ADVANCED SPINE CENTER

1705 Ohio Dr. Ste #300, Plano, TX 75093 • Ph. 972-499-5457 • Fax 972-499-5342

# ✅ NEW PATIENT REGISTRATION FORM

| | | | | |
|---|---|---|---|---|
| Legal Name: | Last First Middle | | | Preferred: |
| Home Address: | Street Apt # City/ST/Zip | | | |
| #Contact Info.: | Home: | Cell: | | Work: |
| SS#: ____ /___ /_____ | | DOB: | Age: | DL#: |
| Gender: ☐Male ☐ Female | Marital Status: ☐Single ☐ Married ☐Divorced ☐ Widow | | Email Address: | |
| Employer Name: | | Employer Address: | | |
| Employer Ph.#: | | Occupation: | | |
| How did you hear about us?: | | | | |
| Primary Care Doctor: | | | Doctor Ph. #: | |

**PRIMARY INSURANCE INFORMATION:**

( ☐ FILL IN INSURANCE INFORMATION BELOW OR CHECK BOX IF COPY OF CARD WAS PROVIDED)

Name of Primary Policy Holder: _____ Relationship to Patient: _____
( as it appears on card)

| | | | |
|---|---|---|---|
| DOB: | Insurance Co.: | | Insurance Co. Ph#: |
| Policy ID#: | | Group#: | SS#: _____ /_____ /_____ |

**MEDICARE SUPPLEMENTAL INSURANCE INFORMATION:**

Name of Primary Policy Holder: _____ Policy ID/Group#: _____
( as it appears on card)

**RESPONSIBLE PARTY INFORMATION:**

Name: Address:

| | | | |
|---|---|---|---|
| DOB: | SS#: | Ph#: | Relationship to Patient: |

**EMERGENCY CONTACT/LEGAL GUARDIAN:**

Name: Ph#: Relationship to Patient:

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS. I hereby authorize the above-named agency to release my treatment information requested by attorneys, physicians, insurance companies, employers, healthcare providers or any other entity which may be concerned with the payment of charges incurred the treatment of services of Advanced Spine Center, and hereby authorize payment directly to Advanced Spine Center for services rendered. I accept responsibility for payment of any charges not paid for or accepted by my insurance. This authorization remains valid and effective from the date of signing until revoked in writing.

| | |
|---|---|
| _____ Signature of Patient or Legal Guardian | _____ Date |

ADVANCED SPINE CENTER

# Stephen P. Courtney, MD., P.A.

*Board Certified Fellowship Trained Orthopedic Spine Surgeon*

## FORM OF PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST AND OWNERSHIP

As required by Section 102.006 of the Texas Occupations Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician, Stephen Courtney, M.D., may receive remuneration for referring you to any of the following healthcare providers for certain healthcare services:

**Eminent Spine, LLC**
**PGBH Monitoring, PLLC**
**Eminent Medical Center**
**Ternion Management, LLC**
**Anesthesia Concepts, PLLC**
**Baylor Scott & White-Frisco**
**Texas Monitoring Group, LLC**

Accordingly, I hereby acknowledge that Stephen Courtney, M.D. has disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation with the foregoing healthcare provider(s) for whom, I, the patient am being referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such healthcare provider. Dr. Courtney wants to be fully transparent regarding his financial and ownership interest. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving healthcare services from any healthcare provider and/or facility that I choose.

Print Patient Name: _____

Patient Signature: _____

Date: _____

ADVANCED SPINE CENTER

*POLICIES & CONSENT TO TREAT*

*(PLEASE INITIAL ALL SECTIONS, SIGN & DATE FORM)*

**_____FINANCIAL RESPONSIBILITY AGREEMENT:**

**Initials**

I agree to assign insurance benefits to Advanced Spine Center. We bill all primary insurance companies that we are contracted with as "network providers as a courtesy to our patients.

I acknowledge full financial responsibility for services rendered by Advanced Spine Center, and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-Insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of a default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to Advanced Spine Center.

**_____CONSENT OF TREATMENT:**

**Initials**

I authorize Advanced Spine Center Physicians and the Physician's Assistants to evaluate and treat me or my family member for any orthopedic illness or injury for which I seek medical care. I have read and understand the above clinic polices and I further acknowledge that I accept the terms outlined in each of the above policies.

