FLORIDA PAIN AND REHABILITATION CENTER

www.flpnr.com

440 SW Perimeter Glen
Lake City, FL 32025
Phone: (386) 719-9663
Fax: (386) 719-9662

1910 SW 18th Court
Ocala, FL 34471
Phone: (352) 629-7011
Fax: (352) 629-7924

6830 NW 11th Place, Suite A
Gainesville, FL 32605
Phone: (352) 331-0909
Fax: (352) 331-0970

1441 Ohio Ave. North
Live Oak, FL 32064
Phone: (386) 330-0163
Fax: (386) 330-0270

PATIENT REGISTRATION INFORMATION

PATIENT NAME____ D.O.B___________AGE____ MALE___ FEMALE___

ADDRESS____CITY________________STATE_______ZIP____________

HOME PHONE # ________________ CELL PHONE_______________E-MAIL ADDRESS___________________________

SS # __________________ EMPLOYER _____________________________OCCUPATION __________________________

MARITAL STATUS: ❑MARRIED ❑SINGLE ❑DIVORCED ❑SEPARATED ❑WIDOWED

SPOUSE NAME_____________________________________ S.S # ________________________ D.O.B.______________

PERSON TO NOTIFY IN CASE OF EMERGENCY ____

HOME PHONE __________________________________ RELATIONSHIP_______________________________________

PRIMARY INSURANCE: _____________________________________ ADDRESS ______________________________

CITY __________________________________STATE_______ZIP __________ PHONE #____________________________

POLICY # ______________________GROUP # _________________ INSURER ____________________________________

SECONDARY INSURANCE:__ ______________________________ ADDRESS ________________________________

CITY _________________________STATE_____ZIP____________PHONE # ____POLICY__________________________

GROUP # ______________________________ INSURER ____

IF WORK RELATED INJURY, PLEASE FILL OUT THE FOLLOWING INFORMATION:

CONTACT PERSON:____PHONE # __________________________

NAME OF EMPLOYER AT TIME OF INJURY ____

ADDRESS_____________________________________CITY_______________________STATE______ZIP___________

NAME OF INSURANCE COMPANY ____DATE OF ACCIDENT___________

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AUTHORIZATION FOR CONSENT TO RELEASE INFORMATION

FACILITY RELEASING INFORMATION: ____

PATIENTS FULL NAME: ________________________________ **DATE OF BIRTH:** ____________

PATIENTS ADDRESS: ____

PURPOSE FOR RELEASE OF INFORMATION: ____

INFORMATION AND/OR REPORTS TO BE RELEASED:

I do hereby release the above facility releasing information from all legal liability that may arise from the release of information, including psychiatric, alcohol, substance abuse, HIV testing, ARC, or AIDS information.

I understand that this consent is subject to revocation by me at anytime except to the extent that action has been taken based on this authorization. I understand that this authorization shall expire without my express revocation, 90 days after the affixed below.

____________________ ______________________________________
DATE **SIGNATURE OF PATIENT**

____
Relation if signed by other than patient

____________________ ______________________________________
DATE **WITNESS**

NOTICE

TO ACCOMPANY RELEASE OF ALCOHOL AND SUBSTANCE ABUSE RECORDS

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law regulation (42 CFR, Part2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

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PATIENT CONSENT FORM

Addition to HIPAA Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for use and disclosure of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. ***When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operation, in order to provide health care operation, in order to provide health care that is in your best interest.***

There are times you may wish other family members and friends to inquire about your appointments or have access to your medical information. We will not release any information unless you have listed them below. If you wish to allow messages other than just to return our calls on your message recorder, please indicate this also.

Recorded Message No __________ Do not leave message other than to "return call"
Yes __________ May leave message

List any family members or others you wish to have access to your records, for example, who may call us regarding your condition or call for you. ***We will not release information to spouses or your children unless they are listed here.***(We will require signed releases by you for anyone wanting access to your records other than the insurance companies you have listed, your healthcare provider necessary to your care, or persons listed below)

List of Names and how related:

____ ________________
____ ________________
____ ________________
____ ________________
____ ________________

I____________________________________ __________***acknowledge that I have received a copy of Florida Pain and Rehabilitation Center's Notice of Privacy Practices.*** This notice describes how Florida Pain and Rehabilitation Center Services may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I also understand I may revoke this authorization at any time, and receive a copy of this authorization

PRINTED NAME ____

SIGNATURE ____ DATE ______________

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Opioid Agreement

This agreement is necessary due to the nature of controlled substances and DEA laws. This is an opioid administration agreement between patient __________________ and Florida Pain and Rehabilitation Center (FPRC). It is agreed upon and patient understands that any breech of this agreement will result in immediate tapering or discontinuation of opioid therapy. Physicians may choose to terminate all services to patient.

