NEUROVERSION
Break the cycle of pain

# Patient Registration Form

PATIENT INFORMATION: (Please print) Date: _____/_____/_____

Last name: _____ First name: _____ MI: _____

Preferred name (if applicable): _____ SS#: _____-_____-_____

Sex: ☐ Male ☐ Female ☐ Transgender Age: _____ DOB: _____/_____/_____

Marital status: ☐ Married ☐ Divorced ☐ Partner ☐ Single ☐ Widowed

Home phone: _____ Work phone: _____ Cell phone: _____

Best number to contact: ☐ Home ☐ Work ☐ Cell Can we leave message: ☐ Yes ☐ No

E-mail address: _____

Physical address (line 1): _____

Physical address (line 2): _____

City: _____ State: _____ Zip code: _____

☐ Mailing address is same as physical address

Mailing address (line 1): _____

Mailing address (line 2): _____

City: _____ State: _____ Zip code: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐ Not employed

If not-employed, is this due to present medical condition: ☐ Yes ☐ No

Occupation: _____

Employer: _____

PLEASE COMPLETE THE FOLLOWING THREE SECTIONS AS PER GOVERNMENTAL HEATH CARE REGULATIONS

Race (Please check all that apply):

□ American Indian □ Alaska Native □ Native Hawaiian □ Black or African American
□ Asian □ White □ Other Pacific Islander □ More than one race
□ Other □ Decline to specify

Ethnicity (Please check one):

□ Hispanic or Latino □ Non-Hispanic or Latino □ Decline to specify

**Preferred language**:
□ English □ Spanish □ Other

Do you require an interpreter: ☐ Yes ☐ No

HEALTH CARE PROVIDERS:

**Referring physician**: _____ Phone number: _____

Location: _____

**Primary care physician**: _____ Phone number: _____

Location: _____

INSURANCE INFORMATION:

**Primary insurance**: _____ ID #: _____ Group #: _____

Ins. address: _____ Phone number: _____

Subscriber's name: _____ Subscriber's DOB: _____/_____/_____

Subscriber's employer: _____

**Secondary insurance**: _____ ID #: _____ Group #: _____

Ins. address: _____ Phone number: _____

Subscriber's name: _____ Subscriber's DOB: _____/_____/_____

Subscriber's employer: _____

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Is this visit related to an accident: ☐ No ☐ Yes, workers compensation ☐ Yes, auto accident ☐ Yes, other

**If YES, the following information must be provided**:

Is there an open claim related to this? ☐ Yes ☐ No

Date of injury: _____/_____/_____ Claim #: _____

Adjuster's name: _____

Adjuster's phone number: _____ Adjuster's fax number: _____

Employer (workers comp): _____

PHARMACY INFORMATION:

Preferred local pharmacy: _____

City: _____ Phone number: _____

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship to patient: _____

Home phone: _____ Work phone: _____ Cell phone: _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

□ Referring doctor □ Friend □ Self
□ Newspaper □ Internet □ Other _____

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INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign):

*I hereby authorize Neuroversion to furnish information to insurance carriers concerning my illness and/or treatments. I assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.*

Signature: _____ Date: _____/_____/_____

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# Email Communication Agreement

For Our Patients: Information About Email Communication and Our Email Policies

You have asked to communicate with our office via email. To do so with safety and confidence, you must understand and agree to our guidelines. Please read the following information about email communication and our email policies. If you have any questions about what you read, please ask us or a member of our staff.

Following this information is an agreement that will protect your well-being and your confidentiality. If you understand our email policies and agree to adhere to them, please sign and date the form. We will give you a copy to take home if requested. If, at any time, you wish to discontinue email communication with this office, please submit your request in writing to us or a member of our staff. Thank you for your cooperation.

- Please be aware that email communication is not a substitute for a face-to-face encounter with a physician.
- It is our practice to make every effort to protect your confidential information in all communication. We acknowledge, however, that no email is 100% secure. Even the most carefully protected messages are stored on a computer's hard drive. Though it is unlikely, this information *could* be retrievable. We cannot guarantee against unknown privacy violations such as unauthorized access achieved by illegal activity.
- We ask you to limit your email communication with us: to ask routine, non-urgent medical questions; to schedule an appointment; or to report a mild reaction to treatment.
- We will try to respond to email messages within 2 business days. However, there is no way to guarantee that this will occur, for a variety of legitimate reasons. If you do not get a response from this office within 2 business days, it is up to you to contact us by telephone, mail, fax, or in person.
- We do not accept medication refill requests by email unless the request was preceded by a recent exam in the office. Even then, good medical practice may mean that it is necessary for you to be seen before we can refill your medication.
- We will do our best to avoid technical problems. However, if a computer virus infiltrates our system, we cannot guarantee that we could prevent it from inadvertently passing to your computer.
- If we are out of the office or if we are with other patients, a medical assistant will print out email messages for us and, at our direction, may respond to you on our behalf.
- If you fail to adhere to our email policies, we will discontinue our communication with you via email.

