UBNS Neurosurgery
UNIVERSITY AT BUFFALO

GENERAL PRACTICE POLICY

AT THE TIME OF SERVICE; failure to provide the following may result in a rescheduled appointment.

- Patient Social Security Number as needed for eligibility verification. You have the right to decline.
- Current Insurance Card along with complete billing information
- Photo ID
- Workers' Compensation or No-fault claims-complete policy information and Notice of Case Assembly for Worker's Compensation, when applicable.
- Co-payment/Co-insurance/Deductible

UBNS PRIVACY PRACTICES are posted at each practice location and on our website. You will be asked to attest that you have read and understand our Privacy Practices statement. A paper copy will be provided upon request.

UBNS NONDISCRIMINATION

University at Buffalo Neurosurgery, Inc. ("UBNS") complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PROXY

An authorized representative form is available if you wish to designate another person to sign practice documents on your behalf

AUTHORIZATION FOR MEDICAL TREATMENT

University at Buffalo Neurosurgery, Inc. ("UBNS") physicians, professionals and other personnel are hereby authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize any insurance carrier with whom I have a policy or claim to pay directly to the UBNS provider(s) who have rendered services to me. I agree to pay all charges deemed by the assigned insurance as patient responsibility.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by UBNS and are accessible to office personnel. UBNS personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. UBNS and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, workers' compensation carrier, or self-insured employer group liable for any part of UBNS's charges and to any health care provider who is or may become involved with my care.

REQUEST FOR RECORDS

We will respond to your request within 30 days. There is a nominal fee to cover the cost of supplies and postage. UBNS requires a completed and signed authorization approved by New York State Department of Health, to release your records. Request this form in person, via UBNS Patient Portal or by calling our office.

REQUEST FOR FORMS COMPLETION

There is a $15 fee for each form a patient requests our office to complete. Payment is due at the time of request. The request is processed within 10 business days.

THIS IS A DOUBLE-SIDED DOCUMENT →

USE OF CELL PHONES OR ANY AUDIO OR VIDEO RECORDERS IS STRICTLY PROHIBITED in our offices or hospitals during any encounter with our physicians and staff. Please note the Acceptable Use of Mobile Devices policy that is posted in UBNS waiting areas.

APPOINTMENT CANCELLATION/NO-SHOW
24-hour notice of cancellation is required for all appointments. Failure to adhere to this policy may result in a No-Show fee of up to $50.00, dependent on appointment type.

DISCHARGE FROM PRACTICE may occur for the following reasons:
- Violation of any UBNS policy, including but not limited to, the policies contained in this packet.
- Failure to keep scheduled appointments
- Behavior that is threatening to physicians, and/or staff or breaches the doctor-patient relationship. Including, but not limited to, behavior determined to be unpleasant, abusive, disruptive, illegal, confrontational or non-compliant with medical advice.
- Non-payment

I have read and understand the above policies and I agree to accept the terms and responsibility for any financial obligations incurred. Additionally, I accept responsibility to notify UBNS of any changes to the information I have provided, including, but not limited to, Medical History, Insurance or Patient information.

PATIENT WILL SIGN ELECTRONICALLY AT FIRST OFFICE VISIT - KEEP THIS COPY FOR YOUR RECORDS

_____ _____

Patient Signature Date

Patients with Medicare Benefits

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION RELEASE
I request that payment of authorized Medicare benefits be made either to me or on my behalf to University at Buffalo Neurosurgery for any services furnished me by University at Buffalo Neurosurgery. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT WILL SIGN ELECTRONICALLY AT FIRST OFFICE VISIT - KEEP THIS COPY FOR YOUR RECORDS

_____ _____

Patient Signature Date

UBNS Neurosurgery
UNIVERSITY AT BUFFALO

TRANSLATED RESOURCES FOR COVERED ENTITIES

Under Section 1557 of the Affordable Care Act (ACA), covered entities are required to post notices of nondiscrimination and taglines that alert individuals with limited English proficiency (LEP) to the availability of language assistance services. The translated resources are available for use by covered entities and are available at: http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Call 1-716-218-1000, (TTY: 1-800-662-1220).

