

**NEW PATIENT INTAKE FORMS**

Welcome to our clinic. We pride ourselves on providing a caring, effective, and high quality medical care. Please help us by completing your intake packet and bringing the requested materials. We look forward to working with you in order to achieve your health goals.

Please prepare the following for your first appointment:

- Please bring your ID or Driver's License.
- Medicare or insurance card.
- Relevant Medical Records, XRAY, MRI.
- List of all Medications.
- List of all opioid Pain Medications.
- Bring the completed intake packet provided to you.
- Please be punctual as a courtesy to our other patients.

Thank you and we look forward to seeing you soon.

Sincerely,

Advanced Orthopedic Pain Management & Wellness Center Inc.



**PATIENT INFORMATION:**

Thank you for taking the time to fill out this confidential patient information form.

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
SS#: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lb  
Gender:  Female  Male  Other: \_\_\_\_\_ Advanced Directives:  Yes.  No  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Relation: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Who referred you to our practice? \_\_\_\_\_  
Who is your primary care doctor? \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary Insurance: \_\_\_\_\_ Policy: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Policy: \_\_\_\_\_  
Are you the Guarantor:  Yes  No. If not, Please fill out Guarantor Information below:  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
SS#: \_\_\_\_\_ Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_



COMMUNICATION CONSENT:

Email, Electronic Medical Record(EMR), Text(SMS), & Voicemail Correspondence Consent

**Please fill out this form to ensure you continue to receive appointment emails and text messaging.**

The federal communications commission now requires consent to receive automated emails and text messages. The health insurance portability and accountability act (HIPAA) also requires Advanced Orthopedic Pain Management & Wellness Center Inc. to take steps to protect your health information and only disclos information with your permission.

I understand that encrypted email, SMS (text) messaging and or voicemail messages are not a secure form of communication. There is risk that my protected health information and other sensitive or confidential information could potentially be misdirected, disclose, or intercepted by unauthorized third parties. I understand that Advanced Orthopedic Pain Management & Wellness Center Inc. will use a minimal necessary amount of personal health information when attempting to correspond with me, whether it is via email, texting, or voice messaging.

By signing this form, you are authorizing Advanced Orthopedic Pain Management & Wellness Center Inc. to use an automated system to periodically deliver automated messages containing information related to your healthcare with Advanced Orthopedic Pain Management & Wellness Center Inc., upcoming appointments, and other communication through email or unencrypted text messaging to the email address and phone number provided above. Standard message and data rates may apply. If you change your phone number or no longer want to receive automated email or text messaging, you agree to inform Advanced Orthopedic Pain Management & Wellness Center Inc. immediately. You agree that this consent will remain valid and you will continue to receive automated phone calls and or messages until you revoke this consent.

I hereby consent to my preferred communication method by checking one of the following boxes:

- Email- Appointment reminders and personal health information correspondence
- SMS (Text) messaging- Appointment reminders and personal health information correspondence
- Voice messaging- Appointment reminders and personal health information correspondence

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



TELEMEDICINE CONSENT:

Telemedicine involves the use of electronic and video communication to enable your medical provider to evaluate and manage your care. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient, identification and medical record. By signing below, I acknowledged the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me will be disclosed without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to request all information obtained and recorded in the course of telemedicine interaction.
4. I understand that a variety of alternative methods of medical care may be available to me and that I may choose one or more of these at any time. In the event of such request, my provider has explained the alternatives to my satisfaction.
5. I have read and understand the information provided above regarding telemedicine and have had the opportunity to discuss it with my provider to my satisfaction. All of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in the course of my medical care.

I hereby authorize Advanced Orthopedic Pain Management & Wellness Center Inc. to use telemedicine in the course of my diagnosis and treatment.

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

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STATEMENT OF PATIENT RIGHTS:

**Patients have the right to:**

- |   |
|---|
| ●Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;   |
| ●Receive treatment that supports and respects the patient's individuality, choices, strength, and abilities;  |
| ●Receive privacy in treatment and care for personal needs;  |
| ●Receive a referral to another healthcare institution if this facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient or recommended by the treating provider; |
| ●Participate or have patient's representative participate in the development of, or decision concerning treatment;  |
| ●Not to be subjected to retaliation for submitting a complaint;   |
| ●Participate or refuse to participate in research or experimental treatments;   |
| ●Not to be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, restraint;  |
| ●Be treated with dignity, respect, and consideration;   |
| ●Receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights;   |
| ●Not be subjected to misappropriation of personal and private property by any clinic personnel, member, employee, volunteer, or student;  |
| ●Consent to or refuse treatment, except in an emergency and to refuse or withdraw consent for treatment before treatment is initiated;  |
| ●Be informed of alternatives to medications or surgical procedure and associated risk risks and possible complications of medications or surgical procedures, except in an emergency;   |
| ●Being informed of the clinics policy on healthcare directives, and the patient complaint process;  |
| ●Consent to photographs before a patient is photographed, except that a patient may be photographed for identification and administrative purposes;   |
| ●Provide written consent to the release of information in the patient's medical record or financial records, except or otherwise permitted by law;  |

**Patients have the responsibility to:**

- Be honest about matters that relate to you as a patient.
- Provide staff with accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters pertaining to your health.
- Report any perceived risk in your care.
- Report any unexpected changes in your condition to those responsible for your care and welfare.
- Follow the care, service, or treatment plan developed.
- Ask questions when you do not understand or have concerns about your plan of care.
- Understand the consequences of the treatment alternatives and not following your plan of care.
- Know the staff who are caring for you.
- Be considerate and respectful of the rights of both fellow patients and staff.
- Honor the confidentiality and privacy of other patients.
- Be considerate of the property of Advanced Orthopedic Pain Management & Wellness Center Inc.
- Assure the financial obligations of your healthcare are fulfilled as promptly as possible.

