Pain & Wellness Centers
of Southern California

801 North Tustin Ave, Suite 507
Santa Ana, CA 92705
P: (949) 566-8688 F: (949) 566-8656

James A. Kim, M.D.
Medical Director
www.pain-wellness.com

Dear Patient,

Welcome to Pain & Wellness Centers of Southern California (PWCSC). To help you with your care efficiently, please complete the enclosed paperwork to the best of your knowledge. Similar documents may need to be completed on an annual basis. You may fax, e-mail or bring this packet with you to your appointment along with your insurance card(s) and a photo ID. If you have had an MRI, CT scan or X-ray please bring in the radiology report and/or CD provided to you by the diagnostic imaging facility.

Please be advised that we may not prescribe any medications at the first visit. If you are currently prescribed medication(s) by another physician, please notify their office that they will need to provide you with medications for up to two to four weeks after your initial consult with us. Medications are prescribed on an as needed basis based on your diagnostic findings and the seriousness of your diagnosis. Opiate pain medications will not be continued or prescribed solely on the reason that you are running out and need refills. The physician and/or provider will make a decision on whether such medications are appropriate or not and will not simply continue your medications because that is what you have been taking for a while. Due to the opiate crisis, these medications are under scrutiny and thus we are limited to prescribing them for chronic pain syndromes. Unless you have cancer or for short term acute post-surgical pain, minimum doses will be considered.

If you are scheduled for a procedure, please arrange for a driver to bring you to and from the appointment unless other arrangements have been discussed. If you are scheduled to take Valium for your procedure, please pick up the medication at your pharmacy the day before your appointment. Do NOT drive yourself while on controlled substances. Please take one Valium 30 minutes prior to your scheduled procedure time.

If you have any questions or concerns, please call our office at 949-566-8688 or visit our website at *pain-wellness.com* by scanning the QR code.

Thank you,
Pain & Wellness Centers of Southern California

PAIN & WELLNESS CENTERS
OF SOUTHERN CALIFORNIA

Patient Information

Today's Date: _____ Date(s) of Injury: _____
First Name: _____ Last Name: _____
Other Names/Maiden Name: _____
Social Security #: _____ Date of Birth: _____ Sex: ☐M ☐F ☐Other
Home Address: _____ City: _____ State: _____ Zip: _____
☐ Home #: _____ ☐ Work #: _____
☐ Cellular #: _____ ☐ Email: _____
(✓ preferred method of communication above)

Preferred Language (if not English): _____ Require Interpreter: ☐ Yes ☐No
Marital Status: _____ Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic ☐ Decline to answer
Current Employment/Job Title: _____ Current Employer: _____
Patient's Employer: _____ Employer's Phone #: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

Pharmacy Name: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____

Referral Source: How did you hear about us? _____
Referring Physician: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____

Primary Insurance Company: _____ Phone #: _____
ID Group #: _____ Group Name: _____
Secondary Insurance Company: _____
ID Group #: _____ Group Name: _____

If insurance is under another person, please complete section below.
Policy Holder First Name: _____ Last Name: _____
Date of Birth: _____ Social Security #: _____
Policy Holder's Employer: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____
_____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____

PAIN & WELLNESS CENTERS
OF SOUTHERN CALIFORNIA

Patient Information (continued)

If Worker's Compensation, please complete the section below.
Injury(s)/Body Part(s) you are being treated for: _____
Primary Treating Physician: _____
Phone #: _____ Fax #: _____
Insurance Company Name: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Claim #: _____ Employer (at time of injury): _____
Attorney Name: _____
Phone #: _____ Fax #: _____
Adjuster Name: _____
Phone #: _____ Fax #: _____
Nurse Care Manager: _____
Phone #: _____ Fax #: _____

☐ Cash patient (please mark box)

EMERGENCY CONTACT/RELEASE OF INFORMATION

Please designate an emergency contact and list the names below of anyone who may need to speak to us regarding your health information (eg. appointments, treatment plans, etc). Please also include anyone who may pick up prescriptions on your behalf.