Please alert us to any questions you have about what you have read.

Patient Name
(please print): _____ DOB: _____/_____/_____

Patient Signature: _____ Date: _____/_____/_____

E-mail address: _____

# Notice of Privacy Practices for Protected Health Information

This notice describes how your Protected Health Information (PHI) may be used and disclosed and how you can get access to this information. Please review it carefully.

Neuroversion takes the privacy of your health information seriously. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

We are required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. We will act according to the terms of this Notice. We are required to notify you if we cannot accommodate a requested restriction or request and accommodate your reasonable request regarding methods to communicate health information to you. We reserve the right to change this Notice of Privacy Practices and to make any new practices effective for all Protected Health Information that we keep. Any changes made to the Notice of Privacy Practices will be prominently displayed, available at our offices and posted on our website (www.neuroversion.com).

The clinic is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. We will attempt in good faith to obtain your signed Acknowledgement that you were offered a copy of this Notice to use and disclose your confidential medical information for the following purposes.

**Treatment Purposes:**

- A medical assistant or scribe obtains treatment information about you and records it in a health record
- During the course of your treatment, the provider determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

**Payment Purposes:** We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given. **Exception: If you have paid a visit in full and have requested the information not be shared with your insurance carrier, we will not disclose that particular visit. **

**Health Care Operations:** We obtain services from our insurers or other business associates such as quality assessment and improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, and legal services. We will share information about you with such insurers or business associates as necessary to obtain these services.

**Other Disclosures and Uses:** Examples of other types of disclosures and uses of your PHI are listed below (note that this is not an exhaustive list). If you would like additional information on these, please contact us.

- Communication with family
- Notification of persons responsible for your care
- FDA, related to adverse events
- Threat to health or safety
- Law Enforcement as required by law; Judicial proceedings
- Abuse & Neglect
- Public Health
- Health Oversight to agencies for health oversight activities

We will not sell your PHI without written authorization. We will not use your PHI for marketing purposes without your written authorization. Patients do have a right to 'opt out' of such marketing information. Except where required by law, we will not disclose your psychotherapy notes without your written authorization. Other uses and disclosures, besides those identified in this Notice, will be made only with your written authorization and you may revoke the authorization as stated under "Your Health Information Rights."

NEUROVERSION

# Your Health Information Rights

The health and billing records we maintain are the physical property of the clinic. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our clinic – we are not required to grant the request, but we will comply with any request granted.
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full? – we must comply with this request.
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information.
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our clinic. Access to your health records will not include information to which your access is restricted by law. We may charge a reasonable fee for providing a copy of your health records or a summary of those records at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Electronic copies are also available on CD or through the patient portal.
- Appeal or denial of access to your protected health information, except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our clinic. We may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not a part of the health information kept by or for the clinic;
  - Is not a part of the information that you would be permitted to inspect and copy; or,
  - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.
- Request the communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our clinic.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our clinic. An accounting will not include uses and disclosures for treatment, payment, or operations; disclosures made to you or made at your request; disclosures made pursuant to an authorization signed by you; to family members to friends relevant to that person's involvement in your care or in payment for such care. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve month period.
- Revoke authorizations that you made previously to use or disclose information by delivering written revocation to our clinic, except to the extent information or action has already been taken.
- You have the right to be notified of any breach of your information that occurs.

