home: ( )_____Cell:( )_____ Alt: ( )_____

Emergency Contact:_____Phone:( )_____

Primary Care Physician: _____

Marital status: (circle one) Single Married Divorced Separated Widowed

Spouse's Name: _____Spouse's DOB: _____

Spouse's SS#: _____

Insurance Co. #1: _____ New? Y N

Insurance Co. #2: _____ New? Y N

ISPC - Assignment of Benefits

Primary Insurance:
I hereby assign payment of medical benefits due to me to be paid directly to:

James R. Nunley, D.O., P.C./Interventional Spine and Pain Center

and I authorize the release of any health information needed to determine these benefits or the benefits payable for related services to the insurance company/companies that I have supplied you with. I understand that filing my claims for services rendered is a service to me provided by Interventional Spine and Pain Center and this assignment does not relieve me of my primary obligation to pay my bill to: James R. Nunley, D.O., P.C./Interventional Spine and Pain Center.

I stand responsible for payment.

Signature _____ **Date** _____

Medicare (One-Time Authorization):

I request that payment of authorized Medicare benefits be made on my behalf to:

James R. Nunley, D.O., P.C./Interventional Spine and Pain Center

for any services furnished me by that provider. I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature _____ **Date** _____

MEDIGAP or any Secondary Insurance (Signature on File Statement):

Name of Beneficiary _____ HICN _____

Name of Medigap or Secondary Insurer _____ Policy Number _____

I request that payment of authorized benefits be made on my behalf to:

James R. Nunley, D.O., P.C./Interventional Spine and Pain Center

for any services furnished me by that provider. I authorize any holder of my personal medical information to release any information needed to determine these benefits payable for related services.

Signature _____ **Date** _____

Workers Compensation or Litigation:

I, _____ hereby authorize my attorney, _____ to withhold sufficient funds from any judgment, settlement, or recovery which I might have or effect in my pending action against _____ to pay any and all medical expenses due and owing to:

James R. Nunley, D.O., P.C./Interventional Spine and Pain Center

and I direct my attorney to pay that sum directly to **James R. Nunley, D.O., P.C./Interventional Spine and Pain Center.** I hereby assign to **James R. Nunley, D.O., P.C./Interventional Spine and Pain Center** to the extent of my outstanding medical expenses due and owing to him, all amounts received by attorney for my benefit. I understand that this assignment does not relieve me of the primary obligation to pay my bill to **James R. Nunley, D.O., P.C./Interventional Spine and Pain Center** and that if a recovery is not made or if the amount of the recovery is not sufficient to pay **James R. Nunley, D.O., P.C./Interventional Spine and Pain Center** in full, then they may proceed against me for payment.

Signature _____ _____
Date _____

Interventional Spine and Pain Center

Policies and Procedures

Thank you for choosing Interventional Spine and Pain Center for treatment of your pain. Our goal is to help you improve your quality of life and level of function. To accomplish this, it is imperative that you work with your physician and follow the treatment plan he designs for you. In our efforts to provide the highest level of medical care to our patients, it is important for you to be aware of the guidelines of our practice and to adhere to the policies set forth:

(Please read and initial beside each policy acknowledging your understanding.)

___ • **Information Updates:** Please keep us informed of any changes to your insurance, name, address, or telephone number.

___ • **Insurance Cards:** Please always bring all your current insurance cards. We are eager to help you receive your maximum allowable benefits but must have current information in order to do this.

___ • **Medications:** *Always* bring your medicine bottles with medicines (prescribed by us) to **every** appointment. I give permission to this office to download my medication history from my pharmacies into my electronic chart.

___ • **Medical Changes:** Make sure you report any tests or hospitalizations since your last appointment.

___ • **Co-Pays:** All co-pays are due and expected at the time of your appointment. We accept cash, check, or credit card.

