Salutations:_____

Appointment Date: _____ Time:_____ Location:_____

Welcome to The Institute for Florida Pain Specialists. Enclosed is a packet of information to help acquaint you with our office as well as prepare you for your iinitial appointment. Please arrive **30 MINUTES** before your scheduled appointment time so we have time to acquire any additional records prior to the provider seeing you. Please allow up to 3 hours for your initial visit. We ask that the following items be brought to your initial appointment:

1. Completed enclosed packet
2. Insurance Cards
3. Valid Photo ID
4. Medical records pertaining to what we are seeing you for
   (including x-ray images and reports, CT scan images and reports, MRI images and reports, etc.)
5. A list of your current medications
6. Insurance referral (only if your insurance carrier requires one)
7. Co-pay (only if your insurance requires one)

if you arrive to the appointment without all the necessary information you will be rescheduled

Directions to the office are available on Google Maps or Waze Maps

FLPainSpecialists.com

1895 Kingsley Ave. STE #1005B	1604 Margaret St.	3010 138th Ave. STE #100
Orange Park, FL 32073	Jacksonville, FL 32204	Tampa, FL 33613

Phone: 904-647-5266 Fax: 904-770-5594

(for all locations)

referral@alifewithoutpainispossible.com

Dear Patient,

Welcome and thank you for choosing us for your health care needs. The Institute for Florida Pain Specialists is here to assist you with your medical care. Our medical and office staff strives to provide you with outstanding care and address your needs. We hope your visit with us exceeds your expectations.

We appreciate your careful consideration of the following guidelines, in accordance with the American Medical Association. Please do not ask the staff to make exceptions to this policy, as it can be disruptive to patient care.

FINANCIAL GUIDELINES

If you are unable to provide the office with complete healthcare insurance, Workers Compensation or Automobile Insurance information, or if your insurance carrier does not cover visits and/or procedures, you will be asked to make full payments at the time of service.We do accept Letters of protection as arranged in advance with local attorneys in personal injury cases on a case by case basis. Please let us know in advance who is representing you and the contact information for their office along with case information and date of injury.

Co-payments and/or deductible, depending on insurance status: are required prior to you seeing a Medical Provider. Our records with insurance carriers dictate co-payments and/or deductibles must be collected on the day of service. All outstanding balances are expected to be paid prior to the time of your next visit. Failure to do so will result in rescheduling your appointment.

Some insurance carriers will send checks for our services directly to the patient. If you receive a check from your insurance carrier for services provided by The Institute for Florida Pain Specialists please endorse the check and send it to us along with all Explanation of Benefits and any balances you, the patient, are responsible for to satisfy your balance due.

Patients who lose/cancel/end their Healthcare, Workers Compensation or Automobile insurance while under the care of The Institute for Florida Pain Specialists will be given a 90 day time period to obtain insurance or risk being terminated from the practice under the guidelines of the American Medical Association Council on Ethical and Judicial Affairs.

Should you have any questions regarding billing issues or billing statements you receive please contact our billing department at **(904) 647-5266**. Monday through Friday from 8:00 AM to 5:00 PM, excluding holidays.

Thank you

Travis Randall Von Tobel, MD

***missed appointment charge policy ***

EFFECTIVE 1/1/2017 THE FOLLOWING CHARGES WILL BE ASSESSED FOR APPOINTMENTS THAT ARE NOT CANCELED AT LEAST 24 HOURS PRIOR TO THE SCHEDULED APPOINTMENT TIME.

$25 – Established patient visit, physical therapy treatment, psychological evaluations/treatments, DME-related visits, All Diagnostic testing (imaging/EMG), scheduled urine drug screens and nurse visits.
$50 – New Patients visits and All procedures

Last name, First name, Middle initial	
Preferred Name	
Date of Birth	
SSN	
MAILING ADDRESS	
HOME / CELL PHONE NUMBER	
DRIVERS LICENSE NUMBER & STATE	
Guarantor (responsible for medical bills)	
EMAIL	
SIGNING UP FOR PATIENT PORTAL?	
MARITAL STATUS	
SEXUAL ORIENTATION	
GENDER IDENTITY & PREFERRED PRONOUN	
ASSIGNED SEX AT BIRTH	
EMERGENCY CONTACT NAME & NUMBER	
ETHNICITY	
PREFERRED LANGUAGE	