TAGLINES: TOP 15 NON-ENGLISH LANGUAGES OF NEW YORK STATE

SPANISH
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-716-218-1000, (TTY: 1-800-676-4290).

CHINESE
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-716-218-1000.

KOREAN
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-716-218-1000.

RUSSIAN
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-716-218-1000.

TAGALOG (FILIPINO)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-716-218-1000.

ARABIC
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-716-218-1000 (قم م

FRENCH CREOLE
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-716-218-1000.

FRENCH
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-716-218-1000.

POLISH
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-716-218-1000.

ITALIAN
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-716-218-1000.

URDU
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں کال 1-716-218-1000.

BENGALI
ল য্করনঃ যদিআপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপল আছে। ফোন করন ১-716-218-1000.

YIDDISH
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-716-218-1000.

ALBANIAN
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-716-218-1000.

GREEK
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-716-218-1000.

THIS IS A DOUBLE-SIDED DOCUMENT →

UBNS Neurosurgery
UNIVERSITY AT BUFFALO

PATIENT FINANCIAL POLICY

1. **Proof of Insurance:**
   Failure to provide current and valid insurance information may result in you paying the full amount of each office visit until we can verify your coverage.

2. **Co-payments and Deductibles:**
   It is our policy to collect all co-payments, co-insurance and deductibles prior to rendering service. If surgery is necessary, any applicable deductible must be satisfied prior to surgery. It is the patient's responsibility to be aware of their insurance plan's copayment, deductible and coinsurance requirements.

3. **Credit balances:**
   Any credit balance resulting from a patient payment will be applied to other patient balances on the account, to a future appointment, or refunded, if the balance is greater than $2.00. Refunds of $2.00 or less must be requested at the office.

4. **Payment for Additional Care Not Covered by Insurance:**
   Some medical procedures performed during office visit(s), surgery or other encounters may not be covered by your insurance provider. I understand that UBNS will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment. Consistent with the terms of our agreements with various health plans and insurers, in the event that UBNS is notified in advance that an item or service will not be covered by a health plan or insurer, UBNS will notify you of non-coverage and your responsibility for payment and your right to appeal the notice of non-coverage consistent with the terms of your health plan and applicable law. You will be billed for any non-covered medical care that becomes your liability. Payment in full is due upon receipt of the billing statement.

5. **Patient Statements:**
   If it is necessary to collect additional payment after your insurance carrier has processed the charge for your care, a billing statement will be sent to you. Payment in full is due upon receipt of the billing statement. Account balances owing less than $10.00 will not receive a statement, but will be collected at the next occasion of service.

   Accounts that remain outstanding after the third mailed notification will be referred to a collection agency and incur an additional 33-1/3% collection fee. Accounts referred to collection may be reported to the Credit Reporting Agencies.

I have read and understand the above policies and I agree to accept the terms and responsibility for any financial obligations incurred.

PATIENT WILL SIGN ELECTRONICALLY AT FIRST OFFICE VISIT - KEEP THIS COPY FOR YOUR RECORDS

Patient Signature _____ Date _____

THIS IS A DOUBLE-SIDED DOCUMENT →

UBNS Neurosurgery
UNIVERSITY AT BUFFALO

UBNS DRUG USE, PRESCRIPTION & OPIOID MAINTENANCE THERAPY AGREEMENT

This contract provides important information about the medications you may be taking or may be prescribed for pain management, and assures that you and your provider comply with all state and federal regulations concerning the prescribing of controlled substances. In some instances, Opioid therapy may be considered for moderate to severe pain with the intent of reducing pain and increasing function. The provider's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the provider/patient relationship and full agreement and understanding of the risks and benefits of using medication to treat pain.