**_____PHYSICIAN ASSISTANT CONSENT:**

**Initials**

This facility has on staff certified Physician Assistants (PA-C) to assist in the delivery of orthopedic medical care. I acknowledge a Physician Assistant is not a physician. A PA-C is licensed by the state medical board and under the supervision of a physician can diagnose, treat, and monitor common acute and chronic disease as well as provide health maintenance care. "Supervision" does NOT require constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. A list of services may be provided that are within the scope of practice for a PA-C upon request. I hereby acknowledge the above information and consent to the services of a Certified Physician Assistant for my health care needs. I understand that at any given time I can request to see the Physician instead of the PA-C.

**_____MEDICATION POLICY CONSENT:**

**Initials**

I authorize Advanced Spine Center Physicians and the Physician's Assistants to obtain a medication history and/or list of current medications via my pharmacy for medical records.

**_____DISCLOSURE OF FINANCIAL INTEREST:**

**Initials**

Advanced Spine Center physician you are seeing may have a financial interest in the facilities listed on page 2. The facilities and our physician are committed to providing clinical excellence in a safe and attractive environment for you and your family members. Their financial interest in these facilities enables them to have a voice in administration and their policies. This involvement helps to ensure the highest quality of care for you. Should you have any concerns regarding this notice, please ask your physician or a member of the staff. My initials above verify that I have read and understand the above statement and information.

ADVANCED SPINE CENTER

*PATIENT HIPPA & PRIVACY PRACTICES AUTHORIZATION FORM*

(Required by Health Insurance Portability & Accountability Act)

I hereby authorize Advanced Spine Center to use and/or disclose my protected health information which specifically identifies me or which can reasonably be used to identify me to carry out my medical treatment, billing or claims payment and other health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Advanced Spine Center can refuse to see me. I have been provided with access to either review and/or receive a copy of "Notice of Privacy Practices" for Advanced Spine Center which more fully describes the uses and disclosures, and I consent at any time by noticing Advanced Spine Center in writing. I understand Advanced Spine Center has the right to change its privacy policies and that I can receive such changed notices upon request. I understand that I have the right to request that Advanced Spine Center restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or other healthcare operations. I understand that Advanced Spine Center does not have to agree to such restrictions, but once such restrictions are agreed to , Advanced Spine Center must adhere to such restrictions.

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our "Notice of Privacy Practices" policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

**RELEASE OF MEDICAL INFORMATION AUTHORIZATION:**

I give Advanced Spine Center authorization for the release of "Medical Records/Privacy Information", which includes your PHI, any medial conditions, billing and/or financial information to the following:

Name: _____ Relationship to Patient: _____

**EFFECTIVE TIME PERIOD/RIGHT TO REVOKE:**

This authorization shall be in force and valid for one year from the signature date or written permission is accepted for withdrawal.

**SIGNATURE AUTHORIZATION:**

I have read this form and agree to the uses and disclosure of the information described. I understand that refusing to sign this form does not stop disclosure of health informations that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure be the recipient and may no longer be protected by Federal or State privacy laws.

**SIGNATURE:** _____ **DATE:** _____

*Signature of Individual or Legally Authorized Representative*

ADVANCED SPINE CENTER

*UNIVERSAL CONDITION, INJURY/ACCIDENT STATEMENT FORM*

(All boxes must be completed before seeing a physician)

**Patient Name:** _____ **Today's Date:** _____

Please complete the following statements. Most insurance companies request accident details. This information may be forwarded with your insurance claim or provided to an adjuster to complete your claim.
We **MUST** have **Box 1: Condition or Date of Injury** completed to file your claim.

1. Please check: ☐ Condition ☐ Injury Injury Date: _____/_____/_____ (on or about)
2. Give a brief summary. How did the injury occur, what were you dong?:
   _____
   _____
3. Did the injury occur during work: ☐ Yes ☐ No
4. Were you clocked in? ☐ Yes ☐ No
5. Were you at lunch? ☐ Yes ☐ No

**THIRD PARTY LIABILITY**

5. Is there a possible third party liability?: ☐ Yes ☐ No
   **If yes**, a letter of subrogation should be provided before seeing the physician. Your health insurance will deny the claim if the letter is not obtained.