REASON FOR VISIT	
REFERRING PROVIDER	
PRIMARY CARE PROVIDER	
PREFERRED PHARMACY	
IS THIS VISIT RELATED TO AN INJURY?	
IF SO WHAT TYPE? AUTO, FALL, WORK RELATED?	
IF THIS IS AN INJURY, DATE OF ACCIDENT:	/ /
IN WHAT STATE DID THIS ACCIDENT OCCUR?	
DID YOU GO TO THE ER / URGENT CARE?	DATE AND LOCATION OF ER / URGENT CARE VISIT:
Are you represented by an attorney in a case which involves the reason you are being seen in our office today?	YES / NO
Name of Attorney and office location:	
DID YOU GET IMAGING POST ACCIDENT? XRAY, MRI, ETC? IF SO, WHERE?	

Florida is a no fault state, so regardless of who's fault the accident was, we need the name of YOUR auto insurance at time of accident, Auto insurance policy number and case number if assigned by your auto insurance. Also any case worker that may have been assigned to your case.	AUTO Insurance Name:_____ AUTO Insurance Policy Number: _____ AUTO Case number Assigned:_____ AUTO Caseworker Name:_____ AUTO Caseworker Phone:_____
Is this visit related to a work injury?	
If this visit is related to a work injury, what was the date of injury?	Date of Injury: / /
Who carries your workers comp insurance? What is your workers comp case number?	Workers comp carrier: _____ Case Number/BODY PART: _____
Name and contact information for your Workers comp caseworker	Name of caseworker: _____ Phone number for caseworker: _____
OTHER TYPE OF ACCIDENT INFORMATION	

Commercial Primary Insurance Name	
Insurance policy ID number and group number	
Insured's name, date of birth and relationship	
Secondary Commercial Insurance name	
Insurance policy ID and group number	
Insured's name, date of birth and relationship	
Tertiary Insurance Name	
Insurance policy ID number and group number	
Insured's name, date of birth and relationship	
Office Use Only, All insurance showing eligible?	

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES, CO-INSURANCE AND / OR BALANCE THAT IS NOT PAID BY MY INSURANCE.

_____

Patient Signature Date

_____

Signature of parent/guardian if minor Date

As required By The Privacy Regulation Created as a Result of the Health Insurance Portability and Accountability Act of 1966

(HIPAA) THIS NOTICE DESCRIBES HOW THE INSTITUTE FOR FLORIDA PAIN SPECIALISTS MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU AND HOU YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE

REVIEW THIS NOTICE CAREFULLY. OUR COMMITMENT TO YOUR PRIVACY

The Institute for Florida Pain Specialists is dedicated to maintaining the privacy of your individually identifiable health information (IHI). In the course of treating you, we will create records of the treatment and services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and our privacy practices.

The terms of this notice apply to all records containing your IHI that we created or retain in our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will be effective for all your records created or maintained by this office in a visible location al all times. And you may request a copy of our most current Notice at any time.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY OFFICERS:
FOR CONCERNS OR QUESTIONS CONCERNING CARE PROVIDED AT OUR OFFICE, PLEASE CONTACT PRIVACY OFFICIAL:
SHANNON RILEY 904-647-5266.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IHI) IN THE FOLLOWING WAYS:

1. Treatment. Our practice may use your IHI to treat you. We may ask you to have diagnostic studies (such as MRI or X ray),and we will use the results of these tests to help us reach a diagnosis. We may use your IHI in order to write a prescription for you, or we may disclose your IHI to a pharmacy when we order a prescription for you. Many of the people who ask for our practice-including, but not limited to, assist others in your treatment. Additionally, we may disclose your IHI to others, upon your designation.

2. Payment. Our practice may use and disclose your IHI in order to bill and collect payments for the services and items that we provide. We may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your IHI to obtain payment from third parties that may be responsible for such costs. Also, we may use your IHI to bill you directly for services and items.