Emergency Contact Name:_____ Relationship:_____
Phone #: _____ Alternate #: _____

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

PAIN & WELLNESS CENTERS
OF SOUTHERN CALIFORNIA

Financial Policy & Disclosures

The physicians, providers and staff of Pain & Wellness Centers of Southern California (PWCSC) are dedicated to providing you with the best medical care and service, and we aspire your understanding of our financial policies as a vital component of your care and treatment. Please read the following Financial Policy and sign. If you have any questions or concerns, please ask our staff.

INSURANCE

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

COPAYS

Copays must be paid at time of service. Please come prepared to pay the specialist copay at each visitor you may not be seen. We accept cash, check and all major credit cards.

DEDUCTIBLES and COINSURANCES

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

REFERRALS

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

MEDICARE

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

MOTOR VEHICLE ACCIDENT

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

WORKERS COMPENSATION

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

LATE CANCELLATION/NO SHOW FEES

We require 24 hours notice for cancelling an appointment. If you do not give adequate notice or fail to show for your appointment, we reserve the right to charge a $50.00 fee for a missed appointment and $100.00 for a missed procedure. The fee must be paid prior to rescheduling the missed appointment.

DISABILITY/DMV & OTHER FORMS

Our goal is to restore you to your highest level of function. When necessary, we can assist you with completion of certain forms in a timely manner. Our requirements of forms are as follows:
There will be a charge that must be paid ***prior*** to completion of the forms. The charge usually ranges from $30-$50 but can be more due to complexity. Ten working days will be required for the completion of the form/letter. The completion of some forms may require an office visit if additional assessment is required. We reserve the right to refuse to complete a form if it requests information that we do not have as part of your treatment with us. Disability forms and other complex forms may not be filled out until we have an established relationship with you for at least 6 months.

RETURNED CHECKS

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

PAST DUE ACCOUNTS

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

Acknowledgement of HIPAA Privacy Notice

By signing below, I acknowledge that I have reviewed the "*Notice of Privacy Practices,"* which sets forth the privacy practices of PWCSC and my rights regarding privacy of my protected health information. A copy may be obtained from the office upon request.

Audio/Video Acknowledgement

In order to better enable us to assure compliance with HIPAA privacy and security laws and regulations, and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited. We reserve the right to terminate any patient as permitted under State law if the patient or anyone accompanying the patient is found to be in violation of this policy. We appreciate your understanding and cooperation.

Please be advised, that terms may change at any time. By signing below, I acknowledge that I have read, understood and agree to the Financial Policy and Disclosures of PWCSC.

Patient Signature _____ Date _____

Print Name _____ Date of Birth _____

PAIN & WELLNESS CENTERS
OF SOUTHERN CALIFORNIA

Consent for Treatment and Release of Information and Payment Authorization

MEDICARE PATIENTS ONLY
I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize and request that payments of authorized Medicare benefits be made directly to *Pain & Wellness Centers of Southern California (PWCSC)*, or its representative, for all services rendered.

ALL OTHER INSURANCE COMPANIES AND/OR THIRD PARTY PAYERS
I hereby authorize *PWCSC* and/or its representative to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s). I authorize and direct my insurance carrier or its intermediaries to issue payment directly to *PWCSC*, or its representative. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered. I authorize the use of this signature on all insurance submissions.

GUARANTEE OF PAYMENT
I understand that filing a claim with my insurance company or other third party payer, under any circumstance, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by *PWCSC*, to me or the patient as indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to, claims filed for Workers' Compensation and/or claims due to personal injury.

PHARMACY AND PRESCRIPTION INFORMATION
I give permission *PWCSC* to access my pharmacy benefits data electronically through SureScripts health information network. This consent will enable *PWCSC* to determine the pharmacy benefits and drug co pays for my health plan, check whether a prescribed medication is covered (in formulary) under my plan, display therapeutic alternatives with preference rank (if available) within a drug class for medications, determine if my health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, and download a historic list of all medications prescribed for me by any provider. Formulary information, and information about prescriptions prescribed by other providers may be obtained using SureScripts.