Patient's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE & ACKNOWLEDGEMENT OF RECEIPT & UNDERSTANDING**

**Medical doctors are licensed and regulated by the**  
**medical board of California.**

To check up on a license or to file a complaint go to:



[www. mbc.ca.gov](http://www.mbc.ca.gov).

Email: [licensecheck@nbc.ca.gov](mailto:licensecheck@nbc.ca.gov)

Or call 1-800-633-2322

Patient's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



HIPPA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION:

Our Notice of Privacy Practices provides you information about how we may use and disclose protected health information. This form is for use when authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize Advanced Orthopedic Pain Management & Wellness Center employees and its agents to use or disclose the following health information:

- All my health information
- My health information for the following condition(s): \_\_\_\_\_
- I do not authorize disclosure of my health information

Advanced Orthopedic Pain Management & Wellness Center may disclose this health information to the following recipient(s), please include medical providers, family and friends:

Name/ Organization _____	Relationship: _____
Name/ Organization _____	Relationship: _____
Name/ Organization _____	Relationship: _____
Name/ Organization _____	Relationship: _____
Name/ Organization _____	Relationship: _____

**My Rights:**

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made. I may not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

**I also Consent to the specific release of other records pertaining to:**

Physical/Sexual/Drug/Alcohol/Substance Abuse, Psychiatric/Mental Health HIV, STD, Genetics

- I consent to have the above information released
- I DO NOT consent to have the above information released

Patient's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DISCLAIMER:** By typing your name above, you are signing this authorization electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document



## FINANCIAL POLICY:

By signing below, you acknowledge your understanding of and agreement to comply with the following financial policies. For the purposes of this policy, “AOPM” refers to Advanced Orthopedic Pain Management & Wellness Center Inc. as well as any other facility affiliated with it.

### Payment Policies:

1. AOPM will submit claims directly to your health insurance provider and will make every reasonable effort to ensure that your insurance plan covers all applicable amounts for your care.
2. All co-payments and fees for services not covered are required at the time of service. AOPM accepts payment by cash, check, debit, and credit card. If you provided a deposit at the beginning of your care, AOPM will apply these funds to your co-payments, deductibles, and co-insurance until the deposit is fully used.
3. AOPM will submit claims to your health insurance provider on your behalf and will make every reasonable effort to ensure that your insurance plan covers all amounts for your care as specified in your policy.
4. AOPM is committed to providing financial transparency by offering estimates of your anticipated out-of-pocket expenses at the outset of care. Please be advised that any payments made at the beginning of your treatment are considered a deposit towards services provided by AOPM . After your insurance carrier processes your claims, you may be responsible for additional amounts not collected initially. By signing below, you acknowledge and accept that you may receive a subsequent bill from AOPM for any outstanding out-of-pocket costs as determined by the terms of your insurance plan.
5. AOPM classifies accounts as Self-Pay under the following conditions: (1) the patient lacks health insurance coverage; (2) the patient's insurance plan is out-of-network for our providers; (3) there is no current, valid insurance card on file; or (4) a valid insurance referral is not available.
6. AOPM requests that you provide at least 24 hours’ advance notice to the office if you are unable to attend your scheduled appointment. By signing below, you acknowledge that failure to cancel an appointment with at least 24 hours’ notice will result in a fee of \$50 for each occurrence. These charges are your personal responsibility and will not be billed to your insurance provider. Patients who consistently miss appointments without proper notification may be discharged from the practice.



### Proof of Insurance

1. Patients are required to present their insurance card(s) and a valid photo identification at each appointment. It is the patient's responsibility to promptly inform AOPM of any changes to health insurance coverage. Should AOPM be unable to submit claims within your insurance carrier's filing deadlines due to delayed notification or lack of response to insurer inquiries, all associated charges will become the patient's responsibility. 2. In the event that your insurance carrier issues payment directly to you, it is your responsibility to promptly forward the received funds to AOPM.

### Referrals and Authorization:

1. AOPM maintains network agreements with many insurance carriers, though not all. It is the patient's responsibility to confirm with their insurance carrier that assigned providers are participants in their specific plan. Please note that your insurance plan may include out-of-network charges, which could result in higher deductibles and co-payments for which you will be responsible.
2. For patients with an HMO plan contracted with AOPM, a referral or authorization from your primary care physician is required prior to receiving care at our practice. If an insurance-mandated referral is not provided, your insurance company may deny payment for services rendered. Should we be unable to obtain the necessary referral before your scheduled appointment, your visit will either be rescheduled or you may be asked to provide payment in advance.
3. AOPM may offer services that are either excluded from your insurance carrier's plan or require prior authorization. If prior authorization is necessary, we will make every effort to obtain it on your behalf. However, it remains your responsibility to confirm that the services you receive are covered benefits and properly authorized by your insurance provider.