3. Health Care Organization. Our practice may use and disclose your IHI to operate our business operations. These uses and disclosures are necessary to monitor the quality of care that we provide. Our practice may use your IHI to evaluate The Institute for Pain Specialist services, including the performance of our staff.

4. Appointments. In order to protect your IHI, appointments, cancellations, and rescheduling cannot be made with the answering service. All calls of this nature must be made during office hours between 8:00 AM TO 5:00PM and must be made directly with practice personnel. Our practice may use your IHI to contact you and remind you of an appointment either by mail or phone, including leaving a message on your designated answering machine.

5. Deceased Patients. Our practice may release your IHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donations/Research. Our practice may release your IHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation or transplantation if you are an organ donor. Our practice may use and disclose your IHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IHI for research purposes except when : (a) our use or disclosure was approved by an Institutional Review Board or Privacy Board: (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IHI is being used only for the research; (iii) the researcher will not remove any of your IHI from our practice; or (c) the IHI sought by the researcher relates only to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide use with proof of death prior to access of IHI of the decedents.

7. Serious Threats to Health or Safety. Our practice may use and disclose your IHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

8. Military. Our practice may disclose your IHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National Security. Our practice may disclose your IHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your IHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

10. Inmates. Our practice may disclose your IHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary; (a) for the institution to provide health care services to you;(b) for the safety and security of the institution and/or (c) to protect your health and safety or the health and safety of other individuals.

11. Worker's Compensation. Our practice may release your IHI for worker's compensation and similar programs.

IHI: You have the following rights regarding the IHI that we maintain about you. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to the Privacy Office, Shannon Riley: Tiffps.sriley@gmail.com Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IHI only to certain individuals involved in your care or for the payment of our care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction on our use of disclosure of your IHI, you must make your request in writing to the Privacy Officer, SHANNON RILEY Your request must describe in a clear and concise fashion in the following items:
a. The information you wish restricted;
b. Whether you are requesting to limit our practice's use, disclosure or both: and
c. To whom you may want the limits apply

PATIENT: I certify that I read a copy of the Notice of Privacy Practices and I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information

Patient Name: _____ Patient DOB:_____

Patient Signature:_____ Date Signed:_____

If signing as legal guardian/patient representative: I certify that I am the authorized

representative of

Patient Name:_____ Patient DOB:_____

Todays Date:_____ Your Printed Name:_____

Relationship to patient:_____

Signature:_____

A copy of this document will be filed in patient medical record

FOR OFFICE USE ONLY: Patient/Representative refused to sign Acknowledgment of Privacy Notice.

Office Personnel Printed Name:_____ Patient Account #_____

Today's Date:_____

MEDICATION TREATMENT CONTRACT

The treatment of chronic pain may involve the use of many different modalities such as nerve blocks, exercise, surgery, psychology techniques, and pain medications. Some of the medications prescribed by your doctor may include substances such as ibuprofen (Motrin & Advil), amitriptyline (Elavil, an antidepressant drugs that may decrease pain) Your doctor may also decide to do a trial with an significant analgesic, such as morphine, to assess its efficacy in treating your pain. The goal of this practice is to identify the source of your pain and assist in your treatment of your pain disorder. Long term narcotic control of your pain may be necessary if other means of treatment do not provide any significant relief. We will assist your primary care physician in developing a narcotic/medication regimen to control your symptoms in that case, but will not thereafter provide long term treatment. Once a narcotic/medication regimen has been established we will help in transitioning this care to your family physician or internist. If you do not have a primary care physician we will assist you in finding one. No controlled substance will be prescribed until after a review of your medical records and signing of this agreement. Some patients have an excellent response to morphine and morphine-like drugs (opioid). These patients experience a notable decrease in their pain without interfering side effects, such as sedation and nausea. This favorable response allows these patients to increase their function. Unfortunately, not all patients have a favorable response to morphine and morphine-like medication and may experience significant side effects that prevent further use of this type of pain medicine. Additionally, these drugs do not decrease all pain syndromes. Your doctor has no way of knowing which side affects you may experience or how much pain relief you may experience. Furthermore, these medicines may cause unintended psychological effects such as a false sense of wellbeing and improved ability to cope with problems. Sometimes patients who experience these psychological effects may use these medicines

in a way other than prescribed. There exists a significant misunderstanding regarding the use of opioid analgesics. The following definitions are important for you to understand.

