Personal Information

Name:________________________________D.O.B:____________________

Home Address (*Required*):______________City:__________State:____Zip Code: __________

Email Address (*Required*):______________________Social Security Number:____________

Home Phone#: (__)________________Mobile Phone#: (_____)__________________

Weight:________Height:__________Sex: ( ) Male ( )Female Primary Language: __________

Marital Status:________________Employer Name: ________________________

Injured Body Part:________________Primary Care Physician:__________________

Insurance Information

Primary

Name of Insurance: ______________________ Pharmacy ____________________

Identification Number:______________Group Number:____________________

Subscriber Name:________________Relationship to subscriber:______________

Secondary

Name of Insurance:________________________

Identification Number:______________Group Number: ____________________

Subscriber Name:________________Relationship to subscriber:______________

** IT IS THE REPSONSIBILITY OF THE PATIENT/ GUARDIAN TO INFORM OUR OFFICE OF ANY CHANGES IN THEIR INSURANCE COVERAGE AND BILLING INFORMATION.**

Important Information Regarding HIPPA

In general, the HIPPA rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Signature:________________________ **Date:**____________________

STANISLAUS
ORTHOPAEDIC
AND SPORTS MEDICINE CLINIC

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Kyle McClintock, D.O.

Financial Policy

Effective: 01.01.2014

PPO/ HMO's - We will submit claims directly on your behalf to your respective insurance courier. The patient/ guardian are responsible for any copays or patient responsibility on the day of the visit. Referrals are the responsibility of the patient/ guardian to obtain from their primary care physician **PRIOR** to their appointment in this office. **IF REFERRALS ARE NOT OBTAINED, THE PATIENT/GUARDIAN IS FULLY RESPONSIBLE FOR CHARGES INCURRED OR THE OFFICE VISIT WILL BE CANCELED.** We are limited by HMO's to provide treatment only for what is authorized. If you choose to have treatment for additional problems not authorized by your plan, you will be financially responsible for the charges.

Workers Comp. - Your workers compensation carrier must authorize all visits in advance. All services are to be paid by workers comp. In the event the workers comp carrier should deny a claim, the patient will be responsible for the bill.

Office Visit Cash Pay – A consultation fee of $300.00 will be collected on the day of the patient's initial office visit. A $100.00 office fee will be due and payable for any office visits thereafter, this charge would not include any additional services outside the office visit such as: casting, injections, medications, etc.

X-Ray Cash Pay: An X-ray fee of $75.00 will be collected for each occurrence within our office. **Cancelled/ No Show Appointments –** If the patient fails to notify office within 48 hours of the patients visit, a cancellation charge of $35.00 will be applied to your account.

Returned Check - In the event of insufficient funds a returned check fee of $25.00 will be added to your account balance along with the payment amount which was on the check.

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Note: USES AND DISCLOSURES MAY BE PERMITTED IN THE CASE OF AN EMERGENCY

Please list any other persons you wish Stanislaus Orthopaedics to release information to

Name:________________________ Contact Number: ____________________

Relationship: ____

By signing the following, I certify that I have read and fully understand all paragraphs of the foregoing and any questions that I have had have been answered.

______________________	______________________	______________
'atients Name (please print)	Patient's Signature	Date
______________________	______________________	______________
lame of Patient's Personal 'epresentative (please print)	Signature of Patients Personal Representative	Relationship to Patient

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DISCRIMINATION IS AGAINST THE LAW

Stanislaus Orthopaedics & Sports Medicine Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Stanislaus Orthopaedics & Sports Medicine Clinic does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Stanislaus Orthopaedics & Sports Medicine Clinic provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and some written information in other formats upon request (large print, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as: qualified interpreters.

If you need these services, you may contact (209)-572-3224. If you believe that Stanislaus Orthopaedics & Sports Medicine Clinic has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex. You can file a grievance in person or by mail or phone. If you need help filing a grievance, Orlando Azueta, Office Manager, will assist you.609 E Orangeburg Ave Suite 201, Modesto, CA 95350.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Stanislaus Orthopaedics & Sports Medicine Clinic cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Stanislaus Orthopaedics and Sports Medicine Clinic, no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Stanislaus Orthopaedics & Sports Medicine Clinic proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes: intérpretes de lenguaje de señas capacitados. Información escrita en otros formatos (letra grande, formatos electrónicos accesibles, otros formatos). Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes: Intérpretes capacitados. Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese al (209)-572-3224 . Si considera Stanislaus Orthopaedics & Sports Medicine Clinic no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: Orlando Azueta, Gerente de Oficina, 609 E Orangeburg Ave Suite 201, Modesto, CA 95350 Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, Orlando Azueta está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH

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Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (209)-572-3224.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (209)-572-3224.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (209)-572-3224.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (209)-572-3224.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (209)-572-3224번으로 전화해 주십시오.
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (209)-572-3224
Persian	توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما (209)-572-3224. تماس بگیرید.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (209)-572-3224
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(209) 572-3224. まで、お電話にてご連絡ください。
Arabic	ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل -(209)-572-3224 بهاتف الصم والبكم:
Punjabi	ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ□ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ□ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (209)-572-3224 'ਤੇ ਕਾਲ ਕਰੋ।
Cambodian	ប្រយ័ត□៖ បើសិន□អ□កនិ□យ □□ខែ□រ, សេ□ជំនួយផ□ក□□ ោយមិនគិតឈ□□ល គឺ□ច□នសំ□ប់បំេរ□អ□ក។ ចូរ ទូរស័ព□ (209)-572-3224
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (209) 572-3224
Hindi	ध्यान द : य द आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। (209) 572-3224 पर कॉल कर
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (209)-572-3224

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DMV & Disability Notice

Document processing fees:
1. FMLA Processing fees are $15.00
2. General forms requiring doctor's signature are $10.00
3. Medical records requests are $15.00

All forms will be processed and made available within 3-5 business days

Initial Disability Filing ONLINE:

1. Visit the EDD website @ www.edd.ca.gov/disability/ and register the patient filing disability.
2. Once you have registered, be sure to file the claim after registering. This can be recognized as a group of questions you will need to answer that are more doctor/medical specific.
3. After successfully filing your claim you will be given a RECIPT NUMBER which is a 16-digit alphanumeric sequence beginning with an "R1".
4. Please provide our office with your receipt number so we may log into your account and complete the physician's portion. You will be expected to pay the fee at this time.
5. Please note there is a $20.00 processing fee for the initial disability requests and $10.00 for all extensions following. This will need to be paid in order to process your requests
6. SOSMC has 3-5 days to compete the physician portion

NOTE: IF YOU HAVE ANY PROBLEMS WITH THE WEBSITE AND/OR FILING THE CLAIM PELASE CALL THE EDD OFFICE, (800)480-3287, LET THEM KNOW ABOUT YOUR DIFFICULTIES AND THEY CAN SEND YOU THE FORMS TO COMPLETE BY MAIL. YOU MUST FIRST TRY THE WEBSITE BEFORE REQUESTING THE PAPER FORMS OR THE CHANCES OD EDD DENYING YOUR CLAIM MAY INCREASE.

Disability Extensions:

1. In order to process your extensions, you will need to provide SOSMC with your "DI" number. This number may be located on the red and white disability forms sent from EDD through the mail or may be provided to you by calling EDD, 800.480.3287
2. Please not there is a **$20.00 processing fee for initial disability requests and $10.00 for all extensions following.** This will need to be paid in order to process your request.
3. SOSMC has 3-5 business days to complete the physician's portion of the disability forms.

DMV Placards:

- Stanislaus Orthopaedics has DMV placard forms at our office and are happy to provide these for you
- You, the patient, are responsible for completing the front portion of the form and bringing the form into our office
- Thereafter, the doctor's assistant will complete the back portion of the form
- You will need to take the completed form into the DMV to receive your placard

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Physician-Patient Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counseling fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nor supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to dispute with this arbitration, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective Date: date of first medical services.

____
Patient or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Physicians or Authorized Representative's Signature	Date	Print or Stamp Name of Physician, Medical Group	Date
Print Patient's Name	Date	Patient/Representative's Signature	Date
		If Representative, Print Name and Relationship to Patient	

A signed copy of this document is to be given to the Patient. Original is to be filed in the Patient's medical records.

