PARAGON
Health Partners
PAIN • OBESITY • ADDICTION

**Patient Name:** _____ **Date:** _____

If you have an open Work Comp or Car Accident Please stop here and inform front Desk. We cannot file on your Medical Insurance

## Referral

Were you referred to our clinic by another physician? If so, whom? _____

If not, how did you hear about us? ❑ PRMC ❑ Other_____ ❑ Family ❑ Friend ❑ PCP

❑ Facebook ❑ Instagram ❑ Other Website _____

## Pain Description

Where is your **worst** area of pain located? _____

Does this pain radiate? ❑ Yes ❑ No. If so, where? _____

Please list any additional areas of pain: _____

Approximately when did this pain begin? _____

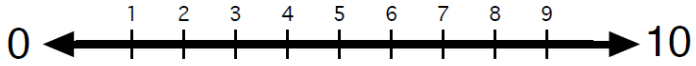
What caused your current pain episode? _____

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out




What number on the pain scale (0-10) best describes your pain **right now**? _____

What number on the pain scale (0-10) best describes your **worst pain**? _____

What number on the pain scale (0-10) best describes your **least pain**? _____

What number on the pain scale (0-10) best describes your **average pain over the last month**? _____

# New Patient Demographic Information

- ☐ Driver's License or State Issued Photo ID.
- ☐ Photocopy of the front and back of your insurance card.

**What is the reason for your visit today?**

| |
|---|
| |

**Patient Information**

| | | | | |
|---|---|---|---|---|
| Name (First, Middle, Last) | Birth Date | Age | Social Security # | Birth Gender ☐ M ☐ F |
| Mailing Address / Apt # | City, State ZIP | | | |
| Email Address | Primary Phone ☐ Home ☐ Cell | Okay to leave message? ☐ Yes ☐ No | | |
| Employer (or parent/guardian employer if patient is a minor) | Work Phone | | | |
| Primary Care Provider (where you go for your routine medical care) ☐ None | | | | |
| Preferred Name/Pronoun<br>Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino | Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer | | | |

**Emergency Contact**

| | | |
|---|---|---|
| Contact Name | Phone Number | Relationship to Patient |
| | | |

**Guarantor/Responsible Party** (person responsible for payment)

| | | |
|---|---|---|
| Legal Name of Responsible Party (First, Middle, Last) | Social Security # ☐ | Date of Birth |
| | | |

**Preferred Pharmacy** I understand I am only allowed to use ONE pharmacy by Paragon ☐ Yes ☐ No

| | |
|---|---|
| Pharmacy Name | Pharmacy Location |
| | |

**Medical Insurance** (please present your ID and insurance card to the receptionist)

| | | |
|---|---|---|
| **PRIMARY** Insurance Company Name | Policy Number/Member ID | Group Number |
| Insured Name | Insured Date of Birth | Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent |
| Insurance Company Address (usually on back of insurance card) | | Phone |

| | | |
|---|---|---|
| **SECONDARY** Insurance Company Name | Policy Number/Member ID | Group Number |
| Insured Name | Insured Date of Birth | Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent |
| Insurance Address | | Phone |

PATIENT SIGNATURE: X_____ DATE:_____

# Patient Agreements and Authorizations

CONSENT FOR TREATMENT

I Hereby consent to the treatment provider by providers at Paragon Health Partners and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.

CONSENT FOR MEDICATION HISTORY.

I authorize Paragon Health Partner and its employees or designee to access my medication history via PMP portal and from participating pharmacies that Paragon Health Partners request medication history.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or the purposes of conducting the healthcare operations of Paragon Health Partners. I authorize Paragon Health Partners to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Paragon Health Partners may release objective clinical information related to my diagnosis and treatment, which may be requested, by my insurance or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GURANTEE/COLLECTION FEE

I authorize payment to be made directly to Paragon Health Partners, Paragon Pain & Rehabilitation, LLP for insurance benefits payable to me. I understand that I am financially responsible for Paragon Health Partners, Paragon Pain & Rehabilitation, LLP for any non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue it may be referred to collection agency.

PRIVACY POLICY

I acknowledge having received Paragon Health Partners, Paragon Pain & Rehabilitation's "Notice of Privacy Practices". My rights including the right to see a copy of my medical record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent Paragon Health Partners has already made disclosures with my prior consent.

