# New Patient Registration Packet

North Shore Pain Management
DIVINUM OPUS SEDARE DOLOREM


Beverly Office:
77 Herrick Street
Suite 201
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

# Patient Registration

North Shore Pain Management
DIVINUM OPUS SEDARE DOLOREM

Patient Name: _____
First Middle Initial Last

Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home (  ) _____ Work: (  ) _____ Cell: (  ) _____

Email Address: _____ Pharmacy: _____ Pharmacy Location: _____

Date of Birth: ____/____/____ Age: ____ Sex: _____ Marital Status: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Emergency Contact: _____ Relationship:_____

Telephone: Home (  ) _____ Work: (  ) _____ Cell: (  ) _____

---

Referred By: _____ Phone #: (  ) _____

Address: _____

Primary Care Physician: _____ Phone #: (  ) _____

Address: _____

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**Primary Insurance:** _____ Subscriber: _____

Member ID Number: _____ Group Number: _____ Co-pay: $ _____

*Please fill in the following information if the subscriber is NOT the patient:*
Subscriber Date of Birth: ____/____/____

**Secondary Insurance:** _____ Subscriber: _____

Member ID Number: _____ Group Number: _____ Co-pay: $ _____

*Please fill in the following information if the subscriber is NOT the patient:*
Subscriber Date of Birth: ____/____/____

*Signature of Patient or Authorized Individual: I authorize the release of medical or other information necessary to process all government, commercial and workers' compensation insurance claims. I authorize the payment of medical benefits to the attending physician or supplier for services rendered. I understand that I am financially responsible for all changes not paid by my insurance and/or workers' compensation carrier.*

Signature: _____ Date: _____

Workman's Compensation - Is this a work-related injury? ☐ Yes ☐ No

Motor Vehicle Accident - Is this a motor vehicle accident? ☐ Yes ☐ No

Charges can NOT be billed to your health insurance carrier.

If Worker's Compensation or MVA information is NOT provided, you will be responsible for any changes incurred.

# Financial Policy

North Shore Pain Management
DIVINUM OPUS SEDARE DOLOREM

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: _____



Updated: 1/4/2024

# Notice of Privacy Practices

North Shore Pain Management
DIVINUM OPUS SEDARE DOLOREM

**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.

North Shore Pain Management
DIVINUM OPUS SEDARE DOLOREM

**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: _____ DOB: _____
Address: _____

_____
City State Zip

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
77 Herrick Street Suite 201
Beverly, MA 01915
Phone: (978)927-7246 Fax: (978)927-7249

☐ North Shore Pain Management
800 West Cummings Park, Suite 1200
Woburn, MA 01801
Phone: (781)927-7246 Fax: (781)305-4683

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:**

Get on I-93 N from Congress St Head north on Federal St toward Milk St Turn right onto Milk St Turn right onto Congress St Turn left onto Atlantic Ave Take the Route 93 N ramp on the left to Concord Follow I-93 N, I-95 N and MA-128 N to Beverly. Take exit 46 from MA-128 N Merge onto I-93 N Keep right to stay on I-93 N Take exit 28A to merge onto I-95 N toward Peabody Keep left at the fork to continue on MA-128 N Take exit 46 toward Sohier Rd/Brimbal Ave/Beverly Continue on Sohier Rd to your destination At the traffic circle, take the 1st exit onto Sohier Rd Sharp left onto Herrick St Turn right Turn right (Destination will be on the right)

**FROM NEW HAMPSHIRE:**

Get on I-89 S from US-202 E/Pleasant St, Langley Pkwy and Clinton St/Rte 13 S Head west on Big Red Alley toward Dunbarton Rd Turn right onto Dunbarton Rd Turn right onto US-202 E/Pleasant St Turn right onto Langley Pkwy Turn right onto Clinton St/Rte 13 S Turn left to merge onto I-89 S toward I-93 Drive from I-93 S and I-95 N to Beverly. Take exit 46 from MA-128 N Merge onto I-89 S Take the exit onto I-93 S toward Manchester/Boston (Toll Road) Keep left at the fork Use the right lane to merge onto I-93 S (Toll Road) Keep right at the fork to stay on I-93 S, follow signs for Interstate 93 S/Salem/Boston (Toll Road / Entering MA) Take exit 28A to merge onto I-95 N toward Peabody Keep left at the fork to continue on MA-128 N Take exit 46 toward Sohier Rd/Brimbal Ave/Beverly Continue on Sohier Rd to your destination At the traffic circle, take the 1st exit onto Sohier Rd Sharp left onto Herrick St Turn right Turn right (Destination will be on the 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.