## To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our Chief Operating Officer (Kristen Washburn) at 907-290-1683.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our COO. You may also file a complaint with the Department of Health and Human Services (DHHS). We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Updated 1/15/2020

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# Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ DOB: _____/_____/_____

**I, _____, acknowledge and agree that I have been offered a copy of Neuroversion's Clinic Privacy Practices.**

Signature: _____ Date: _____/_____/_____

Relationship to Patient (if unable to sign): _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reasons:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining the acknowledgement
□ Other (Please specify):

_____

_____

_____

_____

_____

Employee name (Please print): _____ Initials: _____

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# Financial Agreement

Patient Name: _____ DOB: _____/_____/_____

Patients are responsible for any and all charges incurred resulting from treatment provided at Neuroversion. As a service to our patients, Neuroversion will file claims with most insurance carriers directly; however, you are primarily responsible in full for your balance and for all services rendered. Please be aware that the contractual agreement is between yourself and your insurance company, not the physician's office. It is your responsibility to call and verify you coverage, know your benefits and know if authorization is required prior to scheduling your appointment. In cases where we participate with your insurance as a preferred provider; deductibles, co-pays, and co-insurance payments are due in full and expected at the time of service. All quotes given by our billing department for services, co-pays, co-insurance, etc. are estimates only. We accept money orders, personal checks, and cash, Visa, MasterCard, and Discover as payment options.

## Collection Procedure

For any surgery center procedures, you will receive two statements; one for the professional physician service, Luke Liu, MD and one for the ambulatory surgery center facility. These separate statements conform to current standards of billing practices within the healthcare industry. For clinic visits, you will receive only one statement from Neuroversion. If you have a urine drug screen, you should expect to see a bill and/or an explanation of benefits from the lab company as well. You will receive monthly statements which will reflect the total amount owing on your account until a payment has been received. If your account does not clear in a timely manner and you have not supplied requested information to our billing department, your account will be turned over to a third party collection agency. To prevent this from happening, we ask that you keep in communication and comply with our billing department in regards to your account.

It is your responsibility to update Neuroversion with any insurance changes prior to a scheduled appointment.

**All billing questions are to be directed to our billing department.**

We will process patient charges as follows:

## Self-Pay/No Insurance

A $250.00 non-refundable deposit is required at the time of scheduling a New Patient Consultation. Future appointments will be given a 20% discount and payment is due in full at the time services are rendered.

## Medicare

Neuroversion is a participating provider of Medicare. All Medicare supplemental insurances will be filed. Patients are responsible for their deductibles, co-pays, and co-insurance payments which are due in full at the time services are rendered.

## Commercial Insurance

As a courtesy to you, we will file your primary and secondary insurance. It is your responsibility to verify your benefits if authorization is required for our participation with you insurance company prior to your appointment. You must provide correct insurance billing information, along with a copy of your insurance card(s) at your appointment. Patients are responsible for the full balance on their accounts.

## Workers Compensation

The injury must have been reported to your employer, reported to the workers compensation carrier, and approved for coverage prior to your appointment. You will need to provide us with the name of the workers compensation carrier, billing address, adjustor's name and phone number, claim number, and date of the injury. Verification must be received prior to you appointment(s). It is your responsibility to verify if authorization has been received.

## No Show Policy

Neuroversion requires a 24 hour cancellation notice for all scheduled appointments not kept or the patient may be charged a $25.00 fee for the missed appointment. Insurance does not cover this charge.

## Returned Check Policy

You will be charged a $25.00 fee on all returned checks regardless of the reason.

I understand that by signing this Financial Agreement form, I agree to all the above (regardless of insurance status). I am ultimately responsible in full for all charges and balances on my account(s) for all services rendered, to Neuroversion. A copy of this agreement will be provided upon request.

Signature: _____ Date: _____/_____/_____
(Parent or guardian if minor.)

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# Clinical Agreement

I,_____, understand that in order to receive care for the treatment of pain at Neuroversion, I agree to comply with the following:

*(Please initial next to each item)*

_____ A. **APPOINTMENTS:** I will contact the clinic if I will be 5 to 10 minutes late. If I arrive more than 15 minutes late, I will be rescheduled. We require a 24 hour notice to cancel or reschedule your appointment. Appointments missed, rescheduled due to tardiness, or cancelled/rescheduled without a 24 hour notice will result in a $25.00 fee to the patient. This fee may be waived due to extenuating circumstances. If you require an interpreter and miss your appointment for any reason, you will be charged a $65.oo fee.

_____ B. **CHARGES:** All fees from patients are due at the time of visit. Non-payment of fees may result in the account being sent to collections and patient termination from Neuroversion.

_____ C. **TERMINATION:** I will no longer be eligible for care at Neuroversion if I am in possession of illicit drugs or substances, trafficking of controlled or illegal substances, intoxicated or convicted for DUI. If I forge or alter the prescriptions in any way, sell or share medications, or fail to comply with this contract, I will no longer be eligible for care at Neuroversion.