I hereby authorize the staff to perform any necessary services needed during diagnosis and treatment of the diseases and/or conditions for which I have consulted this practice. I understand that a 48-hour notice of cancellation is required. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Patient Signature _____ Date _____

Print Name _____ Date of Birth _____

If other than patient,
Responsible Party Signature _____ Date _____

Print Name _____ Relationship to Patient _____

PAIN & WELLNESS CENTERS
OF SOUTHERN CALIFORNIA

Authorization to Release Medical Records/Information

Patient Name _____ Date of Birth _____

I authorize and request the below named institution or treating practitioner to provide medical and/or psychological records pertaining to my medical history, mental or physical condition, services rendered, or treatment provided during the period from initial visit to present.

Name _____

Address _____

City _____ State _____ Zip _____

Fax _____

Please send or fax all records to:

Pain & Wellness Centers of Southern California
801 North Tustin Ave, Suite 507
Santa Ana, CA 92705
Fax: (949) 566-8656

I agree that a photocopy or facsimile of this authorization is as valid as the original.

This authorization is valid for one (1) year from the date of the signature. I understand that I may revoke this authorization at any time by notifying Pain & Wellness Centers of Southern California in writing at the address listed above. I further understand that any such revocation does not apply to information already released in response to this authorization.

I have read and understand this information. I may receive a copy of this form if requested. I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the about stated terms.

Patient Signature_____ Date_____

_____ _____ _____

Signature of Legal Guardian/Representative/Witness Print Name Relationship to Patient

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Controlled Substance Agreement

The purpose of this agreement between Pain & Wellness Centers of Southern California (the provider) and you (the patient) is to make sure you understand the risks of taking controlled substances, including narcotics (opiates) and other schedule II, III and IV medications. These risks include adverse effects like constipation, nausea and vomiting, liver damage, end organ damage due to hypoxia, death and have a high potential for misuse/abuse. Medications can be helpful if taken the correct way and as prescribed. They are prescribed with intention of relieving pain specifically to improve function and/or ability to work and improve quality of life. It is unrealistic, however, to expect your medications to relieve all of your pain. The decision to start or continue controlled substance medications (opiates or pain medications) is made if your provider decides that your condition(s) are serious and/or other non-opiate treatments have not helped control your pain (i.e. NSAIDS, muscle relaxants, etc.). Due to my pain management physician prescribing these medications, I agree to the following conditions:

1. I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.
2. I am solely responsible for my controlled substance medications. If the prescription is lost, misplaced or stolen, or if I run out of it sooner than expected, I understand that it will not be replaced.
3. I will not request or accept controlled substance medication from any other physician or individual while I am receiving medications from Pain & Wellness Centers Medical Group.
4. There will be no early refills and no refills will be made over the phone for controlled substances. They will not be refilled if I run out early for any reason including if I lose a prescription or misplace the medication. I will safeguard my medications and place them in a safe or lock box and place them out of reach of children and youths.
5. I agree to comply with random urine and/or blood testing to document the proper use of medications.
6. I understand that my pain medications are NOT expected to provide 100% complete pain relief, rather a decrease in pain and make it more tolerable. I will use my medication to improve my function and increase in activity level.
7. I understand that if I have taken a controlled substance, I will not drive a motor vehicle or operate any other heavy machinery.
8. I further understand that driving a motor vehicle may not be allowed while taking controlled substances. It is my responsibility to comply with the laws of the state while taking these medications.
9. I agree to waive any applicable privilege or right of privacy or confidentiality with respect of prescribing my pain medication.