### Billing:

1. Should a statement be issued, the full balance is payable within 30 days from the date of the statement.
2. If your outstanding balance exceeds 120 days and payment arrangements have not been established or maintained, your account may be referred to a collection agency and/or attorney for further action. This could result in negative credit bureau reporting and possible legal proceedings. The Practice reserves the right to withhold treatment from patients whose balances remain unpaid for over 120 days.



By receiving our services, you consent to being contacted at any telephone number associated with your account, including mobile numbers, which may incur charges. We may also communicate with you via text message or by email, using any address you have provided.

3. Our goal is to ensure that patients do not experience financial hardship due to out-of-pocket healthcare expenses.

4. In the event of an overpayment on your account, a refund will be processed only if there are no remaining balances for medical services on your account or any other accounts associated with the same financially responsible party.

Additional Information:

1. Under the Privacy Rule, you are entitled to obtain a copy of your personal medical and billing records, and the Practice may request that individuals complete and sign an Authorization for Disclosure and Release of Medical Records Form.

2. By initialing this section, I confirm that I have received and reviewed, or have been afforded the opportunity to receive and review, the Practice's Notice of Privacy Practices, Statement of Patient Rights.

Agreement and Assignment of Benefits:

By affixing my signature below, I, the patient, hereby confirm my acknowledgment and agreement to the above provisions as well as to the following terms. I acknowledge that I have reviewed and understand the Financial Policy of Advanced Orthopedic Pain Management & Wellness Center Inc., and I agree to comply with its provisions. I further recognize that I am financially responsible for all services provided to me by Advanced Orthopedic Pain Management & Wellness Center Inc., including any charges not covered by my health insurance. I hereby irrevocably assign and transfer to Advanced Orthopedic Pain Management & Wellness Center Inc. (including all legal entities identified at the top of this Financial Policy) my rights as your designated authorized representative to receive any insurance benefits otherwise payable to me for services provided by Advanced Orthopedic Pain Management & Wellness Center Inc., regardless of their managed care network participation status. I authorize Advanced Orthopedic Pain Management & Wellness Center Inc. to: (1) access information regarding my insurance claims to the same extent that I am entitled; (2) submit supporting evidence; (3) present statements pertaining to facts or law; (4) make requests, including providing or receiving notice of appeal proceedings; and (5) participate in any administrative or judicial actions and pursue claims or legal actions against any responsible party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Advanced Orthopedic Pain Management & Wellness Center Inc. is permitted to initiate legal action against any such health care benefit plan, employee benefit plan, plan



administrator, or insurance company in my name with derivative standing, at its own expense. This assignment applies to all administrative and judicial reviews under applicable state or federal law. A copy of this assignment shall be deemed as valid as the original.

DISCLAIMER: By entering your name below, you provide your electronic signature for this policy. You acknowledge that your electronic signature holds the same legal validity as your handwritten signature on this document.

Patient's (Representative) Name : \_\_\_\_\_

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_



NOTICE OF PRIVACY PRACTICES:

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information.

**PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this notice, please contact the Privacy Officer at (949)642-0042.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information in a reasonable and appropriate manner. We create a record of the care and the services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by our Practice. This notice will tell you about the ways in which we may use and disclose medical information about you, your rights and certain obligations we have regarding the use and disclosure of medical information.

**We are required by law to:**

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and practices concerning medical information about you; and
- follow the terms of this notice that is currently in effect.

How We May Use and Disclose Medical Information About You.

The following describes the ways we may use and disclose health information that identifies you (“Health Information”). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our Privacy Officer.

- For Treatment. We can use your health information and share it with other professionals who are treating you.
- For Payment. We can use and share your health information to bill and get payment from health plans or other entities.
- For Health Care Operations. We can use and share your health information to run our practice, improve your care, and contact you when necessary.



- Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We can share and disclose Health Information to contact you to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
- Individuals Involved In Your Care or Payment for Your Care. When appropriate, we can share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend.
- Research. Under certain circumstances, we can share and disclose Health Information for research. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.
- As Required by Law. We can share and disclose Health Information about you when required to do so by federal, state or local laws.
- Right to Correct Your Medical Records. You can ask us to correct health information about you that you think is incorrect or incomplete. We may also say “no” to your request, but we will tell you why in writing within 60 days. To request an amendment, you must make your request, in writing, to our Privacy Officer.
- Right to an Account of Disclosures. You can ask us for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except those about treatment, payment and health care operations, and certain other disclosures. We will provide one accounting per year for free. There will be a reasonable, cost-based fee if you ask for another accounting within the 12 month period. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.
- Right to Limit Information We Share. You have the right to ask us not to use or share certain Health Information for treatment, payment, or health care operations. We are required to agree to your request, unless it would affect your care. If you pay for services out-of-pocket in full, for a specific item or service, you can ask that your Protected Health Information is not shared with your health insurer for the purposes of payment. We will say yes unless a law requires us to share that information.
- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing to our Privacy Officer. We will say yes to all reasonable requests.



- Right to a Paper Copy of This Notice. You have right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy, contact our Privacy Officer.
- Changes to this Notice. We reserve the right to change this notice and make a new notice that applies to the Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.
- Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office by contacting our Privacy Officer at (949)642-0042. The Secretary of Health and Human Services at [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). All complaints must be in writing. You will not be penalized for filing a complaint.