Physical Dependence– is a pharmacological property of certain drugs, such as caffeine and opioids, because biochemical changes in the body such that abruptly stopping these drugs will result in a "withdrawal" response.

Addiction– is a psychological and behavioral syndrome in which there is drug craving and drug seeking behavior, for purpose other than those intended by your physician, For example, addictive behavior would include increasing your usual dose of opioid(without prior discussion with your doctor) for psychological benefit to self-medicate during a stressful situation. The risk *of addiction* in patients who do not have a prior addiction history (to any substance) is extremely low. The risk of addictive behavior is much higher in patients who have a prior history of addiction. If you do develop an addiction problem your doctor will help you with this. Your doctor may decide that you should not continue on the particular drug or may decide that you may continue on the medicine, but only with very careful treatment guidelines.

URINE DRUG SCREENS/ORAL SWABS: We conduct randomized Urine/Oral drug screens on all patients. Some patients will have to complete a urine drug screen more frequently depending on our clinical assessment of each patient. In addition to random drug screens, patients could be subjected to random medications counts. Our drug screen process is to provide better compliance, safety and care for our patients.

INFORMED CONSENT: I understand that the use of opioid analgesics can be safe and effective treatment for my chronic pain. I also understand that there exists a risk of developing an addiction disorder; however, I also understand that this is extremely rare in patients who have no prior addiction history. I have truthfully advised my doctor.

MEDICATION REFILL POLICY: A Patient must be seen in the office every 7, 14 or 28 days for medication refills dependent on the state laws and how the medication that is prescribed is regulated by those laws. A patient may be required to be seen every 7, 14 or 28 days for medication per their insurance guidelines as well. We will need to follow the guidelines as required.

***All medications will be filled at time of office visit for a follow up, we do not do refills at procedure visits. No refill will be given except, if your office visit date is changed by our staff, requiring additional medication for that extra time period. Lost or stolen medication will not be refilled or replaced under any circumstances. *If the provider requests that the patient comes into the clinic for a "Pill count"the patient is required to keep the scheduled appointment and bring in their medication. All Medication will be counted by two staff members at that appointment to verify amounts. Failure to show or failure to bring your medication, will result in a breach of our medication policy. *Only the doctor or physician assistant may change the way medications are prescribed. Your medication will not be filled early if you adjust the dose yourself. If you are seen at the emergency room, please contact our office immediately. Do not fill the prescription without speaking with our providers.**

MEDICATION REFILLS ARE NOT MEDICAL EMERGENCIES. After your appointment, your medication should be sent to your pharmacy within 24 hours. If it has been greater than 24 hours, please let us know. Please do not call the office repeatedly. If you have spoken to someone or left a message, allow time for it to be worked on.

Pharmacies: Choose only one pharmacy to fill your prescription. The use of more than one pharmacy is a violation of our narcotic contract and you may be denied medication in the future. If you do switch to another pharmacy, you will need to fill out a new medical contract prior to receiving medication.

The Following are violations of the Medication Treatment Contract: Taking pain medication (including tramadol/ultram/ultracet/ medical marijuana) other than those prescribed by this practice (including form other physicians, friends, family, stranger, other patients or medication previously prescribed by this practice or by other physicians.) This includes using Illicit drugs and tampering in any way with urine/oral specimens.

By adhering to these guidelines, we sincerely hope to serve you better and alleviate any concerns about your prescriptions Patient

Signature _____Date_____

RELEASE OF INFORMATION:

This authorization gives The Institute For Florida Pain Specialists permission to use or disclose health information about you.

Patient Name: _____ Date of Birth: _____/_____/_____

Covered health information: The following health information is covered by this authorization (except as limited below) :

□ Office Visit Notes
□ Laboratory Reports
□ Imaging Studies (X-ray, MRI, EMG)
□ Consultation report (Please supply consulting physician's name and date below)
□ Operative Report: Procedure_____ Date_____
□ Billing Information (Claims, Explanation of Benefits)
□ Other (Please give specific description)

_____

Psychotherapy notes are not covered unless specifically included in a separate authorization. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded below.