I certify that this information to be true and accurate. I hereby authorized the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury, condition and/or the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a **non-covered** service and may make me personally liable for the charges incurred.

**SIGNATURE:** _____ **DATE:** _____

*Signature of Individual or Legally Authorized Representative*

ADVANCED SPINE CENTER

# *X-RAY CONSENT*

The doctor has explained that the purposes of the x-rays about to be taken are to analyze the spine for vertebral subluxation and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic unusual finding when reviewing the x-ray, I will be informed. I understand that I must then make a determination to seek additional advice, diagnosis or treatment for the unusual finding from a health care provider. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

**MINOR PATIENTS ONLY → CONSENT TO EVALUATE A MINOR CHILD**

☐ By my signature below I, the Parent/Legal Guardian of the minor patina, hereby grant permission for my child to receive chiropractic examinations and x-rays.

**FEMALE PATIENTS ONLY → PREGNANCY RELEASE**

Please read carefully and check boxes, include the date and sign below. Please see our office manager for further explanation or to discuss any questions.

☐ The date of my last menstrual cycle was on _____ - _____ -_____ date
☐ I have been provided a full explanation of when I am most likely to become pregnant,.
☐ To the best of my knowledge I am not pregnant.
☐ By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child. I have conveyed my understanding of the risks associated with exposure to x-rays.

After careful consideration I hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

**PRINT PATIENT NAME: _____ DATE: _____**

**PATIENT SIGNATURE: _____ DATE: _____**

*Signature of Individual or Legally Authorized Representative*

☐ Witness

ADVANCED SPINE CENTER

1705 Ohio Dr. Ste #300, Plano, TX 75093 • Ph. 972-499-5457 • Fax

# NEW PATIENT HISTORY FORM

✅ Please Check Patient Information **Today's Date:** ____/_____/____

| | | | |
|---|---|---|---|
| Patient Name: | | Birthdate: | |
| Preferred Pharmacy: | | Ph.: | ZIP: |
| Dominant hand:: | ▫ Right hand ▫ Left hand ▫ Ambidextrous | | |
| Race / Ethnicity : | ▫ African American ▫ Asian ▫ Caucasian ▫ Native American ▫ Pacific Islander ▫ Hispanic ▫ Non-Hispanic ▫ Unknown/Other: _____ ▫ Decline to Answer | | |
| Preferred Language: | ▫ English ▫ Spanish ▫ Chinese ▫ Other: _____ | | |
| Referral Source: | Physician: | Other: | |
| Representation: | Are you represented by an attorney? ▫ Yes ▫ No | If yes, Name: | |

## ✅ ALLERGIES

**Medication Allergies:** Do you have any Allergies? ▫ Yes ▫ No ▫ No Known Drug Allergies

_____

_____

**Please list all Medication Allergies. Include Seasonal and Food Allergies**:

_____

_____

## ✅ CHIEF COMPLAINT

▫ Neck ▫ Upper Back ▫ Shoulder ▫ Arm ▫ Hand ▫ Mid Back ▫ Low Back ▫ Hip ▫ Buttocks ▫ Lower Leg ▫ Tail Bone ▫ Fracture ▫ Other: _____

## ✅ MEDICATION HISTORY

**Medications:**
Please list all Medications you take on a regular basis:

_____

_____

_____

**Are you in Pain Management?** ▫ Yes ▫ No If Yes, providers name:

## ✅ VITALS

Height: ‘ “ Weight: lbs.