DISCLAIMER: By entering your name below, you provide your electronic signature for this policy. You acknowledge that your electronic signature holds the same legal validity as your handwritten signature on this document.

Patient's (Representative) Name : \_\_\_\_\_ Date: \_\_\_\_\_

Patient signature: \_\_\_\_\_



AUTHORIZATION FOR CREDIT CARD/HSA CARD ON FILE:

I, \_\_\_\_\_, authorize Advanced Orthopedic Pain Management & Wellness Center Inc.(AOPM), to charge my credit card/HSA card for any outstanding balances after applicable insurance reimbursements have been applied for medical services received at AOPM.

I also understand that this card on file will be ran for any no show fees, cancellation fees, or past due balances, as applicable, in accordance with the policies of AOPM. I understand that all copays are due at the time of service provided and my card will be charged accordingly.

Type of Card:  Mastercard  Visa  Discover  American Express

Full Name on Card: \_\_\_\_\_

Card Number: \_\_\_\_\_

CV Code (3 digits on back): \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notice: After insurance benefits are applied, if a balance remains, you will receive notifications before your card is charged.



GENERAL CONSENT AND AUTHORIZATION FOR TREATMENT,

EVALUATION & INFORMATION RELEASE:

**TO THE PATIENT:**

**You have the right, as a patient, to be informed about your condition and the recommended medical, physical therapy, diagnostic procedure, chiropractic care, and other modalities that may be used in your treatment so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks involved. At this point in your care, no specific treatment plan has been recommended, but Advanced Orthopedic Pain Management & Wellness Center Inc.'s healthcare providers will make recommendations for your care and treatment after evaluating your condition(s).**

This consent form gives Advanced Orthopedic Pain Management & Wellness Center Inc. (AOPM) permission to perform the evaluations necessary to identify the appropriate treatment and procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that

(1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and

(2) you consent to treatment at this office or any other AOPM office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your healthcare team about the purpose, potential risks and benefits of any treatment, procedure, or diagnostic test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

Alternative treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers



- Hospitalization

- Surgery

If you choose to use any of the above noted “alternative treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**For patients receiving medical treatments or procedures:** If interventional treatment is recommended, you will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

**Risks and Dangers of Remaining Untreated for All Patients:** If you choose not to move forward with care you acknowledge that any symptoms and diagnoses have the potential of getting worse.

### **Agreement and Consent**

1. I hereby certify that I have accurately and thoroughly completed the medical history forms provided by AOPM, to the best of my knowledge and ability.

2. I hereby voluntarily request that the healthcare providers at AOPM administer pain management care, treatment, physiotherapy services, and other related care as deemed reasonable and necessary. I give my consent for appropriate medical examinations, evaluations, testing, and treatments, which may include diagnostic, radiological, and laboratory procedures. I acknowledge that I may be asked to provide urine, oral swab, and/or blood samples. I understand that I have the right to refuse specific tests; however, I recognize that such refusal may affect my pain management treatment.

3. I hereby authorize the use and disclosure of my health information as outlined in the Notice of Privacy Practices provided to me. I permit AOPM physicians and their staff to obtain my medication history and other pertinent health care information—whether communicated verbally, in writing, or electronically—as necessary for the purpose of my treatment. I also consent to the release of my health information to federal or state health plans, insurance companies, collection agencies, employers, or other entities responsible for service payment, as deemed appropriate. This authorization may include information regarding my diagnosis, treatment, payment for services, or demographic data.

4. I acknowledge that I will refrain from any verbally or physically abusive conduct towards AOPM's providers or staff members. I understand and accept that, at AOPM's sole discretion, any behavior regarded as verbally abusive will result in an official warning. Should such behavior persist following the initial warning, AOPM reserves the right to discharge me as a patient. In instances of behavior



deemed physically abusive—as determined solely by AOPM— AOPM is authorized to immediately terminate my status as a patient. For the purposes of this agreement, “physically abusive” includes any actions that AOPM considers physically threatening or intimidating, even in the absence of physical contact with the provider or staff member involved.

5. Use of Clinical Documentation Technology

I acknowledge that this practice may use secure, computer-assisted documentation technologies, including artificial intelligence–assisted tools, to help generate and organize clinical notes and medical records. I understand that these tools are used solely to support documentation efficiency and do **not** replace the independent medical judgment of my physician or other licensed healthcare providers. All clinical documentation is reviewed, edited as necessary, and finalized by my healthcare provider. I understand that the use of such technology is subject to applicable privacy and security laws, including HIPAA. I consent to the use of these documentation tools as part of my medical care.

6. I hereby agree to the consents and releases outlined in this form. I have read this consent, or it has been read to me, and I have had the opportunity to ask questions.

7. I understand that this document will become part of my medical record.

DISCLAIMER: By entering your name below, you acknowledge and agree that your electronic signature will serve as the legal equivalent of your handwritten signature on this document.

Patient's (Representative) Name : \_\_\_\_\_

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

NEW PATIENT COMPLAINT HISTORY:

Date of Injury: \_\_\_\_\_ Injury location: \_\_\_\_\_

What is the reason for your evaluation? \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

When did this pain begin?    \_\_\_ Days    \_\_\_ Weeks    \_\_\_ Months    \_\_\_ Years

What caused your current pain or injury? \_\_\_\_\_

Was the pain or injury due to a work comp, car accident or personal injury?    Yes    No

Please mark pain severity from a scale of 0 through 10 (10/10 being most severe)

Pain Level: Please check box or circle.