1. If this office receives notification, from any source, that a patient is receiving controlled substances from more than one physician, you will be discharged from UBNS group practice.

2. I am to use ONE pharmacy to obtain all prescriptions
    a. PHARMACY NAME _____
    b. PHARMACY PHONE NUMBER _____

3. If prescribed, the potential side effects of medications will be explained to me. These include, but are not limited to:
    a. Allergic reaction
    b. Increased drowsiness or sleepiness
    c. Constipation, decreased appetite
    d. Confusion or difficulty thinking
    e. Slowing of reflex/reaction time, balance or coordination problems
    f. Respiratory depression (slowing of breathing)
    g. Tolerance (requiring more medication to get the same effect)
    h. For male patients, lowering of testosterone levels. These may affect mood, stamina, sexual desire and/or sexual performance.
    i. Physical and/or psychological dependence (i.e. addiction).
        I. This would result in withdrawal symptoms if the medication(s) is abruptly discontinued. These symptoms include, but are not limited to: sweating, nervousness, diarrhea, abdominal cramps, insomnia, and mood alterations.
        II. Physical dependence is a normal physiological response and does not equal addiction. You can be dependent on a medication to an illness without being addicted to it (i.e. a patient is dependent on insulin to treat diabetes)
        III. Addiction is a primary, chronic neurobiologic disease with genetic, psychological and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and drug cravings.

4. All the risks and benefits of long-term opiate use are not yet known.

5. My treatment plan may change. These changes are at the discretion of the provider and will be communicated to me. These changes may be due to a change in my clinical condition or they may be the result of changing treatment protocols, government regulations and recommendations from national bodies of healthcare (e.g. The Centers for Disease Control (CDC), American Medical Association (AMA), etc.).

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6. I will provide my provider with a complete and accurate medical history. This is to include:
    a. Past medical treatments
    b. All medications being used (prescribed, over-the-counter and herbal/supplement medications, illicit drugs)
    c. Any history of drug or alcohol dependency and/or drug or alcohol abuse and/or addiction
    d. Female patients only: Informing the provider immediately if I am or might be pregnant.

7. I will take my medication ONLY as prescribed and ONLY for its intended purpose. If I take my medication more frequently or at a higher dosage than prescribed I will not be given any more medication until my expected renewal date and/or my provider may decide to discontinue prescribing controlled substances to me.

8. I will follow my provider's instructions about engaging in activities that might be dangerous to me, including but not limited to: driving a motor vehicle, operating heavy machinery, performing tasks at an unprotected height or taking responsibility for another individual (e.g. providing child or elder care). I understand that medications can cause increased drowsiness which may interfere with my ability to safely drive, operate heavy machinery or complete tasks which may require quick response time.
    a. Due to the potential side effects of controlled medications, driving while using these substances could result in criminal charges (i.e. DUI, DWI).

9. I will not use alcohol or any other medications without my provider's prior knowledge and agreement.

10. I will not use any illegal substances, including but not limited to, marijuana, cocaine, methamphetamines, heroin or similar substances.

11. I will not sell, possess illegally, divert or transport any controlled substances. I further agree to not share my medication with any other individual or allow any other individual to share their medication with me.

12. I will safeguard my medication from theft, loss or damage. I understand that if my medications are lost or stolen they will not be replaced until 30 days from the date the last prescription was written.

13. I will keep all scheduled appointments. If I cannot keep an appointment I agree to contact my provider's office at least 24 hours prior to my appointment to notify them. The interval for scheduling follow-up appointments is at the sole discretion of the provider.
    I understand that failure to comply with timely follow up appointments may result in discontinuation of medication, refusal to fill medication until I am seen and/or discharge from UBNS group practice.