_____ D. **DRIVING AND OPERATING EQUIPMENT:** Many pain medications and procedures can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment while under the influence of prescription medications (i.e. narcotics/opiates) and whenever I feel drowsy.

_____ E. **TREATMENT OF STAFF:** I will be courteous and respectful to all staff members. Neuroversion does not tolerate verbal or physical abuse towards our staff. Swearing, yelling at, or threatening our staff may result in forfeiture of appointment and/or termination from Neuroversion.

_____ F. **MENTAL HEALTH:** A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with the healthcare providers of Neuroversion.

**I have thoroughly read this agreement before receiving treatment at Neuroversion. I understand and agree to the conditions of care described above and will comply with them. All of my questions about the terms of this agreement have been answered. I know that failure to comply with any of the terms of this agreement may result in immediate termination of service.**

Patient Signature _____ Date _____

Practitioner Signature _____ Date _____

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# Alcohol/Opioid/Benzodiazepine (CNS Depressant) Risk Acknowledgment

Neuroversion acknowledges the serious responsibility of caring for patients with pain, and the inherent risks of pain medications that act as central nervous system (CNS) depressants. While you may or may not be prescribed medication while in our care, nevertheless we want you to be aware of these risks so that you can make informed decisions.

In 2016, the FDA and CDC addressed the rising number of deaths associated with the opioid crisis by issuing guidelines for prescribing opioids for chronic pain. One of the chief concerns is the risk of opioids in combination with other CNS depressants; up to 30% of deaths from opioid overdose also involve benzodiazepines (a class of medications used for anxiety and insomnia), and up to 20% of opioid overdose deaths involve consumption of alcohol.[1] The guidelines state that opioids and benzodiazepines should not be used together, unless there is no other reasonable alternative medication available.

The FDA requires "black box warning" (the strongest warning possible) and patient-focused Medication Guides for prescription opioids and benzodiazepines, warning of the increased risks when taking them together.[2]

Example of FDA warning:

**Important Information for Patients**

FDA is warning patients and their caregivers about the serious risks of taking opioids along with benzodiazepines or other central nervous system (CNS) depressant medicines, including alcohol. Serious risks include unusual dizziness or lightheadedness, extreme sleepiness, slowed or difficult breathing, coma, and death. These risks result because both opioids and benzodiazepines impact the CNS, which controls most of the functions of the brain and body.

- Opioids are powerful prescription medicines that can help manage pain when other treatments and medicines cannot be taken or are not able to provide enough pain relief. They are also approved in combination with other medicines to reduce coughing. Common side effects include drowsiness, dizziness, nausea, vomiting, constipation, and slowed or difficult breathing. Opioids also carry serious risks, including misuse and abuse, addiction, overdose, and death. Examples of opioids include oxycodone, hydrocodone, codeine, and morphine.
- **Benzodiazepines** are drugs prescribed for to treat conditions like anxiety, insomnia, and seizures. Examples of these drugs include: alprazolam, clonazepam, and lorazepam. Common side effects include drowsiness, dizziness, weakness, and physical dependence.

If you are taking both opioids and benzodiazepines together, consult your health care provider to see if continued combined use is needed. For more information, please see the FDA Drug Safety Communication.

The following risks have been identified when opioids and benzodiazepines are used together:

1. Extreme sleepiness
2. Coma
3. Respiratory depression
4. Death (Four times greater risk than with either independently)

We ask that you sign below to acknowledge that you have been made aware of the risks of combining opioids with other CNS depressants such as benzodiazepines and alcohol. Your signature will indicate that you are aware of and accept these risks if you are prescribed or use opioids or CNS depressants while in our care.

Patient Name (please print clearly) _____ DOB _____

Patient Signature _____ Date _____

Witness/Practitioner Signature _____ Date _____


1. Tori ME, Larochelle MR, Naimi TS. Alcohol or Benzodiazepine Co-involvement With Opioid Overdose Deaths in the United States, 1999-2017. JAMA Netw Open. 2020;3(4):e202361.
2. https://www.fda.gov/drugs/information-drug-class/new-safety-measures-announced-opioid-analgesics-prescription-opioid-cough-products-and

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# Release of Information to Person

Patient Name: _____ DOB: _____/_____/_____

**I, _____, give permission to Neuroversion to provide information regarding my care to the following person:**

Name: _____ DOB: _____/_____/_____

Relationship to Patient: _____

**The following items may be released to the above named person. Note that releasing the information to the above named person to pick up items does not necessarily give them the right to open any sealed information or read any of the information labeled strictly for the patient.**

☐ **Prescription pick-up**

☐ **Receive medical information in person and/or over the phone**

☐ **Appointment information**

Signature: _____ Date: _____/_____/_____

Relationship to Patient (if unable to sign): _____

This document expires one year from date signed. A copy of this signed form will be provided to patient or legal representatives as well as the specified recipient upon request. An original copy will reside in patient chart.