Body Part 1: \_\_\_\_\_

Now:      1    2    3    4    5    6    7    8    9    10

Best:      1    2    3    4    5    6    7    8    9    10

Worst:     1    2    3    4    5    6    7    8    9    10



# ADVANCED ORTHOPEDIC PAIN MANAGEMENT & WELLNESS CENTER

Body Part 2: \_\_\_\_\_

Now:    1   2   3   4   5   6   7   8   9   10

Best:    1   2   3   4   5   6   7   8   9   10

Worst:   1   2   3   4   5   6   7   8   9   10

Body Part 3: \_\_\_\_\_

Now:    1   2   3   4   5   6   7   8   9   10

Best:    1   2   3   4   5   6   7   8   9   10

Worst:   1   2   3   4   5   6   7   8   9   10

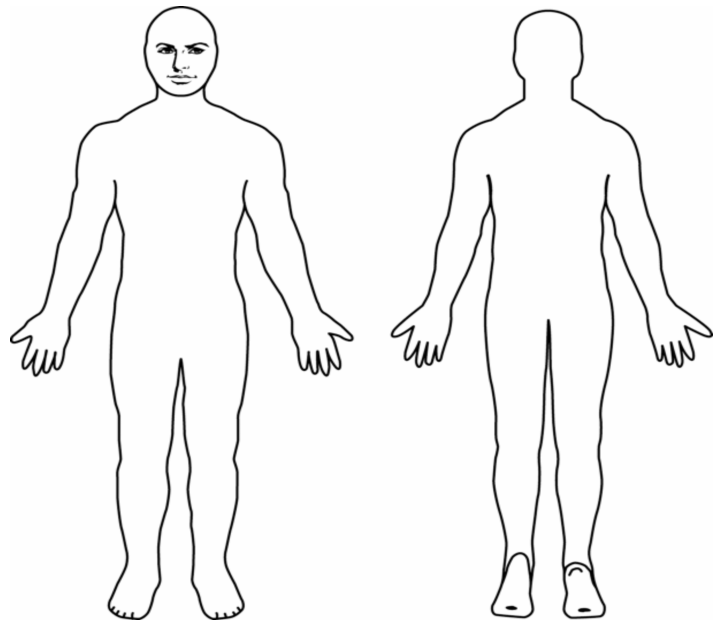
Please mark location of pain on the diagram.

Please offer details if you like:

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Where is your worst area of pain located? \_\_\_\_\_

Where else do you have pain? \_\_\_\_\_

Does the pain radiate?  Up  Down

If yes, from where to where? From: \_\_\_\_\_ To: \_\_\_\_\_

Is your pain:  Constant  Frequent  Intermittent  Occasional  Rare

How severe:  Severe  Moderate  Mild  Slight

Since your pain began, has your pain:  Increased  Decreased  Stayed the same

When is your pain at its worst?  Morning  During the day  Evenings  Middle of the Night

Check all that describe your pain today:

Aching  Cold  Cramping  Dull  Hot/Burning  Numb  Shock-Like

Shooting  Spasms  Squeezing  Stabbing  Sharp  Throbbing  Tingling

Arm or leg symptoms:  Numbness  Tingling  Weakness  Burning  Fatigue

Pain worse with: \_\_\_\_\_

Pain improved with: \_\_\_\_\_

Do you have significant back/buttock/leg pain with prolonged standing and/or prolonged walking that is relieved with sitting and/or lying down?  No  Yes

If yes to the above question, is your pain also alleviated with bending forward (using a shopping cart, leaning on kitchen counter, etc.)?  No  Yes

Does your pain affect your sleep?  No  Yes

If yes, How?  Fall asleep  Stay asleep  Early awakening  Fatigue

Are you?  Depressed  Anxious  Suicidal thoughts  Suicidal Plans  Hopeless

Other: \_\_\_\_\_

**FACTORS THAT AFFECT YOUR PAIN**

	Increased Pain	Decreased Pain	No Change in Pain
Bending backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending sideways	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting to the side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking downward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn head side to side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tilt head side to side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough or sneeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deskwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ACTIVITY LEVEL**

How many days per week do you exercise? \_\_\_\_\_

Type of exercise: \_\_\_\_\_

How many minutes do you exercise per week? \_\_\_\_\_

Have you had any falls in the last 12 months?      No      Yes

If yes, how many falls? \_\_\_\_\_ and when? \_\_\_\_\_

Does your pain interfere with any of the following?

- Work      School      Home Duties      Daily Living      Exercise      Hobbies

**IMAGING & DIAGNOSTIC TESTS**

Please list relevant imaging you have undergone related to your pain complaints:

IMAGING TYPE	DATE	FACILITY
MRI	_____	_____
X-RAY	_____	_____
CT	_____	_____
NCV/EMG	_____	_____

**PAIN TREATMENT HISTORY**

**PAIN TREATMENTS:**

Have you had previous treatment for this complaint?  No       Yes

Treatment	Number of Weeks	When did you undergo this therapy?	No Relief	Minimal Relief	Moderate Relief	Excellent Relief
Chiropractic	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat/Ice	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bracing	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aquatic PT	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



# ADVANCED ORTHOPEDIC PAIN MANAGEMENT & WELLNESS CENTER

**INJECTIONS:**

Have you had any INJECTIONS for this complaint?    YES    NO

Injection type	Dates	% Relief	Duration

Other details regarding past procedures:

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Revised Oswestry Pain Disability Questionnaire

Please Read: This questionnaire has been designed to give your doctor/therapist information as to how your pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the one box that best describes your condition today. We realize you may feel that two of the statements in any one section can relate to you, but please just mark the box which most closely describes your current condition.