Exclusions: _____

Specially protected information: The following information is specially protected by state and/or federal law. Please indicate below whether you would like the following information to be released.

Substance abuse records (drug or alcohol) **Yes □ No □ Initials ____**

HIV/AIDS related information **Yes □ No □ Initials____**

Mental health records protected by the Mental Health Procedures Act Yes □ No □ Initials ____

I, _____, acknowledge that I received a copy of the Notice of Privacy practices which summarizes the way my protected health information may be used and disclosed by the practice and stated my rights with respect to my protected health information. I understand the practice has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event the practice changes this Notice, a revised Notice will be posted in the practice and that I may obtain a current Notices of Privacy Practices at any time from the Privacy Officer. Shannon Riley at Tiffps.sriley@gmail.com

PROVIDE APPROPRIATE SIGNATURE(S) BELOW:

Signature of Patient: _____

Printed Name: _____

Date: _____

OR, IF PATIENT IS A MINOR OR HAS GUARDIAN/REPRESENTATIVE OR, IF PATIENT IS LEGALLY INCOMPETENT OR INCAPACITATED:

Signature of Patient/Guardian: _____

Printed Name: _____

Date: _____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, _____,

whose signature appears below, authorize The Institute For Florida Pain Specialists and its affiliated providers to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and The Institute for Florida Pain Specialists staff.

My signature certifies that I have read and understood the scope of my consent and that I authorized the access.

Signature of Patient: _____

Printed Name: _____

Date: _____

OR, IF PATIENT IS A MINOR OR HAS GUARDIAN/REPRESENTATIVE OR, IF PATIENT IS LEGALLY INCOMPETENT OR INCAPACITATED:

Signature of Patient/Guardian: _____

Printed Name: _____

Date: _____

Physician's Signature: _____

Date: _____

RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____

Please forward the requested information,on the above patient to:The Institute for Florida Pain Specialists at Fax: 904-770-5594.
If you have any questions regarding this request, please call us at 904-647-5266.

Name of facility you are requesting records from, along with address and Phone/Fax if available:

_____

_____

Name of facility you are requesting records from, along with address and Phone/Fax if available:

_____

_____

Information requested:

☐ **Office Notes**
☐ **MRI Reports**
☐ **Lab Work**
☐ **X-Ray Reports**
☐ **EMG Reports**
☐ **Other:** _____

I hereby authorized the release of the above requested information to The Institute For Florida Pain Specialists.

Patient Signature: _____

the Institute for Florida Pain Specialists

PATIENT INTAKE FORM

Name: _____ DOB:_____

Reason for visit today:

_____

_____

Pain currently:_____ Pain at its most severe:_____

Pain Scale for reference: 0 (no pain); 1-2 (tolerate without medication); 3-4 (tell someone about my pain, take aspirin or Motrin); 5-6 (Mild narcotic, ex. Tylenol #3); 7-8 (go to the ER, take strong narcotics); 9-10 (admission to hospital for pain control).

Where is your pain located? _____

When during the day you have your pain?_____

What makes your pain worse? _____

What makes your pain better? _____

Describe your pain (circle all that apply): Sharp, Burning, Shooting, Achy, Knife-Like, Twisting, pressure, Lancinating, Tooth-Ache, Deep, Heavy, Gnawing.

If pain is related to an accident or work injury, please explain here, if you need additional space please use the back of this paper.