• **Financial Policy:** As a service to you, we will gladly submit your claims to your insurance company. However, you are financially responsible for all charges. ∞ Along with your co-pay, we require payment for any expected deductible or co-insurance. ∞ If you do not have insurance, you are expected to pay in full at time of service. ∞ As the patient, though we may help, you are responsible to obtain any pre-cert, authorization, or referral necessary for your appointment. ∞ If your insurance denies your charges, you are responsible to call them for an explanation. We expect payment of all services within 60 days. This may require you to pay your account in full if your insurance company fails to pay. ∞ Payment options are available by speaking with our billing staff. ∞ There is a $25 charge for all checks returned to us for insufficient funds. ∞ Delinquent accounts of greater than 90 days will result in your discharge from this facility, up to 50% collection fee added to your account, and will be referred to our collection agency. It will also be reported to the credit bureau.

___ • **Appointment times:** All patients will be seen in order by appointment time. Please arrive on time. If you are *more than 15 minutes late* for an appointment you will be rescheduled.

• **Cancellations:** A fee will be charged for any and all missed appointments. Out of consideration for others in pain, *please give 24 hours' notice* if you cannot keep your appointment to allow the time to be used by another hurting patient. *If notice is not given, a $25 fee will be charged.* Multiple missed or cancelled appointments will be considered non-compliance and may result in discharge from the clinic. Due to the length of the reserved time slot, *if you miss an RFTC or RACZ appointment without giving 24-hour notice, a $100 fee will be charged.*

___ • **Treatment:** It is your obligation to tell your physician the truth about the nature and duration of your symptoms and medical history. You are also obligated to follow your physician's instructions concerning diet, medication, exercise, personal habits, and follow-up appointments.

• **Drug tests:** Random laboratory tests will be performed to make your medication regimen as safe as possible. By signing this form, you agree to submit to random blood or urine tests, as is required by your Medication Management Contract. You will be responsible for the charges incurred for these tests. Any Illegal substances (including marijuana, cocaine, etc.) or controlled substances not prescribed by this office detected in these tests may result in termination from this practice.

___ • **Prescription Refills:** All prescriptions *must* be obtained by appointment. *No refills or new prescriptions will be phoned in.*

• **Telephone calls:** All telephone calls will be returned within twenty-four hours. If your condition is such that you feel like you can't wait that length of time, please go to the nearest emergency room.

___ • **Medical Records Release:** Medical records will be released only with the patient's signed consent. There will be a charge for reproduction of medical records or completing FMLA or other papers. Requests will be completed within ten business days and payment is due at time of pickup. If records are to be mailed, payment must be made in advance.

• **PHI:** Interventional Spine and Pain Center uses and discloses patient health information to provide treatment, to obtain payment, and for health care operations, including administrative purposes. By signing below, you consent to such use and disclosure of your health information.

By signing below, I understand and agree to abide by the above office policies.

Signature: _____ Date: _____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that **I have received or have been given the opportunity to receive** a copy of **Interventional Spine and Pain Center's** Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name	Date of Birth
Patient Signature	Date

Interventional Spine and Pain Center
Clinical Laboratory Services Agreement

Interventional Spine and Pain Center is pleased to offer our in-house clinical laboratory services. Your medical provider has requested to perform testing on a specimen you provided. ISPC will conduct urine drug screens (UDS) per Palmetto CMS guidelines, which includes an initial screening and confirmation test (at the discretion of your provider). All laboratory services rendered by ISPC are charged to the patient. Our billing department will file a claim and send a statement to you (the patient) if the insurance carrier has determined a deductible, co-payment, and/or co-insurance amount applies. After a claim is filed you will see an E.O.B. (explanation of benefits) which is not a bill but will outline how much of your benefits were applied.

Medicare and Medicaid: ISPC is currently in network with both. However, we are only providing services to Medicare patients. Medicaid will only be billed as a secondary if a patient carries both. The patient is responsible for any deductible, co-payment, and/or co-insurance amount.

Third Party Insurance Carrier: ISPC is in network with many commercial insurance carriers. The patient is responsible for any deductible, co-payment, and/or co-insurance amount.

Secondary Insurance: if the patient has secondary insurance that supplements primary coverage, ISPC will file a claim with the secondary when provided with the necessary information.

Self-Pay Patients: The patient will be responsible for payment and will receive an invoice from our billing department. The front office staff will provide the self-pay prices for the testing, payment in full is due at the time of visit.