New Patient Health Questionnaire

Name: ______________________________ Date of Birth: ______________________________

Constitution Symptoms

Yes	No	
___	___	Good health lately
___	___	Recent significant weight change
___	___	Frequent headaches

Eyes

Yes	No	
___	___	Change in vision
___	___	Eye disease or injury

Ears/Nose/Mouth/Throat/Neck

Yes	No	
___	___	Do you wear hearing aids?
___	___	Chronic sinus problems/runny nose
___	___	Nose bleeds
___	___	Mouth sores
___	___	Bleeding gums
___	___	Lumps or swollen glands in neck
___	___	Neck pain or stiffness

Cardiovascular

Yes	No	
___	___	Swelling feet/ankles/hands
___	___	Waking at night with shortness of breath

Gastrointestinal

Yes	No	
___	___	Loss of appetite
___	___	Frequent diarrhea
___	___	Rectal bleeding/blood in stool
___	___	Black or tarry stools

Genitourinary

Yes	No	
___	___	Frequent urination
___	___	Blood in urine
___	___	Change in force/strain when urinating
___	___	Incontinence

Musculoskeletal

Yes	No	
___	___	Joint pain
___	___	Joint stiffness or warmth
___	___	Muscle pain or recurrent cramps
___	___	Back pain
___	___	Cold hands/feet
___	___	Difficulty walking

Integumentary (Skin/Breast)

Yes	No	
___	___	Rashes/itching
___	___	Change in moles or skin color
___	___	Change in hair or nails
___	___	Varicose veins

Neurological

Yes	No	
___	___	Frequent recurring or increasing headaches
___	___	Light-headedness or dizziness
___	___	Numbness or tingling sensations
___	___	Tremors

Psychiatric

Yes	No	
___	___	Memory loss or confusion
___	___	Nervousness
___	___	Insomnia

Endocrine

Yes	No	
___	___	Glandular or hormone problem
___	___	Heat or cold intolerance
___	___	Excessive skin dryness
___	___	Excessive thirst or urination
___	___	Change in hand or glove size

Hematologic/Lymphatic

Yes	No	
___	___	Slow to heal cuts/wounds
___	___	Tendency to bruise/bleed easily

New Patient Health Questionnaire

Yes	No	Allergic/Immunologic
		Have you ever had a reaction to: (if yes, please describe reaction)
___	___	Penicillin or other antibiotic
		Reaction: ____________________
___	___	Morphine, Demerol or other narcotic
		Reaction: ____________________
___	___	Novocain or other anesthetics
		Reaction: ____________________
___	___	Aspirin or other pain remedies
		Reaction: ____________________
___	___	Iodine, methylate or other antiseptics
		Reaction: ____________________
___	___	Tetanus antitoxin or other serums/vaccines
		Reaction: ____________________
___	___	Bandage adhesive/Latex/other skin reactions
		Reaction: ____________________
___	___	Other Medications: ____________________
		Reaction: ____________________
___	___	Other known food allergies: ____________________
		Reaction: ____________________

Comments: ____

____

____

____

____

Patient Signature: ____________________ Reviewed by: ____________________

Date: ____________________ Date: ____________________

Physician Signature: ____________________ Date: ____________________

Medical History

Check if you have/had any of the following:

List of Current Medications:____________________________________

Yes	No	
❑	❑	Major illness or conditions? If yes, please describe:
❑	❑	Could you be pregnant? ❑N/A

❑Glasses ❑Contacts ❑Upper Dentures ❑Lower Dentures ❑Upper Partials ❑Lower Partials
❑High Blood Pressure ❑Heart Attack, Date(s):____________________
❑Congested Heart Failure ❑Other Heart Conditions:____________________
❑Seizure Disorder ❑Respiratory Disorder:____________________
❑Diabetes ❑Kidney Disease ❑Bladder Problems ❑Prostate Problems
❑Stomach Ulcers ❑Acid Reflux
❑Other Conditions not listed:______________________________

Past Surgical History (Please list all past surgeries minor/major):

Social History:

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed
Occupation:____________________ How long?______________
Work Status: ❑Fulltime ❑Part-time ❑Seasonal ❑Unemployed: Last day work:____________
❑Retired ❑Disabled
Do you have restrictions? ❑No ❑Yes, ____________________________
Are you currently involved in a: ❑Disability claim ❑Workers compensation ❑Lawsuit
Do you smoke? ❑No ❑Quit (year)__________ ❑Yes: Packs per day,________ Years______
Do you drink alcohol? ❑No ❑Rarely ❑Occasionally ❑Socially ❑Regularly ❑Heavily
Do you use other substances? ❑No ❑Marijuana ❑Cocaine ❑Amphetamines ❑Other:________
Do you exercise (outside of work)? ❑No ❑Yes, but not regularly ❑Regularly(3-5x/wk)
Do you need help lifting? ❑No ❑Yes
Do you need help with household chores? ❑No ❑Yes
Do you currently drive? ❑No ❑Yes