14. I will participate actively in therapies my provider may recommend.

15. I will submit to the following to ensure compliance with my medications:
    a. Random blood or urine testing (toxicology testing)
    b. Random pill count.
    I understand that upon notification, I will be required to present to the office for random pill counts and/or blood or urine testing on the date and time designated by the provider.
        - If you fail to acknowledge this request on the same business day as it is presented to you, you will be considered non-compliant.
        - If you are unwilling to comply with the request you will be considered non-compliant.

- Failure to provide accurate and current contact information or the office is unable to reach you will be considered non-compliant.
- You will notify the office PRIOR to any travel that will cause you to be unavailable to receive communications regarding random testing and pill count. You will provide travel itinerary/receipts, that include your name and dates of travel, if requested by the office. Failure to do this will be considered non-compliant.

Non-compliance with any or all of these requirements will place your medical treatment plan under review and the plan will be altered appropriately.

16. I authorize the UBNS provider to speak with my pharmacist regarding any concerns that the provider may have regarding my care.

17. I agree to the following medication refill policy:
    a. All refill requests are due 5 business days (e.g. Mon–Thurs) prior to the refill date.
    b. Refill requests should be made via the UBNS Medent Patient Portal or may be called in at **(716) 218-1000, Monday-Thursday 8am to 4pm**. It is my responsibility to provide the following information accurately: Medication name, medication dosage and frequency of use (e.g. Ibuprofen 200mg, 1 tablet twice a day). Failure in providing accurate information may result in a delay in processing my refill.
    c. There will be no refills completed on Fridays, weekends, or holidays.
    d. Urgent requests after hours due to failure to call in a timely manner will not be honored.
    e. Requests will not be honored if medication is damaged, lost or stolen. (SEE 12)

18. If my insurance changes or I am no longer able to pay for my medication I agree to contact my provider immediately to discuss alternatives or safe discontinuation. I will immediately notify the practice if my phone number, address or insurance changes.

19. I must fully comply with the terms of this agreement in order to obtain the trust and confidence of my provider(s). My treatment will be based on this agreement. Failure to comply with the conditions of this agreement may result in:
    a. Danger to my life and health
    b. Danger to the life and health of other individuals
    c. Decrease or discontinuation of medications.
    d. Cancellation of office appointment or scheduled surgery
    e. Discharge from the practice.

20. I understand all terms and conditions of this agreement. Any questions have been answered to my satisfaction. I was provided a copy of the agreement.

By signing below, I understand and agree to follow the policies of UBNS Drug Use, Prescription and Opioid Maintenance Therapy Agreement.

PATIENT WILL SIGN ELECTRONICALLY AT FIRST OFFICE VISIT - KEEP THIS COPY FOR YOUR RECORDS

_____ _____

Patient Signature Date

_____ _____

Witness: Date

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UBNS Neurosurgery
UNIVERSITY AT BUFFALO

PATIENT INFORMATION

Please complete and sign form at bottom

Patient Name	Social Security #	Sex M F	Date of Birth

Street Address (If student, permanent address)	City and State	Zip Code	Home Phone
	Email		Cell Phone

Marital Status S M D W	Spouse's Name	Spouse's Phone	Permission to release your info? Y N

Employer (Indicate if retired)	Occupation (Indicate if student)	Business Phone & EXT	Currently working? Y N

Employer Street Address	City and State	Zip Code

Emergency Contact	Phone	Permission to release your info? Y N

Referring Physician (First Name, Last Name)	Address	Phone

Primary Care Physician (First Name, Last Name)	Address	Phone

Race/Ethnicity	Spoken Language

PHARMACY INFORMATION

Pharmacy Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

PLEASE PROVIDE <u>ALL INSURANCE</u> INFORMATION REQUESTED BELOW.