10. I understand that side effects of sedation, itching, nausea, vomiting, difficulty urinating, constipation, liver and end organ damage and other side effects are possible**.** For males, chronic opiate use is associated with low testosterone levels. This may affect mood, stamina, sexual desire and performance. For females, if you become pregnant, you agree to contact us and your obstetrician immediately and inform them of your controlled substance and/or opiate medication use. I further understand that a possibility of addiction and the probability of physical dependence exists, and I consent to all of these risks.
11. I also understand that in addition to the side effects listed above**, respiratory depression and even death** can occur from these medications. I assume and accept these risks.
12. I am amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems it necessary.
13. I will not use any illegal or illicit substances, including marijuana, cocaine, heroin, etc. nor will I misuse or self-medicate with legal controlled substances. I will not share my pain medications with anyone else.
14. I agree that refills of my prescriptions for pain medications will be made only at the time of my office visit and during regular office hours. No refills will be available during after-hours or on weekends.
15. I understand that violating any of the conditions of this agreement may result in dismissal from this practice. Violation of this agreement may also result in narcotics no longer being prescribed.
16. I agree to use one pharmacy for my pain medications and not use multiple pharmacies to obtain my pain medications. I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the states' Board of Pharmacy, in the investigation of any possible, misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
17. I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.
18. I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
19. I agree to bring my pain medications to every office visit if requested by my provider and may be subject to a pill count.
20. I further agree that my narcotics prescription may be stopped or decreased at any time for any reason by my physician or any other PWCSC physician, physician assistant or nurse practitioner.

I agree and understand all of the above and fully comply with this Controlled Substance Agreement. All of my questions and concerns regarding treatment have been adequately answered. I am responsible for keeping a copy of this document.

Patient Signature _____ Date _____

Print Name _____ Date of Birth _____

PAIN & WELLNESS CENTERS
OF SOUTHERN CALIFORNIA

Pain Comprehensive Questionnaire

Patient name_____ **DOB**_____ **Date** _____

Date of injury _____ **Accepted body parts** _____

Chief complaint (main problem)_____

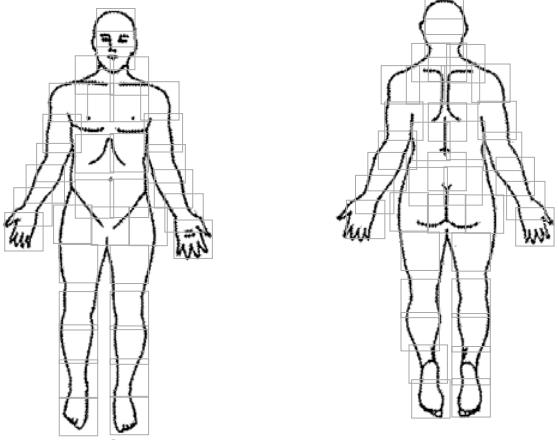
Work status: ☐unemployed ☐retired ☐disabled ☐employed ☐student ☐ not working (last work day: _____)

Work restrictions prescribed: _____

_____

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

R Front L **L Back R**



Pain Scale (circle a number)	☺ mild - - - - - - - - - - - - - - - severe ☹
	1 2 3 4 5 6 7 8 9 10
Pain level today	○ ○ ○ ○ ○ ○ ○ ○ ○ ○
Over the last month, please identify your pain levels below:	
Severe pain level (on a bad day)	○ ○ ○ ○ ○ ○ ○ ○ ○ ○
Average pain level (on an average day)	○ ○ ○ ○ ○ ○ ○ ○ ○ ○

The onset of your pain was:

☐Insidious onset ☐Lifting an object ☐Slipping/falling (from what height?____) ☐Trauma ☐Tripping/uneven surface

Occupation: _____ Years worked: _____

Type of work: ☐Sedentary ☐Light ☐Medium ☐Heavy ☐Very Heavy

Activities performed at work: _____

How did the injury occur? (include as much detail as possible) _____

_____

_____

Witnessed? ☐Yes ☐No Supervisor aware? ☐Yes ☐No Sent to occupational clinic? ☐Yes ☐No

If MVA: (mark all that apply) ☐Driver ☐Passenger (☐Front or ☐Rear) ☐Motorcyclist Seatbelt? ☐Yes ☐No
Airbags deploy? ☐Yes ☐No Loss of consciousness? ☐Yes ☐No Police arrived? ☐Yes ☐No Police report? ☐Yes ☐No
Vehicle total loss? ☐Yes ☐No Hit from: ☐behind (rear-ended) ☐head-on collision ☐hit from driver side
☐hit from passenger side ☐struck another vehicle making illegal turn ☐struck another vehicle that failed to stop
Body parts hit inside car? ☐steering wheel ☐window ☐dashboard ☐airbag ☐headrest ☐other: _____
Patient's car position when accident occurred: ☐slowing down ☐stopped ☐moving
Went to ER or Urgent care? ☐Yes ☐No If so, when?_____
What treatment(s) done?_____