1. The Doctor or PA or ARNP at FPRC has provided information to this patient regarding uses of medications and goals of treatment. Side effects of medication include but are not limited to: sedation (sleepiness), nausea, vomiting, constipation, change in mental status, decreased breathing, sleep disturbances, dry mouth, diarrhea, change in heart rate and blood pressure, drug dependence, addiction and even death in case of overdose.
2. Patient has been provided information about withdrawal symptoms resulting from abrupt stoppage or decrease in the dose of an opioid after prolonged use. Early symptoms of which include but are not limited to: sweating, goose flesh, tearing of the eyes, runny nose, cramps, increased temperature, increased breathing, and increased blood pressure.
3. Patient also understands that an opioid may impair mental/physical ability required for performance of potentially hazardous task, i.e. driving, or operating machinery.
4. Patient agrees that during the period when you are under the care of FPRC and obtaining prescriptions of narcotics from this facility, you will not accept any prescriptions for narcotics from any other facility without notifying physicians in FPRC. Violation of this rule will lead to the dismissal of the patient from this facility.
5. Patient agrees to random urine drug test or saliva test for medications and other drugs whenever asked by the physician at FPRC at patient's expense. Use of illegal drugs (e.g. marijuana, cocaine, and methyamphatamine) is not tolerated. If illegal drugs are found as a result of these tests, FPRC has the option of dismissing the patient and notifying the proper authorities.
6. Patients are required monthly visits for their prescriptions. Patient should strictly follow the doctor's instruction on dose and frequency of narcotics and not increase the dose of narcotics without notifying the doctor. Call our office and get permission first before you increase your narcotic dose. Otherwise, no early refills will be granted. **No extra prescription will be given for excuses such as "lost prescription, stolen prescription, stolen medication, dog ate my medication, left pills in hotel, or accidentally flushed medication down into toilet et al".** Patient agrees to appropriate planning, because no refills will be given on weekends or over the telephone. Patient is required to schedule and keep monthly appointments during regular office hours.
7. Patient agrees to allow FPRC to communicate with the primary/referring physician and any pharmacy/pharmacist regarding use of opioid/controlled substances.
8. Patient will make every effort to improve his or hers quality of life through friends and service to the community.
9. Patient will use only one pharmacy for filling of an opioid prescription and will be responsible for providing name, address, and telephone number of the pharmacy to FPRC.
10. Patient agrees to attend appointments with other specialists as ordered by physicians at FPRC regarding therapy and counseling. The patient understands in such cases that the physician does not see any improvements in function and pain relief while taking medications, medications will be discontinued and alternatives will be tested.
11. If female, patient certifies that she is not pregnant and will use appropriate contraceptive methods with the treatment of medications. She will notify the physician immediately if pregnancy occurs.
12. Patient may be asked to bring in unused medication to our office at any time for the purpose of pill count.
13. Any behavior believed as unacceptable by the practice including but not limited to: frequently asking for early refills, loosing prescriptions, asking for early refills because medication was stolen, sharing, selling, illicit/street drug use, medication hoarding, altering prescription, refusing for pill count etc., may be considered grounds for dismissal.
14. I herby give my consent to FPRC and its agents to give full access to my medical records to the law enforcement agent for any legal investigation related to my receiving of prescriptions with or without order of a court.

________________________________	________________________________
Patient Name	Witness
________________________________	________________________________
Patient Signature	Date
________________________________	________________________________
Pharmacy for narcotic prescriptions	Phone number

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Assignment of Benefits and Financial Responsibility

Assignment of Benefits

I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, auto insurance, private insurance and any other health/medical plan, to issue payment check(s) directly to Florida Pain and Rehabilitation Center for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility

I have requested medical services from Florida Pain and Rehabilitation Center (FPRC) on behalf of myself and/or my dependents, and I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I understand that FPRC will verify my insurance Benefits. I also understand at time of verification my insurance company may provide FPRC with a disclaimer that states “Verifying benefits does not guarantee payment of services rendered.”

I understand that if FPRC does not participate with my insurance carrier, FPRCis not required to file my insurance claim but will do so as a courtesy.

