

New Patient Registration Packet



North Shore Pain Management

DIVINUM OPUS SEDARE DOLOREM

Beverly Office:

900 Cummings Center,
Suite 221U
Beverly, MA, 01915
Tel: 978-927-7246
Fax: 978-927-7249

Woburn Office:

800 West Cummings Park,
Suite 1200
Woburn, MA 01801
Tel: 781-927-7246
Fax: 781-305-4683

This New Patient Registration Packet contains:

1. Registration form
2. New patient questionnaire
3. Financial policy/HIPAA policy
4. Authorization for Release of Medical Records (to NSPM)
5. Directions
6. Consent for TeleHealth Services

Please complete the enclosed forms as accurately as possible and bring them with you to your appointment.

To prevent any unnecessary delays please also bring with you:

- Updated Medication List
- Insurance card(s)
- Insurance copay due at time of appointment
- Driver's License or Government ID

At North Shore Pain Management your time is important to us. We greatly appreciate your arriving on time and will always do our best to stay on schedule so that you don't have to wait for your appointment.

Sincerely,

North Shore Pain Management

What to Expect



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Welcome! We at North Shore Pain Management are happy that you have chosen to add us to your healthcare team. Our goal is to work with you and your other healthcare providers to improve your function and manage your pain.

We are an integrated pain management service, meaning that we work with you to optimize your ability to manage your pain, using procedures and medications, as well as referrals to mental health, physical therapy, and other specialties.

On your first visit, you will be seen by one of our physicians, and possibly by one of our nurse practitioners or physician assistants. Your past history will be reviewed, a physical exam will be done, and we will start to develop a treatment plan personalized for you. We will generally ask you to return for follow-up within a month, but sometimes as early as the next day. **We will not be able to do injections or other procedures, and usually will not prescribe opioid (narcotic) pain medications for you on your first visit.** Your treatment plan may include injections or other procedures, medications, X-rays or MRIs, and referrals to other specialists.

On subsequent visits, you may see your pain physician for injections or other procedures, or you may see your physician assistant or nurse practitioner for follow-up or medication management. **All of our providers are in frequent communication, so even if you do not see your pain physician at the given visit, your team will still know what is going on with you!**

Notes from every visit to North Shore Pain Management are sent to your primary care provider and to your referring provider, so that your whole healthcare team is aware of your treatment plan.

Before your first visit, your New Patient Packet must be filled out before you arrive. Please arrive 30 minutes before your scheduled appointment time so that any last minute concerns can be addressed. If you are not ready for your appointment, you may need to reschedule.

It is helpful if you call us 3 to 4 days before your first appointment to make sure we have all the materials we need. Please sign and send an Authorization to Release Medical Records, if needed. Here is a list of important materials we may need to get:

- Notes from your primary care provider
- Notes from other pain providers you have seen in the past.
- Notes from any other providers who may be involved in managing your pain, such as neurologists, orthopedic surgeons, rheumatologists, etc.
- Reports of relevant X-rays, MRIs, CT scans, EMGs, etc.
- Insurance approvals, if needed

Financial Policy



North Shore Pain Management participates with most insurance plans including Workman’s Compensation, with the exception of MassHealth/Medicaid. Motor Vehicle Accidents (MVA) and liens are not acceptable forms of insurance. You must have active health insurance coverage as well.

- **"SELF PAY" patients must pay cash for the initial visit, and any consecutive visits, in full at the time of the visit.**
- **CO-PAYS ARE DUE AT THE TIME OF SERVICE.**
- **FOR HMO's - A VALID REFERRAL MUST BE OBTAINED PRIOR TO YOUR VISIT.** (Without a valid referral, your appointment may be cancelled and/or rescheduled until the appropriate referral is obtained. Payment for unauthorized services will be required at the time of service.)
- **PAYMENT CAN BE IN THE FORM OF CASH, CREDIT CARD, CHECK OR MONEY ORDER.**
- **You are responsible for any charges incurred in the collection of your account, including, but not limited to legal fees, collection fees, interest, or late charges.**

INSURANCE:

Insurance is a contract between you and your insurance company. We are **not** a party to this contract. We file insurance claims on behalf of our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, pre-existing conditions, etc. other than to supply factual information as necessary. **You are responsible for the timely payment of your account.**

WORKERS' COMPENSATION:

We will submit claims on your behalf for open workers compensation claims only. It is your responsibility to provide the office staff with accurate workers compensation insurance information as well as your current claims adjuster’s phone number. We will bill your private health insurance if your claim should be denied. Any balance not paid by the worker’s compensation carrier or your private health insurance will be your responsibility.