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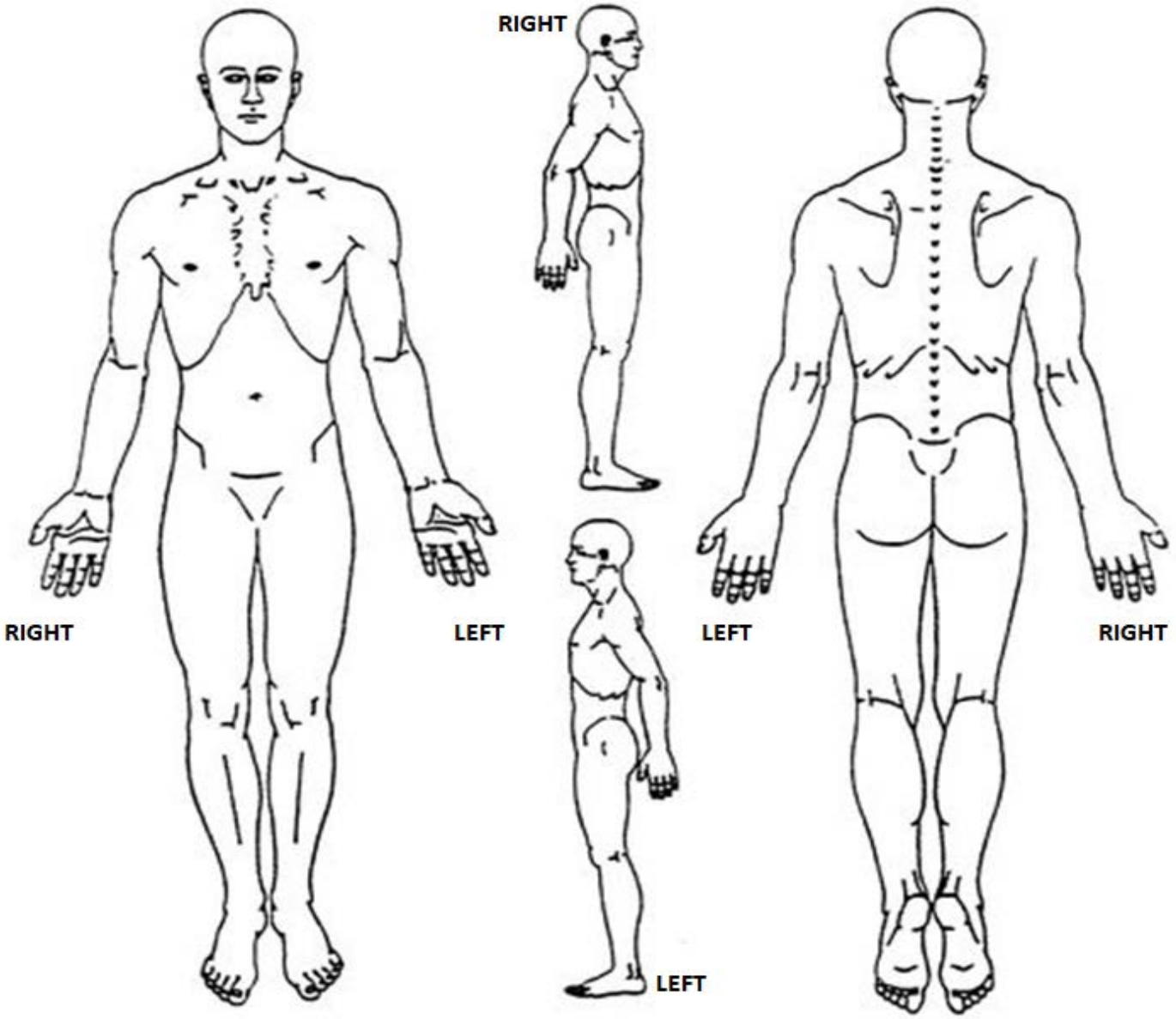
# New Patient Medical Summary

Name: _____ DOB: _____/_____/_____

Chief complaint(s): _____

Using the diagram below, please mark the location(s) of your pain and/or condition:




When did your pain begin? Date: _____/_____/_____ **OR** _____ DAYS _____ MONTHS _____ YEARS

How did your pain begin?