<p>Section 1– Pain intensity.</p> <p><input type="checkbox"/> I can tolerate the pain I have without having to use pain medication.</p> <p><input type="checkbox"/> The pain is bad, but I manage without having to take pain medication.</p> <p><input type="checkbox"/> Pain medication provides me complete relief and pain.</p> <p><input type="checkbox"/> Pain medication provides me with moderate relief from pain.</p> <p><input type="checkbox"/> Pain medication provides me with little relief from pain.</p> <p><input type="checkbox"/> Pain medication has no effect on the pain.</p>	<p>Section 4– Walking.</p> <p><input type="checkbox"/> Pain does not prevent me from walking any distance.</p> <p><input type="checkbox"/> Pain prevents me from walking more than 1 mile.</p> <p><input type="checkbox"/> Pain prevents me walking more than a 1/2 mile.</p> <p><input type="checkbox"/> Pain prevents me from walking more than 1/4 mile.</p> <p><input type="checkbox"/> I can only walk using crutches or a cane.</p> <p><input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.</p>
<p>Section 2– Personal Care(washing, Dressing, Etc.)</p> <p><input type="checkbox"/> I can take care of myself normally without causing increased pain.</p> <p><input type="checkbox"/> I can take care of myself normally, but it increases my pain</p> <p><input type="checkbox"/> it is painful to take care of myself and I am slow and careful.</p> <p><input type="checkbox"/> I need help, but I can manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of my care.</p> <p><input type="checkbox"/> I do not get dressed, Wash with difficulty, and stay in bed</p>	<p>Section 5 – Sitting</p> <p><input type="checkbox"/> I can sit in any chair as long as I like.</p> <p><input type="checkbox"/> I can only sit in my favorite chair as long as I like.</p> <p><input type="checkbox"/> Pain prevents me sitting more than 1 hour.</p> <p><input type="checkbox"/> Pain prevents me from sitting for more than a ½ hour.</p> <p><input type="checkbox"/> Pain prevents me from sitting for more than 10 minutes.</p> <p><input type="checkbox"/> Pain prevents me from sitting at all.</p>
<p>Section 3– Lifting.</p> <p><input type="checkbox"/> I can lift heavy weights without increasing pain.</p> <p><input type="checkbox"/> I can lift heavy weights, but it causes Increased pain.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage If weights are conveniently positioned, e.g. on a table.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights If they are conveniently positioned.</p> <p><input type="checkbox"/> I can only lift very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p>Section 6– Standing.</p> <p><input type="checkbox"/> I can stand as long as I want without Increased pain.</p> <p><input type="checkbox"/> I can stand as long as I want, but It increases my pain.</p> <p><input type="checkbox"/> pain prevents me from standing for more than one hour.</p> <p><input type="checkbox"/> Pain prevents me from standing for more than a half hour.</p> <p><input type="checkbox"/> Pain prevents me from standing for more than 10 minutes.</p> <p><input type="checkbox"/> Pain prevents me from standing at all.</p>

<p>Section 7– Sleeping.</p> <p><input type="checkbox"/> Pain does not prevent me from sleeping well.</p> <p><input type="checkbox"/> I can sleep well only by using pain medication.</p> <p><input type="checkbox"/> Even when I take pain medication, I sleep less than six hours.</p> <p><input type="checkbox"/> Even when I take pain medication, I sleep less than four hours.</p> <p><input type="checkbox"/> Even when I take pain medication, I sleep less than two hours.</p> <p><input type="checkbox"/> Pain prevents me from sleeping at all.</p>	<p>Section 9– Travel.</p> <p><input type="checkbox"/> I can travel anywhere without increased pain.</p> <p><input type="checkbox"/> I can travel anywhere but it increases my pain.</p> <p><input type="checkbox"/> Pain restricts travel over 2 hours.</p> <p><input type="checkbox"/> Pain restricts travel to one hour.</p> <p><input type="checkbox"/> Pain restricts my travel to short necessary journeys under half an hour.</p> <p><input type="checkbox"/> Pain prevents all travel except visits to the doctor/therapist or hospital.</p>
<p>Section 8– Social Life.</p> <p><input type="checkbox"/> My social life is normal and does not increase my pain.</p> <p><input type="checkbox"/> My social life is normal, but it increases my level of pain.</p> <p><input type="checkbox"/> My pain prevents more energetic activity, such as sports, dancing, etc.</p> <p><input type="checkbox"/> Pain prevents me from going out very often.</p> <p><input type="checkbox"/> Pain has restricted my social life to my home.</p> <p><input type="checkbox"/> I have hardly any social life because of my pain.</p>	<p>Section 10–. Employment &amp; Homemaking.</p> <p><input type="checkbox"/> Homemaking and job activities do not cause pain.</p> <p><input type="checkbox"/> My normal homemaking/job activities increased my pain, but I can still perform all that is required of me.</p> <p><input type="checkbox"/> I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities ( i.e lifting, vacuuming.)</p> <p><input type="checkbox"/> Pain prevents me from doing anything but light duties.</p> <p><input type="checkbox"/> Pain prevents me from performing any job or homemaking duties.</p>
<p>For office use:            Score: _____</p>	

Physician Notes:

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**CURRENT MEDICATIONS:**

Are you taking a prescribed blood-thinner or anti-coagulant? If so, which one?