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

Patient Name

PARAGON Health Partners

Date

## FINANCIAL AGREEMENT & OFFICE BILLING / INSURANCE POLICIES

1. I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance. I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account.

2. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.

3. I understand that if my insurance(s) require a referral from my primary care physician, Norberto Vargas, M.D or JP Benavides, D.O. at Paragon Pain & Rehabilitation, LLP. must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).

4. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s), including that an insurance company representative may review the clinical record.

5. I authorize direct payment by my insurance company(s) to Paragon Pain & Rehabilitation, LLP.

6. I accept ultimate responsibility for payment for the services that I or my dependent(s) receive, whether or not my insurance(s) cover these services. This includes, but is not limited to fees for: clinical services or treatment, failed appointments and/or appointments not cancelled with 24 hours notice, report/letter writing, time spent in court or talking with attorneys on my behalf or the behalf of my dependent(s), telephone conversations longer than 5 minutes, site visits, reading records, longer sessions, travel time, etc.

7. I am aware of Paragon Health Partners office policy requiring 48 hours notice to cancel an appointment. I understand that I may notify the office staff or the answering service of my intention to cancel an appointment. I further acknowledge that I will be charged $50.00 for any New Evaluation, procedures, testing, injections appointments and $10.00 for Follow Up Appointment which I or my dependent(s) fail to keep without providing 48 hours notice.

**My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies.**

_____

Patient Name (Printed)

_____

Responsible Party (Printed) (If patient is a minor or dependent adult)

_____ _____

Signature of Responsible Party Date

Paragon Health Partners
2895 Lewis Lane Paris, TX 75460
Phone: 972-203-3600 Fax: 972-203-3601
www.paragonphp.com

PARAGON
Health Partners
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# Cancellation/Late Policy Form

**Payment Policy**

All Co-payments and any past due balances are due at the time of visit. If you receive a bill and would like to make payment. Our website has a online payment option. Simply go to website at www.paragonphp.com and in the upper right click online payment and follow steps.

**Cancellation Policy**

As our practice continues to grow, we have updated our cancellation policy to better serve our patients. Your appointment time is reserved especially for you. Please call 972-203-3600 at least 48 hours before your scheduled appointment if you will be unable to keep your appointment. This allows our practice to offer that appointment to another patient who needs medical care. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" calendar for the day. **If you do not cancel your appointment at least 48 hours in advance, you will be charged a no-show or late cancellation fee. This fee is not covered by insurance. Payment will be required before another appointment is scheduled**

We understand that life gets busy. However, a pattern of missed appointments without proper notice does not show mutual consideration. Patients who fail to provide advanced cancellation for three appointments in the span of one year may be subject to dismissal from the practice.

**Late Arrival Policy**

We know that delays can happen when you are trying to get to your appointment. However, we must try to keep the other patients and doctors on time. If you arrive 15 minutes past your scheduled time, we may have to reschedule your appointment.

**Fee Amounts:**

**$50.00 Fee- New Evaluation, Procedure, Injection, EMG/NCV**

**$10.00 Fee- Follow Up Appointment.**

I have read and acknowledged your payment, cancellation, and late policies.

Patient Signature: _____ Date: _____

# HIPAA NOTICE OF PRIVACY PRACTICES

Paragon Pain Rehabilitation LLP ("Paragon") is committed to maintaining the privacy of your health information. We understand that health information about you is personal. We are required by law to maintain and protect health information about you. We are required by federal law to provide you with this Notice of Privacy Practices ("Notice") that describes how health information that we maintain about you may be used or disclosed. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

**This Notice describes how medical information may be used and disclosed and how you can get access to this information. Please review it carefully**.

**Uses and Disclosures of Your Health Information**
We are permitted to use and disclose your health information under a variety of circumstances. Some of the reasons that we may use or disclose your information include:

- For Treatment: We may use and disclose health information about you to provide you with medical treatment or services. For example, your doctor might use your name, age, possible diagnosis, and other information required to obtain laboratory testing.
- For Payment: We can use and disclose your health information to bill and get payment from you, your health insurers or other entities. For example, we may need to give your health plan information about your visit so that they will pay us or reimburse you.
- For Health Care Operations: We may use and disclose your health information for our operations. For example, we may need to use your information when in the course of quality assurance or utilization review activities. We may also combine medical information about our patients to decide what services we should offer or to see where we can make improvements..
- Use or Disclosure Required By Law. We may use or disclose your health information to the extent such use or disclosure is required by law.
- Health Agency Oversight Activities. We may disclose your health information to governmental, licensing, auditing and accrediting agencies for health oversight activities.
- Law Enforcement. We may disclose your health information for law enforcement purposes.
- To Avert a Serious Threat to Health or Safety. We may use or disclose your health information when necessary to prevent a serious threat to health or safety of a person.
- Public Health Risks: We may disclose health information about you for public health activities.
- Workers' Compensation. We may disclose your health information to covered entities that are government programs providing public benefits and for workers' compensation.
- To Respond to Lawsuits and Legal Actions: We may disclose your health information in response to a court or administrative order, or in response to a subpoena.
- Business Associates: We may disclose your health information with third-party vendors that provide services on our behalf, which are referred to as "Business Associates."
- Individuals Involved in Your Care or Payment for Your Care: We may use or disclose health care information to a family member or friend involved in your care or payment for your care.
- Marketing and Sale of Health Information: We must obtain your written authorization prior to most uses of your health information for any marketing purposes or disclosures that constitute a sale of your health information.
- Appointment Reminders and Communications. We may use and disclose your health information and the contact information you provide us with to contact you with appointment reminders or other health-related communications, including via email, text message or telephone or mail. While email or text messages may not be encrypted or secure and could be intercepted in transit, we will assume you understand these risks if you provide us with your mobile telephone number or email address and that you consent to us communicating with you in this manner.

**Other Uses of Your Health Information**
Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. Your written, signed authorization is required before Paragon may use or disclose health information containing psychotherapy notes, if Paragon intends to use your health information for marketing purposes, or for the sale of your health information. You may revoke this permission for any of those purposes requiring authorization, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**Your Rights**

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy: You have the right to inspect and obtain a copy of your health information maintained in a designated record set. We may charge a reasonable, cost-based fee. We may require you to submit your request in writing.
- Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, as those functions are described above. We will provide you one accounting of disclosures each year free of charge but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months. We may require you to submit your request in writing.
- Right to Amend: If you feel the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our organization. We may require that you submit a request in writing and provide a reason to support the requested amendment.
- Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. We may require you to submit such a request in writing. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny such request. However, we must agree to the request for a restriction if the request involves a disclosure about your health information to a health plan (1) when the disclosure regards carrying out payment or health care operations (and is not otherwise required by law), and (2) the health information solely pertains to health care that you, or a person other than a health plan, has paid to Paragon in full.
- Right to Request Confidential Communications: You have the right to request that we communicate your health information with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- Right to be Notified of a Breach. You have the right to be notified if there is any impermissible use or disclosure of your health information that compromises the privacy or security of your health information.
- Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

**Changes to this Notice.**

We are required to abide by the current version of this Notice, and we reserve the right to change this Notice. The revised or changed Notice will be effective for health information we already have about you as well as any information we receive in the future. The new notice will be available upon request, in our office and on our website.

**Complaints**

If you believe that we may have violated your privacy rights, or you disagree with a decision about your health information, you may file a complaint with us by contacting the Privacy Officer at the address listed below or with the Secretary of the Department of Health and Human Services. You will not face retaliation for filing a complaint.

**Privacy Officer**

For further information, please contact our Privacy Officer, Karen McNerney at:

[PO Box 1200 Colleyville, TX 76034]

**Effective Date: June 15, 2022**

## PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Paragon's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Paragon may use and disclose your health information. I understand that the Notice is subject to change.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Personal Representative Relationship (e.g., Attorney-In-Fact, Guardian, Parent if a a minor)

Date Signed _____/_____/_____

PARAGON
Health Partners

## PARAGON PAIN REHABILITATION, LLP

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's name: _____ Prior Name, if any: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____ DOB: _____

**RECEIVING PARTY**: I hereby authorize Paragon Pain Rehabilitation, LLP ("Paragon") to release my health information, including copies of my medical records, to the following person or entity:

_____
Name of Person or Entity Telephone No

.