RETURNED CHECKS:

A fee of \$25 will be charged to your account for any/all returned checks(s). All future payments must be made by way of cash or credit card.

PAST DUE BALANCES:

To avoid interruption in your plan of care, all past due balances are expected to be paid in full prior to future treatment, unless you have established a mutually agreed upon payment plan.

PPO/HMO:

Each time you make an appointment with any physician, it is your responsibility to make sure your physician is currently under contract with your plan and to obtain the appropriate referral or authorization for your visit.

Verification of your insurance plan is required. Therefore, you must provide current insurance information and/or inform our office if there have been any changes to your insurance plan or benefits prior to your appointment date.

CANCELLATION POLICY:

We require 24-hour notice for any appointment cancellations. **A fee of \$40** will be charged to your account for no shows or cancellations of **office visits** without 24 hour notice. **A fee of \$100** will be charged to your account for no shows or cancellations of **procedures** without 24 hour notice. Repeated cancellations or no shows for appointments could result in discharge from the practice.

Your signature below indicates that you have read and understand our **Financial Policy**. If you have any questions, or need any further information, please let us know.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for our health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosure. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Notice of Privacy Practices (continued)



Your Rights:

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administration action or proceeding, and protected health information that are subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternative i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 978-927-7246.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Authorization for Release of Medical Records



North Shore Pain Management
DIVINUM OPUS SEDARE DOLOREM

Name: _____
Address: _____

City State Zip

DOB: _____

I hereby authorize and consent to the release of medical records obtained in the course of my treatment at _____ for the purpose of:

Medical Care Legal Insurance Personal Other: _____

Release to:

North Shore Pain Management 900 Cummings Center, Suite 221U Beverly, MA 01915 Phone: (978)927-7246 Fax: (978)927-7249
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North Shore Pain Management 800 West Cummings Park, Suite 1200 Woburn, MA 01801 Phone: (781)927-7246 Fax: (781)305-4683
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The specific information to be disclosed is:

- Complete Medical Records Lab Reports Operative Report(s)
 MRI Report(s) X-Ray Report(s) History and Physical
 Other: _____

_____ (initials) I authorize the release of drug abuse, alcohol abuse, sexually transmitted disease, and/or psychiatric records.

_____ (initials) I authorize the release of my HIV test results. I have read this consent form, have asked all questions I have about the reason for the release of my HIV test and I agree to the release of all this information.

I have carefully read and understand the above statements and do herein expressly and voluntarily consent to the disclosure of the above information about, or medical records of, my condition. I hereby release the above-named keeper of the records from all liability that may arise from the release of these medical records.

I understand that any person or organization to whom my records are disclosed may re-disclose this information if legally mandated.

I understand that this consent is subject to revocation at any time in writing, unless action has already been taken in reliance upon it. This authorization will expire 1 (one) year from the date shown below unless otherwise stated here.

Signature of patient, responsible person, or legal guardian (if minor)

Date

Witness

Date

Directions



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Driving directions to our Beverly office:

FROM DOWNTOWN BOSTON:

Take Route 93 North to Route 1 North turn-off (via Tobin Bridge). Follow for about 10 miles into Lynnfield, and then take the combined I-95 North/Route 128 North exit (after going through short tunnel). When I-95 and Route 128 split, stay on Route 128 North toward Gloucester. Shortly after passing two large shopping malls on your left, take Exit 22 onto Route 62 East. Follow Route 62 East for less than two miles to Cummings Center on your left. At the traffic lights (across from Stop & Shop), turn left into Cummings Center.

FROM NEW HAMPSHIRE:

Follow Route 95 South to the Danvers/Peabody MA area. Take Route 128 North (right lane). Shortly after passing two large shopping malls on your left, take Exit 22 onto Route 62 East. Follow Route 62 East for less than two miles to Cummings Center on your left. At the traffic lights (across from Stop & Shop), turn left into Cummings Center.