Aspirin   Plavix.   Eliquis   Coumadin   Xarelto   Pradaxa

Other: \_\_\_\_\_

Name/phone of the doctor that prescribes your blood thinner: \_\_\_\_\_

Please list ALL medications you are currently taking including OTC medications, ibuprofen, aspirin, supplements, and fish oil.

Drug Name	Dose	How often	How Long have you taken this drug?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Attach additional sheet if necessary.

**ALLERGIES:**

Medication that I am allergic to:	The allergic reaction is:

Are you allergic to any of the following?

Iodine:  No     Yes     
 Shellfish:  No     Yes     
 Imaging contrast:  No     Yes  
 Local anesthetic  No     Yes     
 Tape:  No     Yes     
 Latex:  No     Yes

**I HAVE NO KNOWN ALLERGIES**



# ADVANCED ORTHOPEDIC

## PAIN MANAGEMENT & WELLNESS CENTER

**PAIN MEDICATIONS:**

Have you taken any MEDICATIONS for this complaint?    No    Yes

Medication Name	Active	Stopped	No Relief	Minimal Relief	Moderate Relief	Excellent Relief
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PAST MEDICAL PROBLEMS: (Please mark all that apply)**

<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Lung disease
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Elevated lipids	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> COPD/Bronchitis
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Clotting disorder	<input type="checkbox"/> Autoimmune disease
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Diabetes / Prediabetes	<input type="checkbox"/> Obesity	<input type="checkbox"/> Spine disease
<input type="checkbox"/> Rheumatological	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Opioid use history
<input type="checkbox"/> Stroke	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Headache	<input type="checkbox"/> PTSD
<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression / Anxiety	<input type="checkbox"/> Addiction/Drug abuse	<input type="checkbox"/> Bipolar disorder
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Chronic steroid use	<input type="checkbox"/> Fractures	<input type="checkbox"/> Toxic exposure
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Radiation therapy	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Peripheral vascular dz.

Other Past Medical History: \_\_\_\_\_

I HAVE NO SIGNIFICANT MEDICAL HISTORY

**PAST SURGICAL HISTORY: (Please mark all that apply)**

Surgery/Procedure	Date	Physician name/Institution

I HAVE NO SIGNIFICANT SURGICAL HISTORY

**PAST FAMILY HISTORY: (Please mark all that apply)**

<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Headache	<input type="checkbox"/> Seizures
<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lung disease

Other family history: \_\_\_\_\_

I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY

**SOCIAL HISTORY:**

1. Living Situation & Support

Marital status:  Single  Married  Partnered  Divorced  Widowed

Who do you live with:  Alone  Spouse  Family  Caregiver  Other: \_\_\_\_\_

Dependents at home (ages): \_\_\_\_\_

Adequate support at home:  Yes.  No

2. Employment & Daily Function

Employment status:  Full-time  Part-time  Retired  Disabled  Unemployed

Job title: \_\_\_\_\_

Physical demands:  Sedentary  Light  Moderate  Heavy

Work-related condition:  Yes  No      Disability or modified duty:  Yes  No

Limits daily activities:  Yes  No

3. Tobacco / Nicotine Use:

Current use:  Yes  No      Type: Cigarettes  Cigars  Pipe  Vaping / Smokeless tobacco

Amount per day: \_\_\_\_\_ Years used: \_\_\_\_\_      Quit year (if former smoker): \_\_\_\_\_

4. Alcohol Use:

Do you drink alcohol:  Yes  No      Frequency:  Daily  Weekly  Occasionally

Average drinks per week: \_\_\_\_\_

History of alcohol-related problems or treatment:  Yes  No

Please detail: \_\_\_\_\_

5. Caffeine & Supplements:

Caffeine per day:  None  1  2  3  4  5  6

6. Recreational or Non-Prescribed Drug Use:

Current use:  Yes  No

Past use:  Yes  No

Substances:  Marijuana  Non-prescribed opioids  Cocaine  Meth  Hallucinogens

Benzodiazepines  Fentanyl  Other: \_\_\_\_\_

Last use: \_\_\_\_\_ History of substance use treatment:  Yes  No

7. Diet & Nutrition General diet:

Balanced  Vegetarian  High-protein  Other: \_\_\_\_\_

Recent unintentional weight change:  Yes  No  Difficulty accessing food:  Yes  No

8. Sleep:

Average hours per night: \_\_\_\_\_ Sleep quality:  Good  Fair  Poor

Pain disrupts sleep:  Yes  No

Sleep disorder diagnosis (e.g., sleep apnea):  Yes  No      CPAP use:  Yes  No

9 Stress & Emotional Health:

Stress level:  Low  Moderate  High      Anxiety or depression:  Yes  No

Receiving mental health care: :  Yes  No

10. Safety & Lifestyle:

Falls in past year: :  Yes  No

Do you feel safe at home: :  Yes  No

**REVIEW OF SYSTEMS:**

Please complete all sections as accurately as possible. This information helps your provider deliver safe and effective care.