Your pain occurs: ☐intermittent ☐frequently ☐constantly ☐worse after activity ☐worse during activity ☐worse in the morning ☐worse during the day ☐worse at end of day ☐worse at night ☐worse during cold weather/seasons

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

PAIN & WELLNESS CENTERS
OF SOUTHERN CALIFORNIA

Pain Comprehensive Questionnaire (continued)

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

Symptoms associated with your pain:

☐Awakens you from sleep
☐Insomnia
☐Changes in bladder function
☐Changes in bowel function
☐Changes in temperature
☐Flushing in affected area
☐Sweating in affected area
☐Depression
☐Suicidal ideation
☐Sexual dysfunction
☐Numbness: (describe where and how often)
_____
_____
☐Other:_____
_____

What activities aggravate/relieve your symptoms?

ACTIVITIES	AGGRAVATES	RELIEVES
All movements	☐	☐
Bending forward	☐	☐
Exercise	☐	☐
Lifting objects	☐	☐
Lying flat	☐	☐
Rest	☐	☐
Rotating the neck	☐	☐
Sitting	☐	☐
Standing for long periods	☐	☐
Walking long distances	☐	☐
Other:_____	☐	☐

How has pain limited your activities?
(mark all that apply)

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

What RADIOLOGY/diagnostic imaging studies have you had for the pain?

Type of imaging	Body part(s)	Date(s) completed & name/contact information of facility
☐ Bone scan		
☐ CT Scan		
☐ EMG/NCV		
☐ MRI		
☐ X-rays		
☐ Other:_____		

PAIN & WELLNESS CENTERS
OF SOUTHERN CALIFORNIA

Pain Comprehensive Questionnaire (continued)

Who have you seen for this problem? (mark all that apply)

- ☐ Acupuncturist
- ☐ Chiropractor
- ☐ Emergency Room
- ☐ General Surgeon
- ☐ Internist
- ☐ Orthopedic Surgeon
- ☐ Physical Therapist
- ☐ Primary care
- ☐ Urgent Care
- ☐ Walk-in Clinic

What TREATMENTS have you used to treat the symptoms?
(Please include as much detail as possible. If more space is needed, please use space below or attach sheet of paper)

TREATMENTS (list body part(s) next to therapy)	**# of sessions** (or # of weeks)	**Date(s)**	**Amount of relief from treatment**			
			None	**Limited**	**Moderate**	**Excellent**
Activity/Lifestyle changes			☐	☐	☐	☐
Chiropractic therapy			☐	☐	☐	☐
Physical therapy			☐	☐	☐	☐
Acupuncture			☐	☐	☐	☐
Aqua therapy			☐	☐	☐	☐
TENS unit			☐	☐	☐	☐
Yoga/Pilates			☐	☐	☐	☐
Heat treatment			☐	☐	☐	☐
Home exercises			☐	☐	☐	☐
Ice treatment			☐	☐	☐	☐
Weight loss maneuvers			☐	☐	☐	☐
Braces/DME: ☐AFO brace ☐Back brace ☐Cervical traction ☐Neck brace ☐Ankle brace (R or L) ☐Knee brace (R or L) ☐Wrist brace (R or L) ☐Other: _____ _____	How long have you had the product? _____	Is your product in good condition? ☐ Yes ☐ No	☐	☐	☐	☐

Injections/Procedures/Surgeries: (list levels of spine or body parts, date(s) and amount of relief respectively)

_____

_____

_____

_____

_____

_____

_____

Additional Notes: _____

_____

_____

_____

_____

_____

PAIN & WELLNESS CENTERS
OF SOUTHERN CALIFORNIA

History and Intake

Past Medical History: (please mark all that apply)

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Defibrillator/Pacemaker
- ☐ Depression
- ☐ Diabetes
  - ○ Insulin Dependent
  - ○ Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Hepatitis (A/B/C)
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ Prostate: BPH
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Stroke
- ☐ **None**
- ☐ Other:_____