Medical History

Family History: (NOTE: provide which family member)

❑None ❑Unknown ❑See attached

❑**Diabetes:** ❑Mother ❑Father Grandparent: ❑Paternal ❑Maternal ❑Siblings ❑Aunt/Uncle

❑**High Blood pressure:** ❑Mother ❑Father Grandparent: ❑Paternal ❑Maternal ❑Siblings ❑Aunt/Uncle

❑**Heart Disease:** ❑Mother ❑Father Grandparent: ❑Paternal ❑Maternal ❑Siblings ❑Aunt/Uncle

❑**Stroke:** ❑Mother ❑Father Grandparent: ❑Paternal ❑Maternal ❑Siblings ❑Aunt/Uncle

❑**Arthritis:** ❑Mother ❑Father Grandparent: ❑Paternal ❑Maternal ❑Siblings ❑Aunt/Uncle

❑**Bleeding disorder:** ❑Mother ❑Father Grandparent: ❑Paternal ❑Maternal ❑Sibling ❑Aunt/Uncle

❑**Cancer:**________________ ❑Mother ❑Father Grandparent: ❑Paternal ❑Maternal ❑Sibling ❑Aunt/Uncle

❑**Other:**________________ ❑Mother ❑Father Grandparent: ❑Paternal ❑Maternal ❑Sibling ❑Aunt/Uncle

Patient Signature:______________________________ Date:________________

Physician Reviewed:______________________________ Date:________________

Please Read

Dr. Taberaee, Dr. Nicholson, & Dr. Wolterbeek patients please continue and complete the last section of the packet, thank you.

******Please remember to bring your insurance card AND your driver's license******

Thank you for your cooperation

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ORTHOPAEDIC
AND SPORTS MEDICINE CLINIC

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Patient Name: ______________________ Date: ______________________
Age: ________ Sex: ________ Wt: ________ Ht: ________ Referring Physician: ______________________
Handed: ☐ Left ☐ Right Primary Care Physician: ______________________
Visit Reason: ☐ Back ☐ Neck ☐ Both, if so, check the box of which is worst.
☐ Other (i.e. Brain injury, amputation): ______________________

Where is your pain/where are your symptoms?

☐ Low Back	☐ Head
☐ Left buttock	☐ Face
☐ Right Buttock	☐ Chest/Ribs
☐ Left hip	☐ Neck
☐ Right hip	☐ Mid-back/shoulder blades
☐ Left groin	☐ Left shoulder
☐ Right groin	☐ Right Shoulder
☐ Left thigh	☐ Left arm
☐ Right thigh	☐ Right arm
☐ Left leg/calf	☐ Left elbow
☐ Right leg/calf	☐ Right elbow
☐ Left ankle/foot	☐ Left wrist/hand
☐ Right ankle/foot	☐ Right wrist/hand

How do you describe the pain?
☐ Comes and goes
☐ Constant
☐ Flares on top of constant
☐ Other: ______________________
AND....

☐ Sharp/stabbing	☐ Dull aching
☐ Shooting/Electrical	☐ Throbbing
☐ Burning	☐ Spasms
☐ Pins & Needles	☐ Tightness

☐ Other: ______________________

Does your pain radiate or move? ☐ Yes ☐ No
If yes, which side? ☐ Left ☐ Right ☐ Both
If both sides, which is worst? ☐ Left ☐ Right
How does it travel?
☐ to the base of my skull
☐ around to the front of my chest
☐ down arm, ☐ past elbow ☐ past wrist
☐ down thigh, ☐ past knee ☐ past ankle

Any numbness or tingling in your...
☐ Fingers? ☐ Left ☐ Right ☐ Both
☐ Toes? ☐ Left ☐ Right ☐ Both
If so, which ones are most involved (i.e. Thumb/great toe)? ______________________.