_____
Street City State Zip

**PURPOSE OF RELEASE:**

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal Copy ☐ Leaving Paragon*
☐ Other

| **TYPE OF INFORMATION TO BE RELEASED (Please indicate by checking applicable box):** | **SPECIFIC INFORMATION TO BE RELEASED (Please confirm release by initialing below):** |
|---|---|
| ☐ Complete medical record<br>(Please specify dates of service):<br>_____<br>☐ Partial Medical record<br>(Please specify which records):<br>_____<br>☐ Billing Records<br>☐ Other | _____ HIV/AIDS/STD test results/information<br>_____ Genetic testing information<br>_____ Alcohol/Drug Abuse<br>_____ Behavioral/Mental Health Information |

1. **EXPIRATION OF AUTHORIZATION:** I understand that this Authorization is valid for three (3) years from the date I sign this authorization and will expire at that time unless another expiration date/event is written here: _____.

2. **SPECIAL INFORMATION**: This authorization may include disclosure of information relating to **DRUG**, **ALCOHOL** and **SUBSTANCE ABUSE**, **MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

3. **RIGHT TO REVOKE AUTHORIZATION**: I understand that I have the right to revoke this authorization at any time by giving written notification to Paragon at info@paragonphp.com. I understand that the revocation will not have any effect on actions taken by Paragon in reliance on this authorization before it receives my written notice of revocation. I also understand that the revocation will not apply to any health information that has already been released in response to this authorization. Once Paragon has released my health information to a recipient, the recipient may re-disclose my health information to third parties.

4. **RIGHT TO REFUSE TO SIGN AUTHORIZATION**: I understand that I may refuse to sign this authorization. I understand that my refusal will not affect my ability to receive treatment at Paragon and that Paragon may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

5. **RIGHT TO COPY OF AUTHORIZATION**: I understand that I have a right to a signed copy of this authorization.

By signing below, I understand the potential that medical records and information disclosed pursuant to this authorization in whatever form and/or means provided may be subject to re-disclosure by the recipient and will no longer be subject to protections under the federal privacy laws and regulations. I hereby release Paragon and its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of these medical records and the information included I have authorized above.

_____ _____

Signature of Patient (or Patient's representative) Date

_____ _____

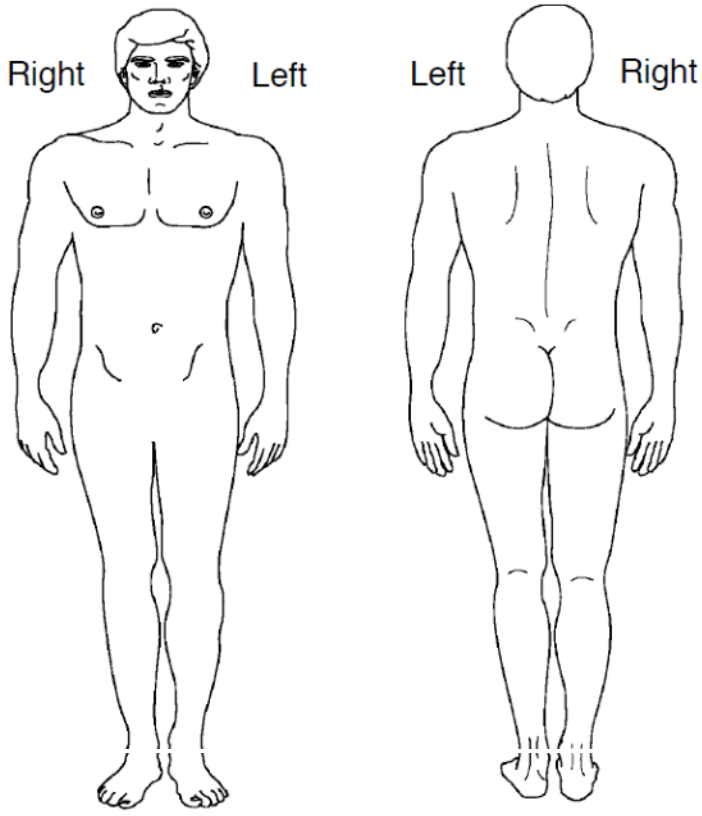
Printed Name If Representative, Basis for Authority

If the patient is minor, the minor individual's signature is also required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____

Date: _____

**Use this diagram to draw the location** of your pain and check all of the following that describe your pain.




- ❑ Aching
- ❑ Cramping
- ❑ Dull
- ❑ Hot/Burning
- ❑ Numbness
- ❑ Shock-like
- ❑ Shooting
- ❑ Spasming
- ❑ Squeezing
- ❑ Stabbing/Sharp
- ❑ Throbbing
- ❑ Tingling/Pins & Needles
- ❑ Tiring/Exhausting