IF YOU ARE HERE FOR A WORK-RELATED INJURY OR MOTOR VEHICLE ACCIDENT, SEE REVERSE SIDE

Primary Insurance Company & Address	Name of Policyholder	Identification #	Group #

Secondary Insurance Company & Address	Name of Policyholder	Identification #	Group #

Signature: _____ Date: _____

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WORKER'S COMPENSATION: Were you injured at work? YES NO (If you circled YES, complete information below).
Are you still working? YES NO

Compensation Carrier Name:	Address:	Phone: Fax:
WCB Number:	Carrier Case Number:	Date of Injury:
Name of Employer (at the time of injury):	Employer Address:	Employer Phone:
Name of Adjuster:	Adjuster Phone:	Adjuster Fax:
Body part(s) injured:	Job duties at time of injury:	

NO FAULT: Were you injured by a motor vehicle? YES NO (If you circled YES, complete information below).

Agent Name:	Insurance Company Address:	Date of Accident:
Insurance Company:		Claim Number:
Name of Adjuster:	Adjuster Phone:	Adjuster Fax:
Body part(s) injured:		

You will need a referral for your insurance if Workers' Compensation/No Fault denies your claim.

Explain in detail how the injury occurred: _____

_____

_____

Explain in detail the nature of your injury, including all body parts injured: _____

_____

_____

_____

Have you given your employer or supervisor notice of this injury? YES NO

Are you disabled from performing your regular job duties? YES NO

A. Does any other doctor have you off of work? YES NO

If yes, who? _____

B. Does your employer have light duties or other jobs you can perform? YES NO UNSURE

Have you had any previous Workers' Compensation or No Fault injuries? YES NO

If yes, body part(s)? _____ Date of injury: _____

Doctor or hospital where treated: _____

Patient name (please print): _____

Signature: _____ Date: _____

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UNIVERSITY AT BUFFALO

PATIENT MEDICAL HISTORY

Patient Name: _____

Age: _____ Height: _____ Weight: _____ Right-handed ____ Left-handed ____ Are you Claustrophobic? YES NO

REASON FOR VISIT:

Chief complaint: _____

_____

_____

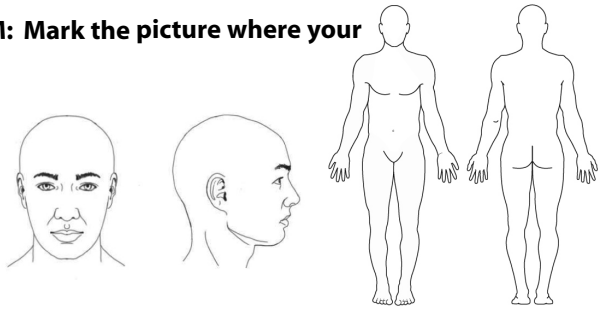
_____

_____

_____

PAIN DIAGRAM: Mark the picture where your symptoms are

Numbness	+++
Burning	XXX
Aching	===
Stabbing	/////
Pins/needles	000



Have you seen another physician for this condition/injury? YES NO If yes, where, when and whom? _____

_____

How bad is your pain? (circle) 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 (worst pain)

Duration? Less than 1 week ____ Less than 1 month _____ Less than 1 year _____ More than 1 year _____

Food Allergies? YES NO (List all, and reactions you might have) _____

Dye Allergies? YES NO (List all, and reactions you might have) _____

Latex Allergies? YES NO (List all, and reactions you might have) _____

Drug Allergies? YES NO (List all, and reactions you might have) _____

Other? _____

****LIST CURRENT MEDICATIONS (names, dosage, frequency) *Attach list if needed*:** _____

_____

Smoker or use tobacco? YES NO How frequent? Every day _____ Some days _____ Pack/day _____ # Years _____

Former smoker/tobacco user: Quit when? _____ Never smoked or used tobacco _____

Do you believe you can quit? YES NO

Alcohol use? YES NO If yes, how frequent? ☐ Daily ☐ Weekly ☐ Socially

Drug use? YES NO If yes, how frequent? ☐ Daily ☐ Weekly ☐ Socially

Drug/alcohol therapy? YES NO If yes, describe: _____

****LIST PREVIOUS SURGERIES**: _____

_____

Hysterectomy? YES NO

Spinal cord stimulator? YES NO

Intrathecal pump? YES NO If yes, ☐ Morphine? ☐ Baclofen?