I understand that should my insurance deny or not pay the entire balance due for any reason (e.g. deductible, co-pays, or non-covered services) I will be held responsible and will make arrangements for payment on my account as soon as I receive notice from FPRC.

I further understand that fees are due and payable on the date that services are rendered and I agree to pay all such charges incurred in full **immediately** upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

In the event I do not pay my account balance or fail to make arrangements for payments I understand that my account is subject to be turned over to a collection agency. I will be responsible for any additional costs of collection and any reasonable attorney fees.

I understand if my insurance carrier or coverage should change or terminate during the course of treatment I am responsible for informing FPRC of such changes.

______________________________ Patient Name (Please Print)

______________________________ (If a minor) Guarantor’s Name (Please Print)

______________________________ Patient Signature

______________________________ (If a minor) Guarantor Signature

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW

FLORIDA PAIN AND REHABILITATION CENTER

MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Florida Pain and Rehabilitation Center (FPRC) is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by FPRC or received by FPRC from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. FPRC will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

FPRC reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not requiring Your Consent

FPRC may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependency. These are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies;

For example, FPRC may determine that you require the services of a specialist. In referring you to another doctor, FPRC may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by FPRC to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

*For example***,** FPRC will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, FPRC may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

FPRC may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power or attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when FPRC is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- ***As permitted or required by law.***
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- ***For public health activities.***
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV results to other providers or persons when there has been or will be risk of exposure.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose or reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- ***For health oversight activities***.

We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- ***Judicial and Administrative Proceedings***

Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order.
A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- ***For activities related to death.***

We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- ***For research.***

Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- ***To avoid a serious threat to health or safety.***

We may report a patient’s name and other relevant data to the Department of Transportation if it is believed the patient’s vision or physical or mental condition affects the patient’s ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient.

- ***For worker’s compensation***

We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

FPRC will not make any other use or disclosure of your protected health information without your authorization. You may revoke such authorization at any time, except to the extent that FPRC has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

- You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by FPRC to carry out treatment, payment, or healthcare operations. You must request such restrictions in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restrictions, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.
- You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. FPRC may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.
- You may request that FPRC send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that FPRC not send information to a particular address or location or contact you at a specific location, perhaps your place or employment. This request must be submitted in writing. We will accommodate reasonable request by you.
- You have the right to request that FPRC amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.
- You may request to receive an accounting of the disclosures of your health information made by FPRC for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization. You may request and receive a paper copy of this Notice.

Any person or patient may file a complaint with FPRC and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with FPRC, please contact:

YiLi Zhou, MD, PhD
Medical Director
Florida Pain and Rehabilitation Center
6830 NW 11th Pl Ste A Gainesville, FL 32605;
Phone: (352) 331-0909 Fax: (352) 331-0970

It is the policy of FPRC that no retaliation action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective September 1, 2005
This notice is prepared in accordance with the Health Insurance Portability and Accountability Act 45 C.F.R. 164.520

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Patient Initial Visit Information Sheet

Date: ___________

Last Name: ____________________ First Name:______________________ Middle Name: _______

Age:_______ Gender: M □ F □ Right handed □ Left handed □

Referring Physician: ______________ Primary Care Physician:_____________

Address: ________________________ Address: ___________________________

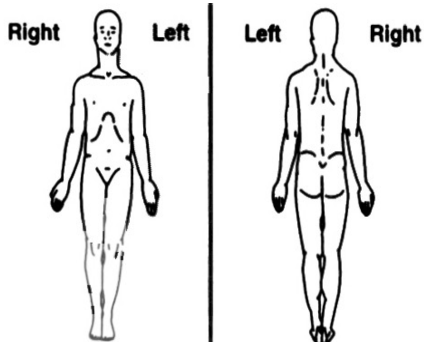
________________________ ___________________________

Phone: ________________________ Phone: ___________________________

Fax: ________________________ Fax: __________________________

Main reason for the visit: _________________________

Pain Diagram
On the picture below, please mark all the area of your pain:



1.When did your pain start: ________________

2. Please describe how your pain started:

a. Did you fall? □ yes □ no. *If yes,* Where____?

How did you fall? ________________________

b. Did you lift/push any thing heavy? □ yes □ no

If yes, where ________? What it was_______?

How heavy _________?

c. Was this a work related injury? □ yes □ no.

d. Did your pain start slowly without any injury?