## Pain Frequency

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

## Mark all of the following activities that are adversely/negatively affected by your pain

| | | |
|---|---|---|
| ❑ Enjoyment of Life | ❑ Normal Work | ❑ Sleep |
| ❑ General Activity | ❑ Recreational Activities | ❑ Walking |
| ❑ Mood | ❑ Relationships with People | ❑ Other: _____ |

❑ My goal is to resume normal activities

## In the past three months have you developed any new:

| | | | |
|---|---|---|---|
| ❑ Balance Problems | ❑ Bladder incontinence | ❑ Bowel incontinence | ❑ Chills |
| ❑ Difficulty Walking | ❑ Fevers | ❑ Nausea | ❑ Vomiting |

❑ Numbness/Tingling – Where?_____ ❑ Weakness – Where? _____

❑ **I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS**

What makes the pain worse? _____

_____

_____

What makes the pain better?_____

_____

_____

## Diagnostic Tests and Imaging

ist the ost recent test(s) you have had that are related to your current pain complaints:

❑ MRI of the _____ Date: _____ Facility: _____

❑ X-ray of the _____ Date: _____ Facility: _____

❑ CT scan of the _____ Date: _____ Facility: _____

❑ EMG/NCV study of the _____ Date: _____ Facility: _____

❑ Ultrasound of the _____ Date: _____ Facility: _____

❑ Other diagnostic testing: _____

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

## Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

❑ Physical Therapy ❑ Psychological Therapy ❑ Podiatrist Treatment

❑ Chiropractic

❑ Epidural Steroid Injection – (circle proper levels) Cervical / Thoracic / Lumbar

❑ Joint Injection – Joint(s)_____

❑ Medial Branch Blocks or Facet Injections – (circle proper levels) Cervical / Thoracic / Lumbar

❑ Pain Pump _____

❑ Radiofrequency Ablation – (circle proper levels) Cervical / Thoracic / Lumbar

❑ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant

❑ Spine Surgery _____

❑ Trigger Point Injection

❑ Vertebroplasty / Kyphoplasty – Level(s) _____

❑ Other:

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

## Medications

Please list **ALL** of the medications you are taking, **Pain meds listed first.** Attach an additional sheet if necessary.

| Medication Name | Dose | Frequency | Medication Name | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Please list ALL pain medications you have taken in the past and are now **not** taking.

_____
_____
_____
_____

## Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____
- ❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat

- ❑ Glaucoma
- ❑ Headaches
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Migraines

Cardiovascular / Hematologic

- ❑ Anemia
- ❑ Bleeding Disorders
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Pacemaker/Defibrillator
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Stroke

Respiratory

- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Exposure to mold

Gastrointestinal

- ❑ Bowel Incontinence/IBS
- ❑ Acid Reflux (GERD)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

Musculoskeletal

- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
- ❑ Chronic Joint Pain
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Phantom Limb Pain
- ❑ Rheumatoid arthritis
- ❑ Tennis Elbow
- ❑ Vertebral Compression fracture

Genitourinary/Nephrology

- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Infection(s)
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Hepatic

- ❑ Hepatitis A (active / inactive / unsure)
- ❑ Hepatitis B (active / inactive / unsure)
- ❑ Hepatitis C (active / inactive / unsure)

Neuropsychological

- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Complex Regional Pain Syndroe

❑ **Other Diagnosed Conditions**

_____
_____
_____
_____

## Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the **date, type,** and any pertinent **details.**

_____

_____

_____

_____

❑ **I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE**

## Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

| | Alcohol problems | Cancer | Diabetes | Drug problems | Abnormal bleeding | Headaches | Heart Disease | High blood pressure | Kidney disease | Liver disease | Rheumatoid arthritis/Lupus | Smoking | Stroke |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | |

Other medical problems: _____

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ❑ **I AM ADOPTED (No Medical History Available)**

## Social History

Are you capable of becoming pregnant? ❑ Yes ❑No *If so*, are you currently pregnant? ❑ Yes ❑No

Highest level of education obtained: ❑ Grammar school ❑ High school ❑ College ❑ Post-graduate

Are you currently working? ❑ Yes ❑ No What is/was your occupation?_____

Alcohol Use: ❑ Denies alcohol use ❑ Current alcohol use How much?_____
❑ History of alcohol abuse