## ✅ FAMILY HISTORY  Have any direct relatives had any of the following disorders?

| | | | | |
|---|---|---|---|---|
| Father: | ▫ None | ▫ Diabetes | ▫ Heart Disease | ▫ Hypertension |
| | ▫ Bleeding Problems | ▫ Epilepsy | ▫ Connective Tissue | ▫ Muscular Dystrophy |
| | ▫ Stroke | ▫ Osteoporosis | ▫ Rheumatoid Arthritis | ▫ Cancer (type): |
| Comments: | | | | |
| Mother: | ▫ None | ▫ Diabetes | ▫ Heart Disease | ▫ Hypertension |
| | ▫ Bleeding Problems | ▫ Epilepsy | ▫ Connective Tissue | ▫ Muscular Dystrophy |
| | ▫ Stroke | ▫ Osteoporosis | ▫ Rheumatoid Arthritis | ▫ Cancer (type): |
| Comments: | | | | |
| Sibling (Indicate brother/sister): | ▫ None | ▫ Diabetes | ▫ Heart Disease | ▫ Hypertension |
| | ▫ Bleeding Problems | ▫ Epilepsy | ▫ Connective Tissue | ▫ Muscular Dystrophy |
| | ▫ Stroke | ▫ Osteoporosis | ▫ Rheumatoid Arthritis | ▫ Cancer (type): |
| Comments: | | | | |

## ✅ SOCIAL HISTORY

| | |
|---|---|
| Do you use tobacco? | ▫ Current Every Day Smoker ▫ Former Smoker ▫ Never a Smoker ▫ Dip/Chew ▫ Unknown |
| Do you drink alcohol? | ▫ Daily ▫ Occasionally ▫ Rarely ▫ Never ▫ No longer drinks |
| Marital History | ▫ Married ▫ Single ▫ Divorced ▫ Widowed ▫ Domestic Partnership |
| Are you currently working? | ▫ Yes ▫ No ▫ Retired ▫ Disabled ▫ Student |

Please list work restrictions, if any:_____

Occupation: _____ Employer _____

## ✅ SURGICAL HISTORY  Select all previous hospitalizations/surgeries:  ▫ None

| | | | |
|---|---|---|---|
| ▫ Arthroscopy: Knee | ▫ Right ▫ Left | ▫ Total Knee Replacement | ▫ Right ▫ Left |
| ▫ Arthroscopy: Shoulder | ▫ Right ▫ Left | ▫ Total Shoulder Replacement | ▫ Right ▫ Left |
| ▫ Carpal Tunnel Release | ▫ Right ▫ Left | ▫ Spinal Surgery - Indicate Level: | Neck: |
| ▫ Rotator Cuff Repair | ▫ Right ▫ Left | | Back: |
| ▫ Total Hip Replacement | ▫ Right ▫ Left | ▫ Appendectomy | ▫ Hernia Repair |
| ▫ Aneurysm (Brain) Surgery | ▫ Aortic Bypass/Vascular Surgery | | ▫ LAP Band/Gastric |
| ▫ Hysterectomy | ▫ Heart Surgery | | ▫ Stents |
| ▫ Mastectomy | ▫ Malignancy/Cancer (type): | | ▫ Cesarean Surgery |
| ▫ Cholecystectomy (Gallbladder) | ▫ Plastic Surgery: | | ▫ Cataract (Eye) Surgery |
| ▫ Other Surgery: | | | |

## ✅ PAST MEDICAL HISTORY

Do you have a personal history of any of the following? If so please check below. If no, please state none:

| | | |
|---|---|---|
| ▫ Aneurysm - Where: | ▫ Emphysema | ▫ Kidney Disease |
| ▫ Angina (Chest Pain) | ▫ Epilepsy | ▫ Kidney Stones |
| ▫ Arthritis - Type: | ▫ Heart Attack | ▫ MRSA Infection |
| ▫ Asthma | ▫ Hepatitis - Type: | ▫ Pacemaker |
| ▫ Bone or Joint Infections | ▫ HIV/AIDS | ▫ Phlebitis (Blood Clots) |
| ▫ Cancer - Type: | ▫ High Cholesterol | ▫ Pulmonary Embolism |
| ▫ Chemo/Radiation | ▫ Hypertension | ▫ Reaction to Anesthesia |
| ▫ COPD | ▫ Hyperthyroidism | ▫ Seizures |
| ▫ Congestive Heart Failure | ▫ Hypothyroidism | ▫ Stomach Ulcers |
| ▫ Diabetes - Type: | ▫ Last A1C: | ▫ Stroke - TIA |
| | | ▫ Tuberculosis |

▫Other:

## ✅ HISTORY OF PRESENT ILLNESS

Is your problem the result of an injury or accident?:

▫ No Injury ▫ Injury ▫ Injury at Work ▫ Auto Accident ▫ Sport Injury ▫ Prior Surgery

Describe the onset: ▫ Acute (sudden) or ▫ Chronic (3+ mo)

How long have the symptoms been present?: # of ▫ Days ▫ Weeks ▫ Mos. ▫ Yrs. _____

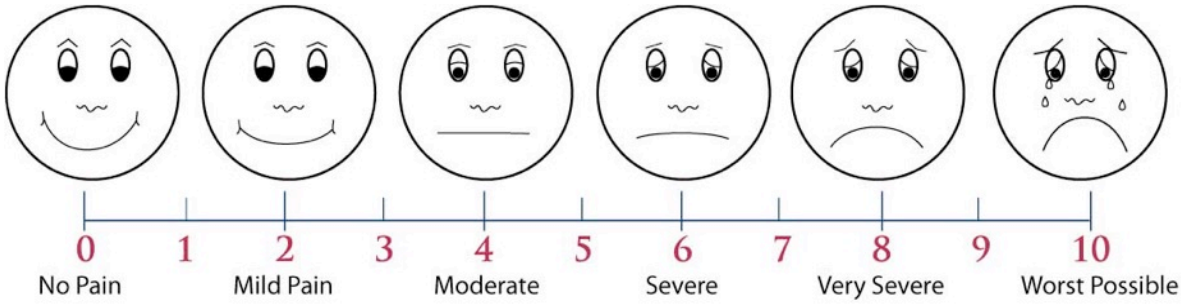
| | | |
|---|---|---|
| Have you had a problem like this before? | ▫ Yes ▫ No | If yes, When: |
| Have you been seen in the ER for this problem? | ▫ Yes ▫ No | If yes, list ER: |

What Happened to you? Tell your story:

What do YOU WANT from today's visit?:

## ✅ DESCRIBE YOUR PAIN

Rate the pain (10 being the most pain):