□ yes □ no.

e. Where is your **main** pain now? _____________

3. Is your pain related to a motor vehicle accident? □ yes □ no. ***If yes, please answer following questions. Otherwise please go to question 4 directly.***

a. Date of the accident _____________

b. Were you □ the driver *or* □ a passenger in front *or* □ a passenger in the back row

c. Were you wearing a seat belt? □ yes □ no

d. At the time of accident, was your vehicle: □ stopped *or* □ moving and □ hit another vehicle *or* hit by another vehicle

e. Were you hit: □ head on, *or* at □ driver side, □ passenger side, □ back of the vehicle, in a speed of about ___ MPH?

f. How bad was your vehicle damaged? □ mildly □ severely or □ towed

g. Was the airbag deployed? □ yes □ no

h. Did you have an episode of loss of consciousness? □ yes □ no. *If yes, how long?*_______

i. Did you go to the emergency room?: □ yes □ no *If yes, Which hospital?* ____________

j. Were you admitted into the hospital? □ yes □ no. *If yes, which hospital and how long did you stay?* ________________________________

k. Did you have any fractures? □ yes □ no. *If yes, which bone(s)?* _________________

l. How long after the accident did your pain start? _________

m. Do you have a history of any other motor vehicle accidents before this one? *If yes, please explain:* ____

n. Did you have any pain prior to the accident? □ yes □ no. *If yes, were was the pain?*

____

---

4. Previous treatment for your current pain

□ Yes □ No Have you ever been to another pain clinic?

If yes, Name of the clinic _________________ Dr.'s name_____________

Name of the clinic _________________ Dr.'s name_____________

Name of the clinic _________________ Dr.'s name_____________

Please list all the pain medications you took before but for some reasons you have stopped (e.g. Ibuprofen, Naproxen, Motrin, Advil, Predinison, Medrol-dose pack, Vioxx, Celebrex, Bextra, Valium,

Flexeril, Baclofen, Neurontin, Tegretol, Elavil, Celexa, Darvon, Darvocet, Roxicet, Percocet, Oxycodone, Oxycontin, Kadian, Ultram, Ultracet et al).

Name	Dose	Effective?	Side effect	Reasons to stop

□ Yes □ No Have you had physical therapy for your pain? How long?___ Helpful?_______
□ Yes □ No Have you had occupational therapy for pain? How long?___ Helpful?_______
□ Yes □ No Have you tried acupuncture for pain relief? Was this helpful? Yes_ No_
□ Yes □ No Have you seen a chiropractor for pain relief? Was this helpful? Yes_ No_
If yes, who was the chiropractic doctor? __________________
□ Yes □ No Have you had any previous injections for your pain?
If yes, what kind of injection? _______________
Did they help? ____________________________
□ Yes □ No Have you had previous surgery for pain your pain? *If yes*, How many _____
Who was the doctor? ____________
Name of the surgery ?____________
When was it done? ____________
Did the surgery help? □ yes □ no
How much pain relief did you have from the surgery? ________(0 to 100%)

5. Current pain level: (no pain: 0; worst pain: 10)

Pain score right this moment: ____ Average Pain score over the last 24 hours:_____

Pain score without medication:____ Pain score with medication:______

6. Pain quality: Check the boxes that best describe what your pain feels like.
□ Throbbing □ Shooting □ Stabbing □ Sharp □ Cramping
□ Burning □ Tingling □ Aching

7. Pain pattern:
□ Continuous □ Rhythmic □ Comes and goes

8. What can make your pain worse?
□ Sitting □ Standing □ Walking □ lifting □ Cough/sneeze □ lying flat on back
□ Others: _______

9. What can make your pain better?
□ Sitting □ Lying flat on back □ Others:

10. Do you have any of following symptoms when you have pain?
□ Nausea □ Vomiting □ Visual disturbance □ Weakness □ Incontinence
□ Shortness of breath □ Others:__________________________

11. Do you have difficulty sleeping because of pain? □ Yes □ No
How many hours a day on average can you sleep recently? ___

12. Have you ever been treated for a different pain condition? □ Yes □ No

If yes, please describe where and when: ____
____

13. Past medical history
Please circle any of the following problems that you currently have/ had:

1. High blood pressure
2. Diabetes
3. Heart Murmur
4. Arrhythmia
5. Heart attack
6. Chest pain
7. Asthma
8. Tuberculosis
9. Stomach ulcers
10. Hepatitis
11. HIV infection
12. Seizure
13. Stroke
14. Cancer
15. Kidney infection/stone
16. Thyroid disease
17. Bleeding disorders
18. Depression
19. Psychosis
20. Others____________

14. Past Surgical History: *Please list all previous surgeries*
Date (MO/YR)   Name of the surgery(ies)

____________   ____
____________   ____
____________   ____
____________   ____

15. Current pain medications
Please list all the pain medications you are taking currently (including any nonprescription medications such as Tylenol, Bengay etc..)