_____

_____

_____

_____

MEDICAL HISTORY

DRUG ALLERGIES: _____

_____

_____

CURRENT MEDICATIONS/DOSAGE:

_____

_____

_____

VACCINE HISTORY :

FLU VACCINE THIS YEAR?_____ DATE:_____

COVID VACCINE? DATE OF 1ST:_____DATE OF 2ND:_____

PNEUMONIA VACCINE?_____ DATE:_____

ADDITIONAL VACCINES:_____ DATE:_____

CURRENT ILLNESSES/MEDICAL ISSUES:_____

_____

_____

FAMILY MEDICAL ILLNESSES, PLEASE CIRCLE ANY THAT APPLY TO FAMILY:

Diabetes, Asthma, High Blood Pressure, Heart Attack, Stroke, Cancer, Peptic Ulcers, Rheumatic Fever, Heart,Murmur, Mitral Valve Prolapse, HIV/AIDs, Hepatitis, Anemia,Seizures, Gallbladder, Hyper/Hypo Thyroid, Urinary Tract Infection,Pneumonia, Deep Vein Thrombosis, Bowel Disorder

ANY OTHER FAMILY MEDICAL ILLNESSES:_____

_____

_____

FOR FAMILY MEDICAL HISTORY, WHICH RELATIVE?_____

AGE OF ONSET_____ AGE AT DEATH_____

FOR FAMILY MEDICAL HISTORY, WHICH RELATIVE?_____

AGE OF ONSET_____ AGE AT DEATH_____

SOCIAL HISTORY:

DO YOU USE TOBACCO PRODUCTS? Yes / No IF YES, FOR HOW LONG:_____

PRODUCT AND AMOUNT:_____ AGE STARTED:_____

ARE YOU A FORMER SMOKER? Yes / No IF YES, FOR HOW LONG:_____

AGE STARTED:_____ QUIT DATE:_____

PRODUCT AND AMOUNT:_____

E-CIGARETTE/VAPE STATUS:_____

MOST RECENT TOBACCO SCREENING:_____

LAST TOBACCO COUNSELING DATE:_____

DO YOU HAVE AN ADVANCED DIRECTIVE?_____

DO YOU USE ALCOHOL? Yes / No IF YES, HOW MANY DRINKS A WEEK:_____

DO YOU USE ILLICIT DRUGS? Yes / No

DAILY CAFFEINE INTAKE:_____

ANY USE OF CHEWING TOBACCO? Yes / No

DIET (ie vegetarian,diabetic):_____

OCCUPATION:_____

EXERCISE LEVEL (circle one): NONE / OCCASIONAL / MODERATE / HEAVY

GENERAL STRESS LEVEL (circle one): LOW / MEDIUM / HIGH

HIGHEST LEVEL OF EDUCATION:_____

LIVE ALONE OR WITH OTHERS? _____

ANY SPORTING ACTIVITIES? _____

HAND DOMINANCE: Left / Right

ARE YOU CURRENTLY EMPLOYED? Yes / No

IF YES, WHERE?_____

IS THIS A WORK RELATED INJURY? Yes / No

DATE OF INJURY:_____

IS THE VISIT RELATED TO AN AUTO ACCIDENT? Yes / No

DATE OF ACCIDENT:_____

PAST MEDICAL HISTORY

PLEASE LIST PREVIOUS SURGERIES AND DATES: _____

_____

_____

_____

PAST MEDICAL HISTORY (circle all that apply): AIDS/HIV, ACID REFLUX, ANEMIA, ANXIETY, ARTHRITIS, ASTHMA, BACK INJURY, BLEEDING DISORDER, COPD, CANCER, CORONARY ARTERY DISEASE (CAD),DEPRESSION, DIABETES, FIBROMYALGIA, GOUT, HEAD TRAUMA/ INJURY, HEADACHES, HEART ATTACK, HEART DISEASE, HEPATITIS, HERNIA, HIGH CHOLESTEROL, HYPERTENSION, KIDNEY DISEASE, LIVER DISEASE, OSTEOPOROSIS, STROKE, SUBSTANCE ABUSE, THYROID ISSUES, TUBERCULOSIS, ULCERS

PLEASE LIST ANY ISSUES YOU WOULD LIKE TO DISCUSS TODAY:

_____

_____

_____

_____

HAVE YOU RECEIVED IMAGING IN THE LAST 3 YEARS? IF YES PLEASE LIST TYPE, BODY LOCATION AND IMAGING CENTER SO THAT WE CAN REQUEST RECORDS: _____

_____

_____

_____

IF HERE DUE TO A WORK RELATED INJURY, WHICH FORMS DO YOU NEED FILLED OUT FOR YOUR CASEWORKER? _____