Metal implants? YES NO Location _____

Pacemaker/AICD? YES NO

PERSONAL HISTORY:

Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Hypertension	☐	☐	Ulcer/GI Bleed
☐	☐	High Cholesterol	☐	☐	Lung Disease/Asthma
☐	☐	Heart Disease	☐	☐	Cancer
☐	☐	Heart Attack	☐	☐	Hepatitis
☐	☐	Heart Surgery	☐	☐	Kidney Disease/Dialysis
☐	☐	Cardiac Angioplasty/Stent	☐	☐	Osteoarthritis/Rheumatoid
		(When? _____)	☐	☐	Aneurysm
☐	☐	Atrial Fibrillation	☐	☐	Other _____

FAMILY HISTORY:

Father	Mother	Brother	Sister	Son	Daughter	
☐	☐	☐	☐	☐	☐	**Diabetes**?
☐	☐	☐	☐	☐	☐	**Stroke**?
☐	☐	☐	☐	☐	☐	**Heart Disease**?
☐	☐	☐	☐	☐	☐	**Cancer**?
☐	☐	☐	☐	☐	☐	**Brain Tumor**?
☐	☐	☐	☐	☐	☐	**Aneurysm - brain**?
☐	☐	☐	☐	☐	☐	**Aneurysm - other**?

Signature _____ Date _____

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REVIEW OF SYSTEMS

Please circle the symptoms you have been experiencing recently. If none apply, select "None."

General	Weight loss Night sweats	Fatigue	Unsteadiness	Fever	Chills	None
HEENT:	Vision changes	Hearling loss	Ringing in ears	Nose bleeds		None
Neck:	Pain/difficulty swallowing	Sore throat	Lumps/masses in neck	Hoarseness		None
Respiratory:	Shortness of breath	Wheezing	Dry cough	Productive cough		None
Cardiac:	Palpitations	Chest pain	Swelling in legs			None
GI:	Nausea/ vomiting Weight loss	Difficulty swallowing	Indigestion	Change in bowel habits	Blood in stools	None
GU:	Difficulty urinating Sexual dysfunction	Pain on urinating	Prostate problems	Urinating multiple times at night	Blood in urine Incontinence	None
Vascular:	Pain in calves when walking	Clots in legs				None
Musculo-skeletal:	Pain/stiffness in bones or joints	Arthritis	Gout	Muscle weakness		None
Neurologic:	Numbness/ weakness Headaches	Tingling	Tremors	Seizures	Blackouts	None
Hematologic:	Easy bruising/ bleeding					None
Endocrine:	Heat/cold intolerance	Excessive thirst				None
Skin:	Skin, hair or nail changes	Rashes	Sores			None
Psychiatric:	Depression	Anxiety	Thoughts of suicide			None

What makes your pain better? _____

_____

What makes your pain worse? _____

_____

Which of the following treatments have you had:

Yes	No		
☐	☐	Physical therapy (Facility?_____)	
☐	☐	Chiropractic (Facility?_____)	
☐	☐	Traction/Spinal decompression (Facility?_____)	
☐	☐	Injections (Facility?_____)	
☐	☐	Orthopedic consult (Where?_____)	
☐	☐	Neurosurgical consult (Where?_____)	
☐	☐	Surgery consult (Where?_____)	
☐	☐	Pain medication	☐ NSAIDs _____ ☐ Muscle relaxants _____ ☐ Narcotics _____ ☐ Other _____

How do the following activities affect your pain?

Better	Worse	No change	
☐	☐	☐	Lying down
☐	☐	☐	Sitting
☐	☐	☐	Standing
☐	☐	☐	Walking
☐	☐	☐	Bending
☐	☐	☐	Lifting
☐	☐	☐	Straining/coughing/sneezing

Patient name: _____ DOB: _____ Date: _____

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