When did you first notice your pain?
☐ Immediately/Suddenly
☐ Gradually over time
☐ Date: ______________ (if known)
☐ Few days ago

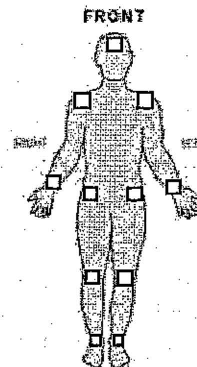
☐ 1-3weeks ago	☐ 3-6 weeks ago
☐ 2-3 months ago	☐ 4-6 months ago
☐ 6-12 months ago	☐ 1-2 years ago
☐ 3-5 years ago	☐ 5-10 years ago
☐ over 10 years ago	☐ my whole life

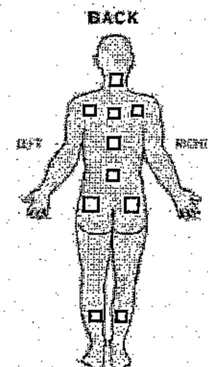
Under what circumstances did the pain begin?

☐ Do not recall	☐ Fall
☐ Work-related accident	☐ Following surgery
☐ Motor-vehicle accident	☐ Following illness

Please EXPLAIN: ______________________
____
____
____

Put a check in the area where you feel pain:
0= No pain, 10= Most pain





Indicate the number that describes the pain at its worst:

Indicate the number that describes the pain at its best:

What makes the pain WORSE?

- ☐ Laying down
- ☐ Walking
- ☐ Sitting
- ☐ Lifting
- ☐ Driving
- ☐ Bending
- ☐ Standing
- ☐ Twisting
- ☐ Vacuuming/Sweeping
- ☐ Sneezing/Coughing
- ☐ Any prolonged position
- ☐ Exercise/Running
- ☐ Wearing shoes

other: ______________________________

What makes the pain BETTER?

- ☐ Laying down
- ☐ Walking
- ☐ Laying on one side
- ☐ Changing position
- ☐ Sitting
- ☐ Exercise
- ☐ Sitting reclined
- ☐ Ice
- ☐ Standing
- ☐ Heat
- ☐ Nothing
- ☐ Medication

Indicate the number that describes how pain has interfered with your functioning.

0=does not interfere, 10=completely interferes

1. General Activity: ______
2. Mood: ______
3. Walking ability: ______
4. Work routine: ______
5. Relationships: ______
6. Sleep: ______
7. Enjoyment of life: ______
8. Concentration: ______
9. Appetite: ______

Overall, is your pain...

☐ Better ☐ Worse ☐ Unchanged

Previous Work-up FOR THIS PROBLEM:

Please provide the most recent date, AND check whether the study was normal (NL) or abnormal (AB)

Study	Date	NL	AB
☐ X-ray	Date: __________	☐ NL	☐ AB
☐ CAT Scan	Date: __________	☐ NL	☐ AB
☐ MRI	Date: __________	☐ NL	☐ AB
☐ Bone Scan	Date: __________	☐ NL	☐ AB
☐ EMG	Date: __________	☐ NL	☐ AB

Have you been evaluated by any of these specialists?

- ☐ Neurologists
- ☐ Neurosurgeon
- ☐ Orthopedic Surgeon
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Physical Med./Rehab

What was your diagnosis? ______________________________

____

Previous Treatment FOR THIS PROBLEM:

Check all that apply. Use the scale to describe how much each intervention helped:

(0=no relief, 10=complete relief)

☐ Surgery. If so, what kind?

- ☐ Cervical (neck) Fusion
- ☐ Lumbar Laminectomy WITHOUT Fusion
- ☐ Lumbar Laminectomy WITH Fusion
- ☐ Shoulder/Rotator cuff ☐ Left ☐ Right
- ☐ Carpal Tunnel Release ☐ Left ☐ Right
- ☐ Hip Replacement ☐ Left ☐ Right
- ☐ Knee Replacement ☐ Left ☐ Right
- ☐ Vertebroplasty/Kyphoplasty
- ☐ Other: ______________________

How much did it help?

☐ Injections. If so, what kind?

- ☐ Epidural
- ☐ Facet ☐ Left ☐ Right
- ☐ Sacroiliac/SI ☐ Left ☐ Right
- ☐ Trigger point ☐ Left ☐ Right
- ☐ Shoulder ☐ Left ☐ Right
- ☐ Hip ☐ Left ☐ Right
- ☐ Knee ☐ Left ☐ Right
- ☐ Other: ______________________

How much did it help? ☐

☐ Physical Therapy.

When was your last session? Date: __________

Were you able to tolerate therapy? ☐ Yes ☐ No

How much did it help? ☐

☐ Osteopathic Manipulation Medicine ☐

☐ Chiropractic Treatment ☐

☐ Acupuncture ☐

☐ TENS unit ☐

☐ Brace. If so, what type? ______________ ☐