Statement Of Financial Responsibility:

A copy of this Statement of Financial Responsibility and any other billing policies and procedures will be provided to me upon request. I understand I am responsible for co-pays, deductibles, and/or co-insurance, as well as amounts not covered by insurance, litigation, or third-party liability. I am authorizing ISPC to submit claims and acknowledging that payment(s) of authorized insurance benefits or attorney settlements, including but not limited to Medicare, Medicaid, third-party insurance, other benefits and/or payments shall be made on my behalf to Interventional Spine and Pain Center for the services provided to me pursuant to a Laboratory Request, a copy of which will be provided to me upon request, and I will pay for amounts not covered by other sources, if applicable.

_____ _____

Patient Signature (or authorized representative) Date

_____

_____ Jason M. Herndon, M.D.

Printed Name ISPC Lab Director

INTERVENTIONAL SPINE AND PAIN CENTER
Restoring Function...Improving Quality of Life

Your Protected Health Information (PHI)

Please indicate who we may give your Protected Health Information (PHI) to.

Y N Spouse's Name _____

Y N Children's Name _____

Y N Other's Name _____

Y N Parent's Name (If patient is minor) _____

Messages: On your answering machine or voice mail, may we leave messages regarding:

Appointments?	Y	N
Billing?	Y	N
Other PHI?	Y	N

Emergency Contacts: Please list two people that DO NOT live with you and indicate if we may give them your Protected Health Information.

Y N Name: _____ Home Phone #_____

Relationship to patient: _____ Work Phone #_____

Y N Name: _____ Home Phone #_____

Relationship to patient: _____ Work Phone #_____

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

INTERVENTIONAL SPINE AND PAIN CENTER
Restoring Function...improving Quality of Life

CONSENT TO LEAVE VOICE & TEXT MESSAGES

I understand that my healthcare information is protected. I understand that, for Interventional Spine and Pain Center and its representatives to leave messages containing my specific health information on my voice mail, cell phone (text) or answering machine, I need to give permission to do so.

Check the appropriate response:

_____ I understand that leaving text and voice messages on mobile devices has risks that are not limited to: lost device/security; charges by carriers; information is not secured; hackers.

_____ I give my permission for voice and/or text messages to be left at the phone number(s) below:

Cell # _____ Email _____

Home #_____

_____ I grant permission for the following information to be left in a voice or text message at the phone numbers listed above (check all that apply):

Voice ____; Text ____ Health notifications (medication and/or test results)
Voice ____; Text ____ Appointment (reminders and/or changes)
Voice ____; Text ____ Announcements
Voice ____; Text ____ Billing (account balances, cost estimates and payment due)

_____ I understand that voice and text messages are not a substitute for professional or medical attention.

_____ I understand that texting is only for Interventional Spine and Pain Center to contact me and not for me to contact Interventional Spine and Pain Center (unless otherwise stated in the text message).

_____ I understand I may opt out of either, or both, voice and text messaging by notifying Interventional Spine and Pain Center at 931.728.5607.

_____ I do **NOT** give permission to Interventional Spine and Pain Center to leave messages for me.

_____ _____
Printed Name (Patient or POA) Date of Birth

_____ _____
Signature (Patient or POA) Date

New Patient Questionnaire

Please fill out the following questions prior to your appointment.

Current Height: _____ **Current Weight:** _____

Current Primary Care Provider: _____

Preferred Imaging Center: _____

Allergies: _____

_____

Medication List:

(please list all CURRENT medications, dosages, and directions)

_____

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_____

History of Present Illness

Please circle items in each section below that pertains to your current problem(s).

Hand Dominance: Right Left

Location of pain: low back, neck, shoulder, hip, elbow, hand, wrist, foot/ankle,
other: _____

Quality (Describe your pain): aching, burning, gnawing, stabbing, throbbing, sharp dull, occasional, frequent, worsening, improving, no change, other: _____

Severity of your pain: no pain, mild, moderate, severe, pain level ____/10, worst pain _____/10,
other:_____

Duration of your problem: Date of onset ____days, _____weeks, ____months, ___years

Timing of pain: cannot identify, acute, chronic, abrupt, gradual, morning, daytime, nighttime, recurrent, rare, occasional, intermittent