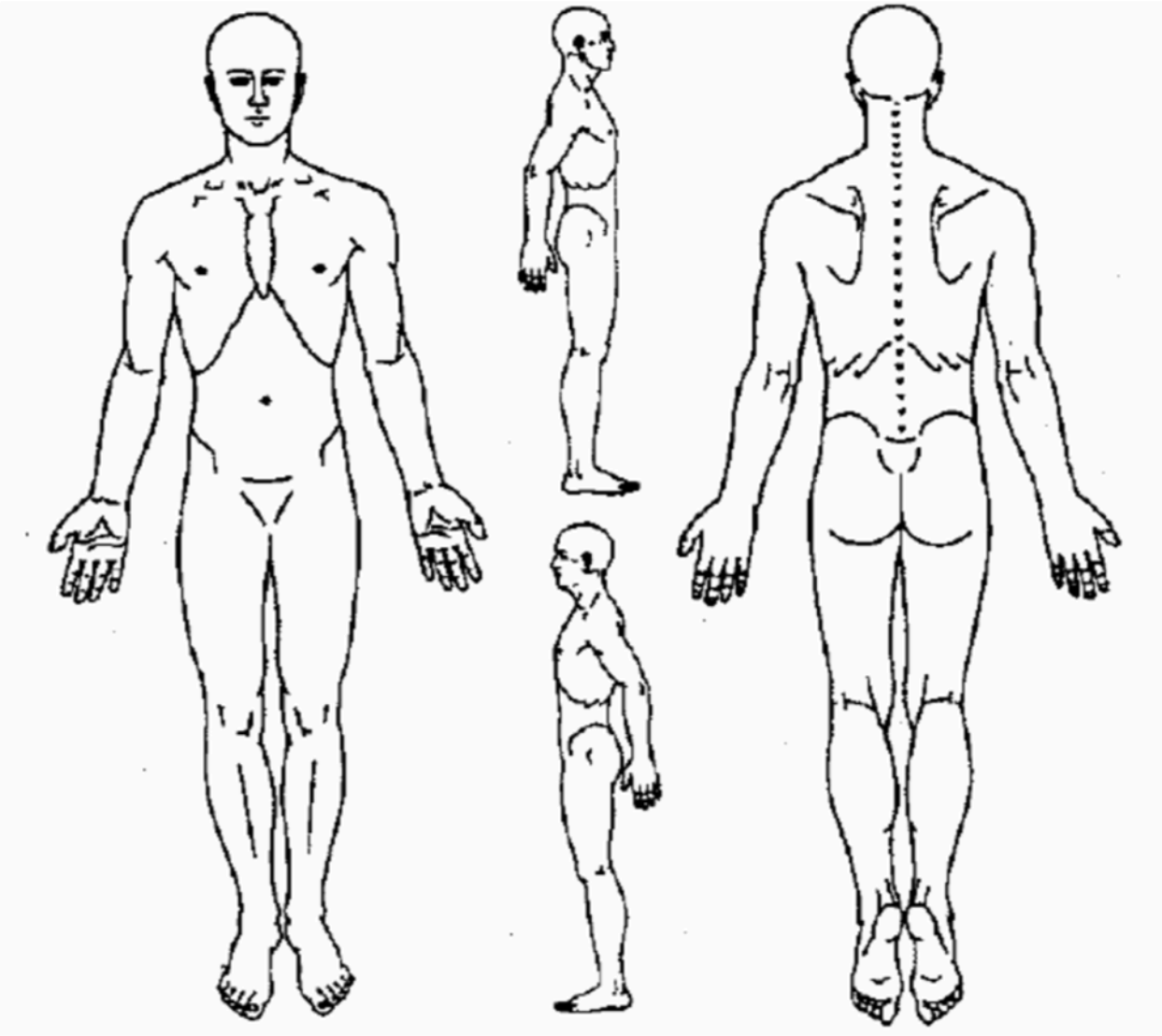

| | | |
|---|---|---|
| Do the symptoms keep you from sleep? | ▫ Yes ▫ No | What is the timing of the symptoms:▫ Constant ▫ Intermittent |

| | |
|---|---|
| What makes the symptoms worse?: | ▫ Squatting ▫ Kneeling ▫ Sitting ▫ Driving ▫ Bending ▫ Twisting<br>▫ Moving ▫ Stairs ▫ Reaching Overhead ▫ Running ▫ Lifting<br>▫ Walking ▫ Athletics ▫ Standing ▫ Lying in Bed |
| Are there any other symptoms associated to this problem?: | ▫ Redness ▫ Bruising ▫ Clicking ▫ Locking ▫ Swelling ▫ Stiffness<br>▫ Limping ▫ Giving Way ▫ Weakness ▫ Popping ▫ Impaired Balance |
| How are you doing overall?: | |

▼▼ MUST FILL OUT ▼▼

Where exactly do you hurt? Use these Symbols to mark. Please draw a line if your symptoms radiate to arms/legs.

| Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|
| - - - - - - | o o o o o | ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |
| - - - - - - | o o o o o | ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |
| - - - - - - | o o o o o | ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |



## ✅ PRIOR TESTING: Have you had any prior tests for this problem?

▫ None ▫ X-Rays ▫ MRI ▫ CAT Scan ▫ Bone Scan ▫ Nerve Test (EMG)

## ✅ PRIOR TREATMENT: Have you had any prior treatment for this problem?

| | | | |
|---|---|---|---|
| ▫ Ice | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Heat | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Rest | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ NSAID's | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Pain medication | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Muscle Relaxers | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Chiropractor | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Physical Therapy | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Home Exercise Program | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Injections | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Bracing | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Tens Unit | ▫ Improved | ▫ Worsened | ▫ Unchanged |
| ▫ Surgery | ▫ Improved | ▫ Worsened | ▫ Unchanged |