□ Injury at work
□ Injury not at work
□ Motor vehicle accident
□ Illness
□ Surgery
□ Due to other medical treatment

□ Other _____

What words best describe your pain?

| | | | |
|---|---|---|---|
| □ Burning | □ Sharp | □ Throbbing | □ Cutting |
| □ Aching | □ Soreness | □ Dull | □ Pins and needles |
| □ Cramping | □ Shooting | □ Pressure | |

□ Other _____

□ Other _____

Does your pain radiate anywhere: □ Yes □ No

If YES, please explain where: _____

_____

My average pain level is (circle one): 1 2 3 4 5 6 7 8 9 /10

How often do you have pain (Please check one):
□ Constantly (100% of the time)
□ Nearly constantly (60-95% of the time)
□ Intermittently (30-60% of the time)
□ Occasionally (less than 30% of the time)

When do you feel your pain is most persistent (Select all that may apply):

| | | | | |
|---|---|---|---|---|
| □ Morning | □ Midday | □ Afternoon | □ Evening | □ Night |

What do you associate your pain with or does your pain influence/cause:

| | | |
|---|---|---|
| □ Anger | □ Headache | □ Numbness |
| □ Anxiety | □ Incontinence | □ Poor sleep |
| □ Blurred vision | □ No bowel function | □ Sexual dysfunction |
| □ Change in appetite | □ Bladder dysfunction | □ Sleep apnea |
| □ Fatigue | □ Nocturnal movements | □ Weakness |

What makes your pain better?

| | | | | |
|---|---|---|---|---|
| □ Sleeping | □ Exercise | □ Injections | □ Ice | □ Physical therapy |
| □ Lying down | □ Heat | □ Medication | □ Rest | |

□ Other _____

□ Other _____

What makes your pain worse?

| | | | | |
|---|---|---|---|---|
| □ None | □ Lifting | □ Standing | □ Sitting | □ Climbing stairs |
| □ Sleeping | □ Walking | □ Straining | □ Driving | □ Bending |

□ Other _____

□ Other _____

What medications have you tried? If you run out of room, please provide a separate list.

| Medication Name | Side Effects (if any) | Effectiveness | | |
|---|---|---|---|---|
| □ Tylenol with Codeine #3 or #4, Fiorecet with Codeine, or Codeine | _____ | □ Worse | □ No change | □ Improved |
| □ Hydrocodone, Norco/Vicodin | _____ | □ Worse | □ No change | □ Improved |
| □ Hydromorphone/Dilaudid | _____ | □ Worse | □ No change | □ Improved |
| □ Methadone | _____ | □ Worse | □ No change | □ Improved |
| □ Buprenorphine/Butrans/Zubsolv Belbuca/Suboxone | _____ | □ Worse | □ No change | □ Improved |
| □ Tramadol or Ultram | _____ | □ Worse | □ No change | □ Improved |
| □ Oxycodone, Oxycontin, Percocet or Roxycodone | _____ | □ Worse | □ No change | □ Improved |
| □ Fentanyl/Duragesic/Sublimaze | _____ | □ Worse | □ No change | □ Improved |
| □ Morphine/Duramorph or MS Contin | _____ | □ Worse | □ No change | □ Improved |
| □ Nucynta | _____ | □ Worse | □ No change | □ Improved |
| □ Cymbalta/Duloxetine | _____ | □ Worse | □ No change | □ Improved |
| □ Lyrica/Pregablin | _____ | □ Worse | □ No change | □ Improved |
| □ Gralise | _____ | □ Worse | □ No change | □ Improved |
| □ Gabapentin/Neurontin | _____ | □ Worse | □ No change | □ Improved |
| □ Topamax/Topiramate | _____ | □ Worse | □ No change | □ Improved |
| □ NSAIDS: Aspirin, Ibuprofen Naproxen, Celecoxib, etc. | _____ | □ Worse | □ No change | □ Improved |
| □ Baclofen | _____ | □ Worse | □ No change | □ Improved |
| □ Flexeril/Cyclobenzaprine | _____ | □ Worse | □ No change | □ Improved |
| □ Tizandine/Zanaflex | _____ | □ Worse | □ No change | □ Improved |
| □ Robaxin/Methocarbamol | _____ | □ Worse | □ No change | □ Improved |
| □ Other _____ | _____ | □ Worse | □ No change | □ Improved |