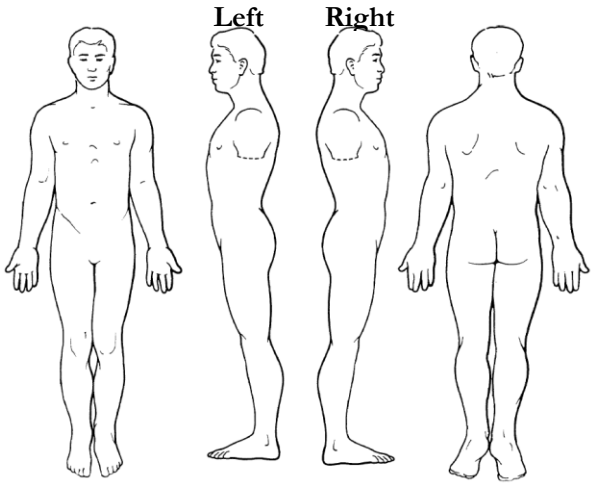
Updated: 1/4/2024

# NSPM New Patient Questionnaire

Name: _____ Date: _____

DOB: _____ Referring MD: _____

1. Where is your pain located? (please use diagram to the right)




2. When did your pain start (specific date if possible)? How long have you had the pain?

3. How did your pain start (injury, at work, random)?

4. What caused your current pain or injury?

5. How has your pain affected your life?

6. If your pain were 50% less, what would you be doing differently?

**Pain Score**

7. Please circle the number that best describes your baseline or constant level of pain over the past few days

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Worst Possible Pain |

8. Please rate your worst pain

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Worst Possible Pain |

9. Describe your present pain?

| | | | |
|---|---|---|---|
| □ Throbbing | □ Dull | □ Numb | □ Deep |
| □ Shooting | □ Sharp / Stabbing | □ Tender | □ Aching |
| □ Shock-like | □ Tingling / Pins & Needles | □ Pressure | □ Cramping |
| □ Heaviness | □ Hot / Burning | □ Cold | □ Other _____ |

10. Describe the timing of your pain:

□ Constant (Always there)
□ Intermittent (Comes and goes)
□ Gets worse as the day goes on

11. What do you do to ease or relieve your pain?

| | | | |
|---|---|---|---|
| □ Bed Rest | □ Chiropractor | □ Massage Therapy | □ Physical Therapy |
| □ Heat/Cold Therapy | □ Counseling | □ Biofeedback | □ Relaxation Therapy |
| □ Medication | □ Exercise Program | □ Acupuncture | □ Trigger Point Injections |

12. What makes your pain worse?

| | | | |
|---|---|---|---|
| □ Coughing/Sneezing | □ Walking | □ Exercise | □ Stair Climbing |
| □ Lifting | □ Hot/Cold Water | □ Sitting | □ Standing |
| □ Lying Down | □ Bowel Movement | □ Damp/Dry Weather | □ Other _____ |

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 <u>what, where, and when.</u>

| | Helpful | Not helpful |
|---|---|---|
| □ Surgery: If yes, year: Type: _____ | □ | □ |
| □ Previous injections: _____ | □ | □ |
| □ Previous Pain Management Doctor: _____ | □ | □ |
| □ Physical therapy _____ | □ | □ |
| □ Occupational Therapy_____ | □ | □ |
| □ Aquatic/Pool therapy _____ | □ | □ |
| □ Passive (heat, ice, gentle massage, TENS) _____ | □ | □ |
| □ Chiropractic _____ | □ | □ |
| □ Alcohol/Drug Detoxification _____ | □ | □ |
| □ Acupuncture / Acupressure _____ | □ | □ |
| □ Pilates, Tai Chi, Home Exercise _____ | □ | □ |
| □ Other (Please describe): _____ | □ | □ |

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

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

**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 |
|---|---|---|---|---|
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**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 | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| Father | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| Brother | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| Sister | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| Daughter | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| Son | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| Maternal Grandmother | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| Maternal Grandfather | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| Paternal Grandmother | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| Paternal Grandfather | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| _____ | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |
| _____ | □ Yes □ No | □ | □ | □ | □ | □ | □ | □ | □ | □ | | |

**Review of Systems**

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

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

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