▫ Other: _____

## ✅ DESCRIPTION OF THE SYMPTOMS

Please check description(s) pertaining to your chief complaint

| | | |
|---|---|---|
| 1.Neck: | ▫ Right ▫ Left | ▫ Pain ▫ Numbness/Tingling ▫ Stiffness ▫ Sharp ▫ Stabbing ▫ Aching ▫ Dull ▫ Throbbing ▫ Shooting ▫ Burning ▫ Stabbing ▫ Weakness |
| 2. Upper Back: | ▫ Right ▫ Left | ▫ Pain ▫ Numbness/Tingling ▫ Stiffness ▫ Sharp ▫ Stabbing ▫ Aching ▫ Dull ▫ Throbbing ▫ Shooting ▫ Burning ▫ Stabbing ▫ Weakness |
| 3. Shoulder: | ▫ Right ▫ Left | ▫ Pain ▫ Numbness/Tingling ▫ Stiffness ▫ Sharp ▫ Stabbing ▫ Aching ▫ Dull ▫ Throbbing ▫ Shooting ▫ Burning ▫ Stabbing ▫ Weakness |
| 4. Arm: | ▫ Right ▫ Left | ▫ Pain ▫ Numbness/Tingling ▫ Stiffness ▫ Sharp ▫ Stabbing ▫ Aching ▫ Dull ▫ Throbbing ▫ Shooting ▫ Burning ▫ Stabbing ▫ Weakness |
| 5. Hand: | ▫ Right ▫ Left | ▫ Pain ▫ Numbness/Tingling ▫ Stiffness ▫ Sharp ▫ Stabbing ▫ Aching ▫ Dull ▫ Throbbing ▫ Shooting ▫ Burning ▫ Stabbing ▫ Weakness |
| 6. Mid Back: | ▫ Right ▫ Left | ▫ Pain ▫ Numbness/Tingling ▫ Stiffness ▫ Sharp ▫ Stabbing ▫ Aching ▫ Dull ▫ Throbbing ▫ Shooting ▫ Burning ▫ Stabbing ▫ Weakness |

## ✅ DESCRIPTION OF THE SYMPTOMS (CONT.)

Please check description(s) pertaining to your chief complaint

| | | |
|---|---|---|
| 7. Low Back: | ▫ Right ▫ Left | ▫ Pain ▫ Numbness/Tingling ▫ Stiffness ▫ Sharp ▫ Stabbing ▫ Aching ▫ Dull ▫ Throbbing ▫ Shooting ▫ Burning ▫ Stabbing ▫ Weakness |
| 8. Hip: | ▫ Right ▫ Left | ▫ Pain ▫ Numbness/Tingling ▫ Stiffness ▫ Sharp ▫ Stabbing ▫ Aching ▫ Dull ▫ Throbbing ▫ Shooting ▫ Burning ▫ Stabbing ▫ Weakness |
| 9. Buttocks: | ▫ Right ▫ Left | ▫ Pain ▫ Numbness/Tingling ▫ Stiffness ▫ Sharp ▫ Stabbing ▫ Aching ▫ Dull ▫ Throbbing ▫ Shooting ▫ Burning ▫ Stabbing ▫ Weakness |
| 10. Lower Leg: | ▫ Right ▫ Left | ▫ Pain ▫ Numbness/Tingling ▫ Stiffness ▫ Sharp ▫ Stabbing ▫ Aching ▫ Dull ▫ Throbbing ▫ Shooting ▫ Burning ▫ Stabbing ▫ Weakness |
| 11. Tail Bone: | ▫ Yes ▫ No | |
| 12. Other: | ▫ Yes ▫ No | Describe: |
| 13. Pain radiates: | ▫ Yes ▫ No | If yes, from/to: (ex. low back to right leg): |

## ✅ REVIEW OF SYSTEMS

Please indicate if you have experienced any of the following symptoms in the last 6 months

### CONSTITUTIONAL:

| | |
|---|---|
| ❑ No significant weight gain | ❑ No significant weight loss |
| ❑ Weight Gain: _____ lbs. | ❑ Weight Loss: _____ lbs. |
| ❑ No Exercise Intolerance | ❑ Exercise Intolerance ❑ None |

### EYES:

| | | | |
|---|---|---|---|
| ❑ No Vision Change | ❑ Vision Change | ❑ No Blurred Vision | ❑ Blurred Vision |
| ❑ No Double Vision | ❑ Double Vision | ❑ No Vision Loss | ❑ Vision Loss |
| ❑ Wear Glasses/Contact Lenses | | ❑ None | |

### ENMT (Ears, Nose, Mouth/Throat):

| | | | |
|---|---|---|---|
| ❑ No Difficulty Hearing | ❑ Difficulty Hearing | ❑ No Hearing Loss | ❑ Hearing Loss |
| ❑ No Hoarseness | ❑ Hoarseness | ❑ No Trouble Swallowing | ❑ Trouble Swallowing |
| ❑ No Sore Throat | ❑ Sore Throat | ❑ No Snoring | ❑ Snoring |