<p><b>Constitutional:</b></p> <p><input type="checkbox"/> Fever  <input type="checkbox"/> Chills  <input type="checkbox"/> Fatigue  <input type="checkbox"/> Night sweats  <input type="checkbox"/> Weight loss/gain  <input type="checkbox"/> Difficulty sleeping</p>	<p><b>Eyes:</b></p> <p><input type="checkbox"/> Vision loss  <input type="checkbox"/> Vision changes  <input type="checkbox"/> Blurry vision  <input type="checkbox"/> Double vision  <input type="checkbox"/> Itchy eyes  <input type="checkbox"/> Eye pain</p>	<p><b>Cardiovascular:</b></p> <p><input type="checkbox"/> Chest pain  <input type="checkbox"/> Palpitations  <input type="checkbox"/> Fainting  <input type="checkbox"/> Irregular heartbeat  <input type="checkbox"/> Hypertension  <input type="checkbox"/> Short of breath</p>	<p><b>Ear/Nose/Throat:</b></p> <p><input type="checkbox"/> Hearing loss  <input type="checkbox"/> Ringing in ear  <input type="checkbox"/> Dizziness / Vertigo  <input type="checkbox"/> Sinus pain  <input type="checkbox"/> Sore throat  <input type="checkbox"/> Difficulty swallow  <input type="checkbox"/> Balance problems</p>
<p><b>Respiratory:</b></p> <p><input type="checkbox"/> Shortness of breath  <input type="checkbox"/> shallow breathing  <input type="checkbox"/> Wheezing  <input type="checkbox"/> Coughing  <input type="checkbox"/> painful breathing  <input type="checkbox"/> Blood in sputum  <input type="checkbox"/> Thick sputum</p>	<p><b>Gastrointestinal:</b></p> <p><input type="checkbox"/> Abdominal pain  <input type="checkbox"/> Nausea  <input type="checkbox"/> Vomiting  <input type="checkbox"/> Heartburn / reflux  <input type="checkbox"/> Constipation  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Bowel incontinence</p>	<p><b>Genitourinary:</b></p> <p><input type="checkbox"/> Difficulty urinating  <input type="checkbox"/> Urinary urgency  <input type="checkbox"/> Urinary frequency  <input type="checkbox"/> Urinary retention  <input type="checkbox"/> Urinary incontinence  <input type="checkbox"/> Pelvic pain</p>	<p><b>Neurological:</b></p> <p><input type="checkbox"/> Headaches  <input type="checkbox"/> Radiating pain  <input type="checkbox"/> Numbness, Tingling  <input type="checkbox"/> Memory loss  <input type="checkbox"/> Electric sensations  <input type="checkbox"/> Loss of sensation  <input type="checkbox"/> Balance problems  <input type="checkbox"/> Tremors <input type="checkbox"/> Seizures</p>

<b>Musculoskeletal:</b> <input type="checkbox"/> Spine pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint swelling <input type="checkbox"/> Decreased mobility <input type="checkbox"/> Weakness <input type="checkbox"/> Falls	<b>Psychiatric:</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Mood disorders <input type="checkbox"/> Focus difficulties <input type="checkbox"/> Suicidal thoughts/plan	<b>Hematological:</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Transfusions <input type="checkbox"/> Swollen lymph <input type="checkbox"/> Bleed tendencies <input type="checkbox"/> Easy bruising	<b>Endocrine:</b> <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Pain at night <input type="checkbox"/> Low energy <input type="checkbox"/> excessive sweating
<b>Skin &amp; Breast</b> <input type="checkbox"/> Discoloration <input type="checkbox"/> Nodules <input type="checkbox"/> Hair loss <input type="checkbox"/> Skin infections <input type="checkbox"/> Skin Breakdown <input type="checkbox"/> Rash or Hives	<b>Allergy &amp; Immunology:</b> <input type="checkbox"/> Sneezing <input type="checkbox"/> Itching <input type="checkbox"/> Infections <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Allergy to Medication <input type="checkbox"/> Seasonal allergies	<b>Sleep:</b> <input type="checkbox"/> Difficulty fall asleep <input type="checkbox"/> Difficulty stay asleep <input type="checkbox"/> Non-restorative sleep <input type="checkbox"/> Pain interrupts sleep <input type="checkbox"/> Snoring / sleep apnea	<b>Pain:</b> <input type="checkbox"/> Pain during activity <input type="checkbox"/> Pain relieved by rest <input type="checkbox"/> Morning stiffness <input type="checkbox"/> Pain at night <input type="checkbox"/> Weather-related pain <input type="checkbox"/> Sensitivity to touch

PATIENT CARE TEAM

:

Please fill out any of the following information for the doctors that you currently see.

Please print legibly. If you do not see any of them, please leave blank.

Blood Thinners and/or Aspirin: \_\_\_\_\_

Provider who prescribes the above medications: \_\_\_\_\_

PCP Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Cardiologist Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_



Vascular Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Pulmonologist Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Infectious Disease Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Endocrinology Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Hematology Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Oncology Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

GI Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Nephrologist Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

General Surgeon Provider/Clinic Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_