When you enter Cummings Center, go past the guard shack, and take a left at Acapulco's. Turn right and go $\frac{3}{4}$ of the way down the side of the 900 building (along the water). Enter through the door marked 121V. Take the elevator to the second floor. When you get off the elevator, go to your right

Driving directions to our Woburn office:

FROM I-93 NORTHBOUND (FROM BOSTON):

Take exit 36 (Montvale Avenue), turn left at bottom of ramp. Turn right at second set of lights (at Wendy's restaurant and two gas stations) onto Washington Street. Follow Washington Street for about one mile through two traffic lights. Turn left into West Cummings Park.

FROM I-93 SOUTHBOUND (FROM NEW HAMPSHIRE):

Take exit 37 (I-95/Rt. 128 South towards Waltham). Follow I-95/Rt. 128 only 1/4 mile, and take exit 36 (Washington Street). Turn right at bottom of ramp and then turn right again at top of hill onto Washington Street. Continue approximately 1/4 mile and turn right into West Cummings Park.

FROM I-95/RT. 128 SOUTHBOUND (FROM PEABODY):

Take exit 36 (Washington Street), turn right at bottom of ramp and then turn right again at the top of the hill onto Washington Street. Continue approximately 1/4 mile and turn right into West Cummings Park.

FROM I-95/RT. 128 NORTHBOUND (FROM WALTHAM):

Take exit 36 (Washington Street), turn right at bottom of ramp and then turn right again at the top of hill onto Washington Street. Continue approximately 1/4 mile and turn right into West Cummings Park.

BY PUBLIC TRANSPORTATION:

Take MBTA (subway) Orange or Green lines to Haymarket Station. Transfer to Bus Route 354 to Woburn.

13. Do you have any weakness in your arms or legs? If yes, where?
14. What treatment do you think will help to improve your pain problem?
15. What percentage improvement do you expect our program to make in your pain (0-100%)? _____
16. Current or former occupation: _____ Working now? Yes No
 If no, last day you worked? _____
 Are you receiving any kind of disability? _____ If so, what kind? _____
17. Please describe your activities in an average day.
18. List the activities you can no longer do because of your pain problem:

19. List any diagnostic tests (i.e. MRI, X-Ray, EMG, CT Scan, etc.) you have had related to your pain:

Date	Imaging/Test	Facility Performed	Results

20. Are you involved in a legal action related to your pain problem? Yes No
 If yes, please describe: _____

21. **Previous Treatments:** Please describe what, where, and when.

	Helpful	Not helpful
<input type="checkbox"/> Surgery: If yes, year: _____ Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Previous injections: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Previous Pain Management Doctor: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupational Therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Aquatic/Pool therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Passive (heat, ice, gentle massage, TENS) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Alcohol/Drug Detoxification _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture / Acupressure _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pilates, Tai Chi, Home Exercise _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (Please describe): _____	<input type="checkbox"/>	<input type="checkbox"/>

22. **Past Pain Medications** Please check all you have tried in the past. Please circle the specific drugs you have tried.

	Helpful	Not helpful
<input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> NSAIDs (Motrin, Advil, Aleve, ibuprofen, naproxen, Celebrex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscle Relaxants (Flexeril, Zanaflex, Soma, cyclobenzaprine, tizanidine, baclofen, valium, methocarbamol)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Opioids (Tramadol, Vicodin, Percocet, hydrocodone, oxycodone, morphine, Dilaudid, fentanyl patch, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Pain Medications (Neurontin, Lyrica, Cymbalta, gabapentin, pregabalin, duloxetine, amitriptyline)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>

Past Medical History Have you had any of these conditions either now or in the past?