Past Surgical History: (please mark all that apply AND list surgery date)

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

Past Orthopedic History: (mark all that apply)

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ Complex Regional Pain Syndrome (CRPS)
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **None**
- ☐ Other:_____

History and Intake (continued)

Past Orthopedic Surgery: (mark all that apply) ☐***None***

Surgery	Left	Right	Surgery date	Surgery	Left	Right	Surgery date
☐ Ankle/Foot Surgery	☐	☐		☐ Joint Replacement: Knee	☐	☐	
☐ Ankle Fracture ORIF	☐	☐		☐ Joint Replacement: Shoulder	☐	☐	
☐ Carpal Tunnel Decompression	☐	☐		☐ Knee Arthroscopy	☐	☐	
☐ Cervical Spine Surgery: ACDF	☐	☐		☐ Kyphoplasty/Vertebroplasty	☐	☐	
☐ Cervical Spine Surgery: Disc Replacement	☐	☐		☐ Lumbar Spine Surgery: Decompression	☐	☐	
☐ Distal Radius ORIF	☐	☐		☐ Lumbar Spine Surgery: Decompression & Fusion	☐	☐	
☐ Hand/Wrist Surgery	☐	☐		☐ Lumbar Spine Surgery: Disc Replacement	☐	☐	
☐ Intermedullary Nailing Femur	☐	☐		☐ Shoulder Surgery	☐	☐	
☐ Intermedullary Nailing Tibia	☐	☐		☐ Rotator Cuff Repair	☐	☐	
☐ Joint Replacement: Hip	☐	☐		☐ Other:_____	☐	☐	

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

☐ ***None.*** I have no known allergies.

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

Allergen	Describe allergic reaction severity & symptoms

Social History: (mark all that apply)

Cigarette Smoking

☐ Never Smoked
☐ Quit: former smoker
☐ Smoke less than:_____
☐ Smoke daily
packs per day:_____

Drug Use

☐ Do not use drugs
☐ Drug Use
☐ IV Drug Use:
_____
_____

Alcohol Use

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

Exercise Frequency

☐ Never
☐ Few times a month
☐ Few times a week
☐ Once a day
☐ Several times a day
☐ Other:_____

Family Medical History:

List medical history of Blood Family Members that may be contributing to your condition. Please include relationship to patient. If unknown or non-contributory, mark here: ☐

_____

_____

History and Intake (continued)

What MEDICATIONS have you used to treat the symptom(s)?

- Select all that apply (mark ✓ if helpful or **X** if NOT helpful) or list medications below with dose and frequency

Did you have any SIDE EFFECTS/adverse effects with any medication?

- If so, write the corresponding letter next to the medication below:

Constipation (**C**) Drowsiness (**D**) Mental slowness (**M**) If other adverse effect(s), list next to drug

Opioids		NSAIDs/Tylenol	
☐ Butrans _____	☐ Methadone _____	☐ Aspirin _____	☐ Ketoprofen _____
☐ Codeine _____	☐ Morphine _____	☐ Celebrex (celecoxib) _____	☐ Mobic (meloxicam) _____
☐ Demerol _____	☐ Nucynta _____	☐ Daypro (oxaprozin) _____	☐ Naproxen (Aleve/Naprosyn)___
☐ Fentanyl _____	☐ Oxycodone (Percocet/ Oxycontin) _____	☐ Etodolac _____	☐ Relafen (nabumetone) _____
☐ Hydrocodone (Norco/ Vicodin) _____	☐ Oxymorphone _____	☐ Feldene (Piroxicam) _____	☐ Toradol (ketorolac) _____
☐ Hydromorphone (Dilaudid) _____	☐ Suboxone _____	☐ Ibuprofen (Advil/Motrin)____	☐ Tylenol (acetaminophen) ____
	☐ Tramadol _____	☐ Indocin (indomethacin) _____	☐ Voltaren (Diclofenac) _____