How did it happen: cannot identify, fall, bending, lifting, twisting, sports injury, work injury, car accident, assault, overuse, non-traumatic, laceration, other: _____

What makes things better: nothing helps, sitting, standing, lying down, position change, heat, ice, rest, elevation, exercise, stretching, limited weight bearing, PT/OT, chiropractor, epidural, OTC medications, pain medications, anti-inflammatories, steroid injection, brace, previous surgery, sling, other: _____

What makes things worse: cannot identify, sitting, standing, lying down, walking, lifting, carrying, twisting, pushing/pulling, gripping, grasping, squeezing, throwing, exercise, previous surgery, computer use, changing clothes, getting out of bed, going from sitting to standing, morning, daytime, nighttime, cold weather, damp weather, other: _____

Things associated with the pain: weakness, numbness, tingling, swelling, redness, warmth, bruising, catching/locking, popping/clicking, buckling, grinding, instability, radiation down arm/leg, radiation down leg, drainage, fever, chills, weight loss, changes in bowel or bladder habits,
other:_____

Previous Surgery for this condition: None
surgery: _____, date_____

Prior Imaging: none, nothing in past year, X-ray, MRI, CT scan, bone scan, EMG, other: _____

Previous injections: none, did not help, helped a little, helped temporarily, helped significantly

Previous PT: none, did not help, helped a little, helped temporarily, helped significantly

Worked related: No, Yes

Currently Working: No, regular duty, modified duty, light duty

Review of Systems

Please circle items in each section below that pertains to your current problems.

Psychological

Cognition: oriented to person, oriented to place, oriented to time, oriented to situation, disoriented, forgetful, impaired memory, distracted, disorganized, obsessive, preoccupied, flight of ideas, delusions, illusion, hallucinations, confused, restless, agitated, combative, labile, unintelligible speech, dementia,
other: _____

Mood and Affect: normal, happy, satisfied, euthymic, cooperative, uncooperative, exaggerated, energetic, euphoric, anxious, hysterical, dysphoric, depressed, tearful, poor coping, blunted, flat, apathetic, irritable, agitated, disruptive, hostile, angry, threatening, violent, guarded, suspicious, paranoid, regressed, poor in sight, hypochondriasis, other:_____

HEENT

Eyes: normal, facial pain, dry eyes, blurred vision, change in vision, tearing, corrective lenses,
other_____

Ears: normal, tinnitus, vertigo, hearing impairment, deaf, hearing aid(s),
other: _____

Nose: normal , congestion , other: _____ _____

Oral Cavity and Throat: normal, dry mouth , hoarse , snoring, obstructive sleep apnea, vocal tremor, change in taste, oral lesions, thrush, throat pain, dental loss, history of difficult intubation, dentures,
other: _____

Cardiac: normal, chest pain, dyspnea on exertion, orthopnea, dizziness, syncope, atrial fibrillation, atrial flutter, palpitations, murmur, claudication, other: _____

Pulmonary: normal, short of breath, cough, productive cough, wheezing, apnea, asthma, COPD,
other: _____

Gastrointestinal: GI normal, GERD, bloating, flatus, nausea, vomiting, constipation, diarrhea, abdominal pain, abdominal cramping, GI bleed, other: _____

Genitourinary: GU normal, frequency, dysuria, hematuria, difficult urination. Loss of bladder control, stress incontinence, flank pain, kidney stones, perineal pain, history of renal failure – acute or chronic,
other: _____

Musculoskeletal: normal, aching , stiffness , weakness , collapsing , cramps , spasms , contractures , rubbing, swelling, impaired coordination, difficulty walking, restless leg, stiff joints, joint swelling,
other: _____

Neurological

Sensory: normal , altered sensation of cold , altered sensation of heat, weakness, paresis, paralysis, flaccid, involuntary movement, seizures, blurred vision, headache, migraines, poor coordination,
other: _____

Quality: burning , tingling , numbness , twitching , stabbing , cutting , pins, and needles, dull, throbbing, deep squeezing, colic, other: _____

Endocrinology

Endocrine: normal, hot intolerance, cold intolerance, libido changes, fatigue, fluctuating body temperature, hot flashes, night sweats, hyperthyroidism, hypothyroidism, gout, other: _____