Yes	No		Yes	No	
		Heart:			Lungs:
		High blood pressure			Bronchitis
		High cholesterol			Asthma
		Angina (chest pain)			Shortness of Breath
		Heart attack			Liver / Kidneys:
		Congestive heart failure			Hepatitis
		Heart surgery			Liver problems
		Irregular heart beat			Kidney problems
		Nervous system:			Bladder problems
		Seizures			Metabolic / Digestive:
		Stroke			Diabetes: Insulin or Non-Insulin Dependent?
		Paralysis			Thyroid disease
		Peripheral neuropathy			Acid reflux
		Musculoskeletal:			Stomach ulcer
		Arthritis			Cancer:
		Neck/back problems			Site:
		Artificial joints (replacement)			Psychological/Psychiatric:
		Other:			Depression/Anxiety
		Blood Disorder:			Panic Disorder
		Anemia (low blood count or low iron)			Post-Traumatic Stress Disorder
		Bruising			Other Medical Problems (Please Describe):
		Bleeding Problems			
		Immune Disorder:			
		HIV			
		MRSA			
		Other:			

Past Surgical History: Please list all surgeries you have had

Surgery: _____	Date: _____	Surgery: _____	Date: _____
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Social History:

Do you smoke? Yes No If so, how many packs per day? _____ For how many years? _____

Do you drink alcohol? Yes No If so, how much beer / wine / liquor do you use per week? _____

Did you ever in your life abuse alcohol, prescription drugs, or any illegal drugs? Yes No

If yes, please describe: _____

Medications - List all you are currently taking and dosages (prescriptions, over the counter, herbal):

Medication	Dose	Frequency	Date Started	Prescribing Doctor

Are you taking any blood thinners (such as Coumadin, Eliquis, Xarelto, Plavix, etc.)? Yes No
 If yes, which one? _____

Allergies – Have you ever had and allergic reaction to any medication?
 (an allergy means a rash, swelling, difficulty in breathing. It does NOT mean causing a stomach upset or dizziness)
 Yes No

If YES please list them:

Family History

Family Member	Living?	Alcohol Abuse Arthritis Asthma Cancer Chronic Pain Depression Drug Abuse Psychiatric disorder Substance Abuse											
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Brother	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sister	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Daughter	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Son	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Maternal Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Maternal Grandfather	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Paternal Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Paternal Grandfather	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Review of Systems

Do you **currently** have any of these symptoms? (Please check all that apply)

Yes		Yes		Yes	
	General:		Cardio:		Allerg/Immuno:
<input type="checkbox"/>	Appetite change	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Environmental allergies
<input type="checkbox"/>	Chills	<input type="checkbox"/>	Leg swelling	<input type="checkbox"/>	Food allergies
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Immunocompromised
<input type="checkbox"/>	Fever		Gastrointestinal:		Neurologic:
<input type="checkbox"/>	Unexpected weight change	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Dizziness
	HENT:	<input type="checkbox"/>	Anal bleeding	<input type="checkbox"/>	Light-headedness
<input type="checkbox"/>	Dental problem	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Drooling	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Syncope (fainting)
<input type="checkbox"/>	Ear discharge	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	Ear pain	<input type="checkbox"/>	Vomiting		Hematologic:
<input type="checkbox"/>	Mouth sores		Endocrine:	<input type="checkbox"/>	Adenopathy (swollen lymph nodes)
<input type="checkbox"/>	Nosebleed	<input type="checkbox"/>	Cold intolerance	<input type="checkbox"/>	Bruises/bleeds easily
<input type="checkbox"/>	Tinnitus (ringing in ears)	<input type="checkbox"/>	Heat intolerance		Psychiatric:
<input type="checkbox"/>	Trouble swallowing	<input type="checkbox"/>	Excessive urination (>3 liters/day)	<input type="checkbox"/>	Agitation
	Eyes:		Genitourinary:	<input type="checkbox"/>	Confusion
<input type="checkbox"/>	Eye discharge	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	Dysphoric mood (sad, depressed)
<input type="checkbox"/>	Eye itching	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	Hallucinations
<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	Self-injury
	Respiratory:	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Suicidal ideas
<input type="checkbox"/>	Apnea (difficulty breathing)		Skin:		
<input type="checkbox"/>	Choking	<input type="checkbox"/>	Color change		
<input type="checkbox"/>	Stridor	<input type="checkbox"/>	Pallor (unhealthy pale appearance)		
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Rash		

Form Completed by: _____ Relationship to Patient: _____ Date: _____