Muscle Relaxants	Antidepressants	Other	
☐ Flexeril (cyclobenzaprine)____	☐ Celexa _____	☐ Ativan (lorazepam)_____	Other:_____
☐ Lioresal (baclofen) _____	☐ Cymbalta (duloxetine) _____	☐ Depakote _____	_____
☐ Lorzone (chlorzoxazone) _____	☐ Desipramine _____	☐ Dilantin _____	_____
☐ Norflex (orphenadrine) _____	☐ Elavil (amitriptyline) _____	☐ Ergotamine _____	_____
☐ Robaxin (methocarbamol)____	☐ Impramine (Tofranil) _____	☐ Imitrex _____	_____
☐ Skelaxin (metaxolone) _____	☐ Pamelor (nortriptyline) _____	☐ Klonopin _____	_____
☐ Soma (carisoprodol) _____	☐ Paxil _____	☐ Lyrica (pregabalin) _____	_____
☐ Zanaflex (tizanidine) _____	☐ Prozac _____	☐ Mexiletine _____	_____
	☐ Savella _____	☐ Neurontin (gabapentin)____	_____
	☐ Serzone _____	☐ Tegretol _____	_____
	☐ Wellbutrin (bupropion) _____	☐ Topamax _____	_____
	☐ Zoloft (sertraline) _____	☐ Xanax (alprazolam) _____	_____

Medications: (list all medications or mark option, which applies):

☐ *Not currently taking any medications*

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

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

Medication Name, Dose & Frequency	Currently Using	Start Date	Not Helpful.....Helpful			Side effects
	☐		○	○	○	
	☐		○	○	○	
	☐		○	○	○	
	☐		○	○	○	
	☐		○	○	○	
	☐		○	○	○	
	☐		○	○	○	
	☐		○	○	○	

History and Intake (continued)

Review of Systems: (mark all the symptoms that you are currently experiencing, add details if necessary)

General
- □ change in appetite
- □ fatigue
- □ fever
- □ chills
- □ night sweats
- □ gained weight
- □ weight loss

Musculoskeletal
- □ ankle swelling
- □ arthralgias
- □ crepitus
- □ deformity
- □ difficulty walking
- □ joint swelling
- □ atrophy
- □ numbness
- □ pain
- □ stiffness
- □ weakness

Skin
- □ discoloration
- □ jaundice
- □ hives
- □ rash
- □ infection
- □ scarring

HEENT
- □ blurred vision
- □ glaucoma
- □ cataract
- □ dry mouth
- □ headache
- □ vertigo
- □ deafness
- □ double vision
- □ eye pain
- □ loss of hearing
- □ nose bleeds
- □ ringing in the ears

Respiratory
- □ cough
- □ difficulty swallowing
- □ hemoptysis
- □ hoarseness
- □ labored breathing w/exertion
- □ pain w/ breathing
- □ shortness of breath
- □ wheezing

Cardiac
- □ chest pain
- □ edema
- □ palpitations

Gastrointestinal
- □ abdominal pain
- □ blood in stool
- □ change in bowel habits
- □ constipation
- □ diarrhea
- □ fecal incontinence
- □ heartburn
- □ nausea
- □ ulcers
- □ vomiting

Genitourinary
- □ change in urinary habit
- □ frequency
- □ genital pain
- □ hematuria
- □ incontinence
- □ infection
- □ urinary hesitancy
- □ urinary retention

Neurology
- □ dizziness
- □ seizures
- □ headaches
- □ tingling
- □ memory loss
- □ tremor
- □ numbness
- □ weakness

Endocrine
- □ diabetes
- □ excessive thirst
- □ heat/cold intolerance
- □ thyroid problem

Hematologic/ Lymphatic
- □ excessive bleeding
- □ excessive bruising

Allergy/Immunologic
- □ environmental allergies
- □ HIV/AIDS
- □ immunosuppression

Psychiatric
- □ anxiety
- □ depression
- □ hallucination
- □ homicidal ideation
- □ suicidal ideation

Sleep Quality (select one)
- □ poor
- □ good
- □ fair
- □ excellent

Vitals:

Weight: _____ lbs

Height: _____feet _____inches