Does your *current* medication regimen provide improvement of daily activities/function? □ Yes □ No

If YES, please list activities/functions you are able to perform with your *current* medication regimen:

Have you had issues with medication regimen compliance? □ Yes □ No

If YES, please explain why: _____

_____

What non-pharmacologic approaches have you tried? Complete following:

| Therapy Type | Date(s) Tried (if known) | Effectiveness | | |
|---|---|---|---|---|
| □ Physical therapy | _____ | □ Worse | □ No change | □ Improved |
| □ Occupational therapy | _____ | □ Worse | □ No change | □ Improved |
| □ Aquatic therapy | _____ | □ Worse | □ No change | □ Improved |
| □ Massage therapy | _____ | □ Worse | □ No change | □ Improved |
| □ Manual therapy | _____ | □ Worse | □ No change | □ Improved |
| □ Chiropractic adjustments | _____ | □ Worse | □ No change | □ Improved |
| □ TENS unit | _____ | □ Worse | □ No change | □ Improved |
| □ Procedures | _____ | □ Worse | □ No change | □ Improved |
| □ Biofeedback | _____ | □ Worse | □ No change | □ Improved |
| □ Acupuncture | _____ | □ Worse | □ No change | □ Improved |
| □ Psychotherapy | _____ | □ Worse | □ No change | □ Improved |
| □ Other _____ | _____ | □ Worse | □ No change | □ Improved |
| □ Other _____ | _____ | □ Worse | □ No change | □ Improved |

What specialists have you seen for your current condition, please provide their names if known:

| Specialty | Provider Name and/or Facility | Date of Last Visit/Consultation (if known) |
|---|---|---|
| □ Primary care physician | _____ | _____ |
| □ Neurologist | _____ | _____ |
| □ Physiatrist | _____ | _____ |
| □ Neurosurgeon | _____ | _____ |
| □ Orthopedic surgeon | _____ | _____ |
| □ Other _____ | _____ | _____ |
| □ Other _____ | _____ | _____ |

## MEDICAL HISTORY

Please check all current and past medical problems that apply to you:

□ High blood pressure
□ Asthma or wheezing
□ Heart attack
□ Chronic cough
□ Liver disease
□ Diabetes
□ Seizure or epilepsy
□ Chest pain
□ Arthritis
□ Kidney disease
□ Stroke/TIA
□ Bleeding problems
□ Peripheral vascular disease
□ Cancer, please specify: _____

□ Other: _____

## SURGICAL HISTORY

Please list past surgeries. If you run out of room, please provide a separate list:

| Type/Name of Surgery | Date (approximate) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## ALLERGIES

Please list all known drug allergies. If you run out of room, please provide a separate list:

| Medication/Drug | Reaction |
|---|---|
| □ Contrast dye | |
| | |
| | |
| | |
| | |
| | |

## FAMILY HISTORY

Please select/list all medical problems that affect family members:

**Father:**

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other _____

**Mother:**
□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other _____

**Brother(s):**
□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other _____

**Sister(s):**
□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other _____

**Other family member(s): _____**
□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other _____

□ **Adopted** □ **Family history unknown**

## SOCIAL HISTORY

Are you a:
□ Nonsmoker
□ Current smoker:
□ Vape user:
□ Smokeless tobacco user

□ Former smoker: Date quit: _____/_____/_____
_____ packs per day **OR** _____ cigarettes per day
How often per day? _____ times per day

□ Other _____

Did you have a drink containing alcohol in the past year? □ Yes □ No
If YES, how often did you have a drink?
□ Monthly or less □ 2-4 times a month □ 2-3 times a week □ 4 or more times a week
If YES, how many drinks did you have on a typical day when you were drinking in the past year?
□ 1-2 drinks □ 3-4 drinks □ 5-6 drinks □ 7-9 drinks 10 or more drinks
If YES, how often did you have 6 or more drinks on one occasion in the past year?
□ Never □ Less than monthly □ Monthly □ Weekly □ Daily
Do you have a history of alcoholism? □ Yes □ No
Have you ever been to a detox program for alcohol abuse? □ Yes □ No
Have you attended Alcoholics Anonymous? □ Yes □ No