❑ None

### CARDIOVASCULAR:

| | | | |
|---|---|---|---|
| ❑ No Chest Pain | ❑ Chest Pain on Exertion | ❑ No Palpitations | ❑ Palpitations |
| ❑ No Treating Cardiologist | | ❑ Cardiologist: _____ | |
| ❑ None | | ❑ Ph.#: (_____)_____ | |

## RESPIRATORY:

| | | | |
|---|---|---|---|
| ❑ No Chronic Cough | ❑ Chronic Cough | ❑ No Sleep Apnea | ❑ Sleep Apnea |
| ❑ No C-Pap | ❑ C-Pap | ❑ No Pneumonia | ❑ Pneumonia |
| ❑ No Shortness of Breath | | ❑ Shortness of Breath | ❑ None |

## GASTROINTESTINAL:

| | | | |
|---|---|---|---|
| ❑ No Heartburn | ❑ Heartburn | ❑ No Loss of Appetite | ❑ Loss of Appetite |
| ❑ No Nausea | ❑ Nausea | ❑ No Vomiting | ❑ Vomiting |
| ❑ No Blood in Stool | ❑ Blood in Stool | ❑ No Constipation | ❑ Constipation |

❑ None

## GENITOURINARY:

| | | | |
|---|---|---|---|
| ❑ No Painful Urination | ❑ Painful Urination | ❑ No Blood in Urine | ❑ Blood in Urine |
| ❑ No Kidney Problems | ❑ Kidney Problems | ❑ No Incontinance | ❑ Incontinance |
| ❑ Bowel/Bladder Changes: _____ | | | ❑ None |

## MUSKULOSKELETAL:

| | | | |
|---|---|---|---|
| ❑ No Muscle Weakness | ❑ Muscle Weakness | ❑ No Difficulty Walking | ❑ Difficulty Walking |
| ❑ No Osteoporosis | ❑ Osteoporosis | ❑ No Fractures | ❑ Fractures |

❑ None

## SKIN:

| | | | |
|---|---|---|---|
| ❑ No Frequent Rashes | ❑ Frequent Rashes | ❑ No Skin Ulcers | ❑ Skin Ulcers |
| ❑ No Lumps | ❑ Lumps | ❑ No Psoriasis | ❑ Psoriasis |
| ❑ No Laceration | ❑ Laceration | ❑ None | |

## NEUROLOGIC:

| | | | |
|---|---|---|---|
| ❑ No Frequent Falls | ❑ Frequent Falls | ❑ No Numbness | ❑ Numbness |
| ❑ No Loss of Coordination | ❑ Loss of Coordination | ❑ No Dizziness | ❑ Dizziness |
| ❑ No Headaches | ❑ Headaches | ❑ No Migraines | ❑ Migraines |

❑ None

## PSYCHIATRIC:

| | | | |
|---|---|---|---|
| ❑ No Depression | ❑ Depression | ❑ No Anxiety | ❑ Anxiety |
| ❑ No Sleep Disorder | ❑ Sleep Disorder | ❑ No Dizziness | ❑ Dizziness |
| ❑ No Drug/Alcohol Addiction | ❑ Drug/Alcohol Addiction | ❑ No Illicit Drug Use | ❑ Illicit Drug Use |

❑ None

| ENDOCRINE: | | | |
|---|---|---|---|
| ❑ No Fever | ❑ Fever | ❑ No Night Sweats | ❑ Night Sweats |
| ❑ No Heat/Cold Intolerance | ❑ Heat/Cold Intolerance | ❑ No Fatigue | ❑ Fatigue |
| ❑ None | | | |

| HEMATOLLOGIC: | | | |
|---|---|---|---|
| ❑ No Easy Bleeding | ❑ Easy Bleeding | ❑ No Easy Bruising | ❑ Easy Bruising |
| ❑ No Anemia | ❑ Anemia | ❑ No Phlebitis (Clots) | ❑ Phlebitis (Clots) |
| ❑ None | | | |

Patient Signature: _____ Date: _____