Name	*Dose (mg)*	*How do you take (example -one tablet twice daily)*	*Is it effective?*	*Any side effect?*

16. Current Other medications
□ Yes □ No Are you currently taking any medications for other non-pain related health conditions?
If yes, please list (be sure to include nonprescription, eye drops, topical drugs such as vitamins)

Name	*Dose (mg)*	*How do you take (example-one tablet twice daily)*

17. Please list any drug allergy

Name of medication	*Reactions*		*Name of medication*	*Reactions*

18. Social History

Are you currently: **(circle one)** Single   Married   Widowed   Divorced   Separated

Yes □   No □   Do you smoke cigarettes? *If yes,* ___ packs per day for__years? Quit__

Yes □   No □   Do you drink alcohol beverages? *If yes*, how much per day? _____

Yes □   No □   Have you ***ever*** used Marijuana, methamphetamine or cocaine? ____

Yes □   No □   Are you currently working?:

How many hours a day? (circle one) 0 1 2 3 4 5 6 7 8 more

If not, when was your last work? Date: _________

Yes □   No □   Is this a worker's compensation case?

Yes □   No □   Are you involved in a lawsuit related to your pain condition?

Yes □   No □   Are you interested to return to work soon, if you are not working currently?

19. Family History

Do you have a family history of (Circle all that apply)?

1. Diabetes   2. Tuberculosis   3. Heart attacks
4. Rheumatoid arthritis   5. Back problems   6. Others: _________________

20. Review of System

Have you had any of the following symptoms recently?

Constitutional: □fever □weight loss □sleep difficulty

Cardiovascular: □chest pain □shortness of breath

Respiratory □cough □wheezing □asthma □breathing difficulty

Gastrointestinal: □nausea □vomiting □abdominal pain □constipation

Genitourinary: □urine incontinence □pain on urination □impotence

Female reproduction: □pregnant □abnormal bleeding

Skeletal muscle: □back pain □neck pain □joint pain □joint swelling

Neurological: □headache □arm weakness □leg weakness □gait unsteadiness

Vision: □visual difficulty □glaucoma □eye pain

ENT: □ ear infection □ear pain

Skin: □rash □ulcer □skin cancer □infection □hypersensitivity □color change □temperature change

Immunology: □ Rheumatoid arthritis □ SLE

Psychological: □depression □anxiety □panic attack □suicidal ideation

Stop here. Thank you very much for your help. You doctor will review all the information with you soon. Following sections are for the nurse and doctor to finish.

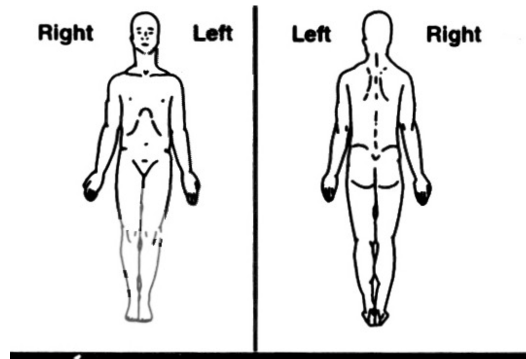
Physical Examination:

T: P: R: BP: Weight: Height:

Mental Status:

Skin:

Spine: Tenderness:



HEET:

Neck:

Cardiovascular:

Lungs:

Abdomen:

Extremities:

Spurling's Sign L__ Right__
Range of motion: Neck ___ Back___
Scoliosis ______
Patrick's test L __ Right __
SLS test L __ Right __
Fortin's Test L___ Right __
SLR test L __ Right __

Cranial Nerves:

Sensory: Decreased sensation to pin prick at
Left:__ Right: __

Motor: Weakness of

Left	Right
EHL__	EHL__
TA__	TA__
TP__	TP__
PL__	PL__
PB__	PB__

Reflex: Gait:

Test results:

EMG
MRI
Blood test

Impression:

1.
2.
3.

Plan:

1. **Medications:**

2. **Physical therapy/IDD therapy/ Massage therapy/Acupuncture:**

3. **Interventional pain management**

4. **Surgery**

5. **Activity**

6. **Working status**

PA/NP ____ ***Physician***____________