## ORT

| | | |
|---|---|---|
| Do you have a family history of alcohol abuse? | □ Yes | □ No |
| Do you have a family history of illegal drug abuse? | □ Yes | □ No |
| Do you have a family history of prescription drug abuse? | □ Yes | □ No |
| Do you have a personal history of alcohol abuse? | □ Yes | □ No |
| Do you have a personal history of illegal drug abuse? | □ Yes | □ No |
| Do you have a personal history of prescription drug abuse? | □ Yes | □ No |
| Are you between the ages of 16-45? | □ Yes | □ No |
| Do you have a history of preadolescent sexual abuse? | □ Yes | □ No |
| Do you have ADD, OCD, bipolar, or schizophrenia? | □ Yes | □ No |
| Do you have history or are currently depressed? | □ Yes | □ No |

Have you used drugs other than those for medical reasons in the past 12 months? □ Yes □ No

If YES, please explain why: _____

_____

Have you ever been in a detoxification program for drug abuse? □ Yes □ No
Have you attended Narcotics Anonymous? □ Yes □ No

## PHQ-9

*Over the last 2 weeks, how often have you been bothered by any of the following problems?*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ | ☐ |
| Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| Feeling bad about yourself or that you are a failure, or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| Thoughts that you would be better off dead or of hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including your current pain?
□ Yes □ No
If YES, when? _____

Have you ever considered suicide?
□ Yes □ No
If YES, when? _____

Living arrangements:
□ Alone □ Spouse/partner □ Friends □ Children □ Other

Highest education level achieved:
□ Graduate or professional training (degree obtained)
□ College graduate (degree obtained)
□ Partial college training
□ High school diploma
□ GED or trade-technical social graduate
□ Partial high school (10th through 12th grade)
□ Partial junior high school (7th through 9th grade)
□ Elementary school (6th grade or less)

## Review of Systems

*Over the last 2 weeks, have you had any of the following symptoms:*

General/Constitutional:
□ Change in appetite □ Chills □ Fatigue □ Fever □ Headache
□ Lightheadedness □ Night sweats □ Sleep disturbance □ Weight gain □ Weight loss
□ No symptoms

**Allergy/Immunology:**

□ Cough □ Rash □ Sneezing □ No symptoms

**Ophthalmologic:**

□ Blurred vision □ Eye problems □ No symptoms

**ENT:**

□ Dry mouth □ Nosebleed □ Ringing in the ears □ No symptoms

**Endocrine:**

□ Cold intolerance □ Diabetes □ Difficulty sleeping
□ Excessive sweating □ Heat tolerance □ Hot flashes
□ No symptoms

**Respiratory:**

□ Asthma □ Breathing problems
□ Shortness of breath at rest □ Shortness of breath with exertion
□ No symptoms

**Cardiovascular:**

□ Chest pain at rest □ Chest pain with exertion □ High blood pressure
□ Irregular heartbeat □ Swelling in hands/feet □ No symptoms

**Gastrointestinal:**

□ Abdominal pain □ Blood in stool □ Change in bowel habits □ Constipation
□ Decreased appetite □ Diarrhea □ Difficulty swallowing □ Nausea
□ No symptoms

**Hematology:**

□ Bleeding problems □ No symptoms

**Genitourinary:**

□ History of kidney stones □ Difficulty urinating □ Kidney problems
□ No symptoms

**Musculoskeletal:**

□ Arthritis □ Back problems □ Carpal tunnel □ History of gout □ Joint stiffness
□ Leg cramps □ Muscle aches □ Painful joints □ Swollen joints □ Weakness
□ No symptoms

**Peripheral Vascular:**

□ Blood clots in legs □ Cold extremities
□ Decreased sensation in extremities □ Pain/cramping in legs after exertion
□ No symptoms

**Skin:**

□ Discoloration □ Hair changes □ Itching □ Nail changes
□ No symptoms

**Neurologic:**

□ Balance difficulty □ Difficulty speaking □ Fainting □ Loss of strength
□ Memory loss □ Pain □ Stroke □ No symptoms

**Psychiatric:**

□ Auditory hallucinations □ Visual hallucinations □ Depressed mood
□ Loss of appetite □ Psychiatric condition □ Suicidal thoughts
□ No symptoms

To the fullest of my knowledge, I have accurately and truthfully completed my health history.

Signature: _____ Date: _____/_____/_____