Tobacco Use ❑ Denies tobacco use ❑ Current tobacco use How much? _____
❑Former tobacco user

Illicit Drug Use: ❑ Denies any Illicit drug use ❑ Currently using Illicit drugs Which? _____
❑ History of illicit drug use

Have you ever abused narcotic or prescription medications? ❑ Yes ❑ No; *If So*, which_____

Are you currently in remission for alcohol or any other addictions ❑ Yes ❑ No ❑ not applicable

Did anything specific happen to cause the pain? ☐ Yes ☐ No
If yes, please Describe:

Is the injury or pain the result of a work-related injury? Yes ☐ No ☐
Date of Injury? _____ Have you reported it to your employer? Yes ☐ No ☐

Is the injury or pain motor vehicle related? ☐ Yes ☐ No
Date of Injury? _____

Is there a lawsuit (pending or considered)? ☐ Yes ☐ No

Do you have a history of sexual abuse? ☐ Yes ☐ No
Do you have a history of physical abuse? ☐ Yes ☐ No
Do you have a history of emotional abuse? ☐ Yes ☐ No
If yes to any please describe:

_____

Please check if you are allergic to ❑ Iodine or ❑ Tape

**Are you allergic to latex?** ❑Yes ❑No

## Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ❑ Yes ❑No

If so, have you ever had any adverse reaction to anesthesia? ❑ Yes ❑No

Which type of anesthesia did you react adversely to? Please check all that apply.
❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

What was the reaction? _____

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?
❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

## Allergies

Do you have any known drug allergies? ❑Yes **Allergic Reaction Type (What Happens?)**

If so, please list all medications you are allergic to: ❑No
**Medication Name**

## Goals of Treatment

Please explain your goals of treatment_____
_____
_____
_____

If on opioids, **please explain how they help you**, what they allow you to do if you were not taking them otherwise_____
_____
_____

## Review of Systems

Mark the following symptoms that you **currently** suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

**Constitutional**: ❑ Weakness ❑ Fatigue ❑ Weight gain ❑ Weight loss ❑ Fever ❑ Chills ❑ Night sweats

**Eyes**: ❑ Recent visual changes ❑ Eye glasses/contact lenses ❑ Double vision

**Ears/Nose/Throat**: ❑ Dental Problems ❑ Ear aches ❑ Hearing probles ❑ Nosebleeds
❑ Recurrent sore throats ❑ Ringing in the ears ❑ Sinus problems

**Cardiovascular**: ❑ Chest pain ❑ Irregular heartbeat ❑ Murmur ❑ Rapid heartbeat ❑ Blood clots
❑ Swollen extremities ❑ Palpitations ❑ Fainting

**Respiratory**: ❑ Cough ❑ Shortness of Breath on Exertion/Effort ❑ Wheezing ❑ Shortness of breath at rest

**Gastrointestinal**: ❑ Acid reflux ❑ Abdominal cramps ❑ Constipation ❑ Diarrhea ❑ Vomiting
❑ Coffee ground appearance in vomit ❑ Dark and tarry tools

**Genitourinary/Nephrology**: ❑ Blood in Urine ❑ Decreased urine flow/Frequency/Volume ❑ Flank pain
❑ Erectile dysfunction ❑ painful urination ❑ Incontinence

**Integumentary/Skin:** ❑ Change in skin color ❑ Rashes ❑ Puritis ❑ Dry skin

**Musculoskeletal** ❑ Joint swelling ❑ Back pain ❑ Muscle spasms ❑ Joint pain ❑Neck pain
❑ Pelvic pain ❑ Joint stiffness

**Psychiatric**: ❑ Depressed mood ❑ Anxiety ❑ Stress ❑ Suicidal Thoughts

**Endocrine:** ❑ Heat Intolerance ❑ Cold Intolerance ❑ Hair changes ❑ Excessive thirst

**Neurological**: ❑ Dizziness ❑ Seizures ❑ Headaches ❑ Numbness/tingling ❑ Memory loss
❑ Difficulty with speech ❑ Uncoordination ❑ Difficulty walking

**Hematologic/Lymphatic:** ❑ Easy bruising ❑ Easy bleeding ❑ Impaired wound healing ❑ Lymphadenopathy

**Allergic/Immunologic:** ❑ Recurrent infection ❑ Hives ❑ Swelling ❑ Itching eyes or nose