Heme/ID

Heme/ID: bruising, melena, hematemesis, fever, pneumonia, UTI, pyelonephritis, HIV, blood transfusion, chemotherapy, chest-x-ray, radiation treatment, other: _____

Skin: normal , photosensitivity , petechiae , jaundice , purple , Raynaud's disease , thin , glossy , fragile , brittle nails , change in hair growth , hair loss , pruritis , rash , b umps, redness, shingles, formication, other:_____

Nutrition

Diet: regular , low sodium , renal diet , liver diet , cardiac diet , low fat diet , soft diet , pureed , thickened liquid , liquid diet , TPN , feeding tube, other: _____

Appetite: normal, anorexia, other: _____

Weight: normal, weight loss____lbs., weight gain_____lbs., malnourished, underweight, overweigh, obese, other: _____

Dependence

Activities of Daily Living: independent with ADLs, unable to feed self independently, unable to ambulate independently, unable to bathe independently, unable to toilet independently, unable to groom independently, unable to dress independently, unable to shop independently, requires - minimal, moderate, total assistance with ADLs, other: _____

Activity: altered activity, baseline level of activity, other: _____

Family Support: social support, other: _____

Past Medical History

Anxiety	Yes | No	**Kidney Issues**	Yes | No
Aspirin Sensitivity	Yes | No	**Obesity**	Yes | No
Asthma	Yes | No	**Osteoarthritis**	Yes | No
Atrial Fibrillation	Yes | No	**Osteoporosis**	Yes | No
Bleeding Ulcers	Yes | No	**Psychiatric**	Yes | No
Blood Clot	Yes | No	**Rheumatoid Arthritis**	Yes | No
COPD/Emphysema	Yes | No	**Scoliosis**	Yes | No
Cancer	Yes | No	**Seizure Disorders**	Yes | No
Depression	Yes | No	**Stomach Reflux**	Yes | No
Diabetes	Yes | No	**Stomach Ulcers**	Yes | No
Headache	Yes | No	**Stroke**	Yes | No
Heart Disease	Yes | No	**Thyroid Issues**	Yes | No
High Blood Pressure	Yes | No	**Vascular Issues**	Yes | No
Insomnia	Yes | No		

Other: _____

Family Medical History (*Illnesses, Problems, etc.*)

Mother' History: _____

Father' History: _____

Sister(s)' History: _____

Brother(s)' History: _____

Social History

Activities of Daily Living

Are you blind or do you have difficulty seeing? Yes | No

Are you deaf or do you have serious difficulty hearing? Yes | No

Do you have difficulty concentrating, remembering or making decisions? Yes | No

Do you have difficulty walking or climbing stairs? Yes | No

Do you have difficulty dressing or bathing? Yes | No

Do you have difficulty doing errands alone? Yes | No

Do you have transportation? Yes | No

Education and Occupation

What is the highest grade or level of school you have completed or the highest degree you have received? (Enter grade completed) _____

Substance Use

Do you or have you ever smoked tobacco? Never | Former | Current

If yes, how many packs do you smoke a day? _____

Do you or have you ever used any other forms of tobacco or nicotine? Yes | No

How long have you smoked? _____

What is your level of alcohol consumption? None | Occasional | Moderate | Heavy

If yes, how many drinks do you have each day? _____

Have you ever been treated for alcoholism? Yes | No

Do you use any illicit or recreational drugs? Yes | No

Have you ever been treated for addiction? Yes | No

Have you ever had psychiatric, psychological, or social work treatments/evaluations for any diagnosis/problem, including your current pain? Yes | No

If yes, what diagnosis or problem were you treated for? _____

Have you ever considered suicide? Yes | No

Have you ever planned suicide? Yes | No

Have you ever attempted suicide? Yes | No

Marriage and Sexuality

What is your relationship status?

Unknown | Married | Single | Divorced | Separated | Widowed | Domestic - Partner

Diet and Exercise

What is your exercise level? Occasional | Moderate | Heavy

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____

Do you have an advance directive? Yes | No

Lifestyle

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)? Not at all | Only a little | To some extent | Rather Much | Very Much

Pain Management

Disabled since _____

Surgical History

List all procedures/surgeries and the dates.