



**PATIENT INFORMATION**

Name (last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(M/F) \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Preferred Phone # \_\_\_\_\_ Work Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Please check here to authorize VISP to send appointment reminders to your cell phone \_\_\_\_\_

Marital Status \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone# \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

**RESPONSIBLE PARTY**

Guarantor's Name \_\_\_\_\_ E-mail: \_\_\_\_\_

Address \_\_\_\_\_

Patient Relation to Guarantor \_\_\_\_\_ Guarantor's Employer \_\_\_\_\_

Guarantor's Social Security No. \_\_\_\_\_ Guarantor's Date of Birth \_\_\_\_\_ (M/F) \_\_\_\_\_

**PRIMARY INSURANCE**

Name of Insurance Company \_\_\_\_\_

Subscriber's ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Patient Relation to Subscriber: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ (M/F) \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Insurance Address \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insurance Company \_\_\_\_\_

Subscriber's ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Patient Relation to Subscriber: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ (M/F) \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Insurance Address \_\_\_\_\_

**PHARMACY INFORMATION**

Whenever possible, Virginia iSpine Physicians, P.C. will electronically transmit your prescription(s) directly to your pharmacy. Please provide us with your preferred pharmacy information in the space below

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

Primary Care Physician: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medications; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory tests, including **urine drug screens** to monitor prescription and illicit drugs, all of which the judgment of the attending physician or their assigned designees may consider medically necessary or advisable.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I hereby authorize Virginia iSpine Physicians, P.C. to release medical information to any healthcare provider or third-party insurance company for the purpose of treatment, payment or operations, which may pertain to my care. I hereby authorize payment directly to Virginia iSpine Physicians, P.C. of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by any third party carrier and in accordance with contractual terms and participatory agreements. Further, I acknowledge that I am indebted for past due charges, and I understand that I am financially responsible for those charges also. Should this account become delinquent, I agree to pay a collection fee not to exceed 33 1/3% of the balance then outstanding in addition to any court costs and/or including attorney fees.

**MEDICARE PATIENTS:** I authorize Virginia iSpine Physicians, P.C. to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Virginia I-Spine Physicians, P.C.

In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia (whenever any health care provider or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may according to the current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented for testing for infection with human immunodeficiency virus. If there is an exposure and the patient’s test is positive the attending physicians will notify the patient, any person exposed, and the Virginia Health Department and appropriate counseling will be offered. I have reviewed and understand my patient rights and responsibilities. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient’s Signature \_\_\_\_\_ Date: \_\_\_\_\_



## Financial Policy

### IDENTIFICATION REQUIREMENTS

This practice is committed to safeguarding your identity. Federal regulations require verification of your identity at each visit to verify the identity of anyone presenting medical insurance identification. To satisfy the Federal requirements, **your driver's license will be scanned into your electronic file.** This allows us to verify your identity for future visits. Refusal to provide the required identification may delay or prevent your being seen by our physicians.

### ASSIGNMENT OF BENEFITS

The patient understands that payment of authorized Medicare or applicable private insurance benefits will be paid directly to Virginia iSpine Physicians, PC for services provided under their care. If insurance payments are sent to the patient directly, the patient is responsible for forwarding payment to our office with a copy of the explanation of benefits (EOB) received.

### HEALTH INSURANCE ELIGIBILITY, POLICY UPDATES & NEW INSURANCES

It is the patient's responsibility to keep Virginia iSpine Physicians, PC updated with correct insurance information. If the insurance company the patient designates is incorrect, the patient will be responsible for payment of the visit. In the patient's agreement with their insurance plan, the patient is responsible for any and all co-payments, deductibles and coinsurances. It is the patient's responsibility to understand his/her benefit plan. All prior balances must be paid prior to your visit.

It is the patient's responsibility to respond to any and all requests from the insurance company for further information and/or patient demographics on their account. Failure to do so in a timely fashion may result in a claim denial and will result in the patient being responsible for any payments due to ViSP in full.

We **DO NOT** participate with all insurances. If we do not accept your insurance and you wish to be seen at our office, you may elect to pay for services in accordance with the FINANCIAL RESPONSIBILITY listed below. It is important to note that any monies paid on your self pay account will not be applied to your insurance deductible.

### REFERRALS and AUTHORIZATIONS

I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of my scheduled appointment, I will be required to reschedule. PLEASE NOTE: When calling your insurance company to find out if a pre-authorization is required for your visit, you will want to tell them you are seeking care at Virginia iSpine Physicians, PC.

### BILLING INFORMATION

You may receive additional patient care services as part of your treatment at Virginia iSpine Physicians PC such as anesthesia, radiology, pathology, laboratory or other services. These services are a vital part of your care. There may be additional charges for these services and you may receive a bill from those specific partnering providers. In addition, you may receive inpatient or outpatient hospital care if and when services are rendered in a facility or at the hospital.

### ABN (Advanced Beneficiary Notice)

The Federal Medicare program, administered through the Center for Medicare and Medicaid Services (CMS), and some private insurance companies, do not cover some services they consider medically unnecessary. You will be responsible for all fees related to these services. Your signature will be required on the ABN prior to receiving any potentially uncovered services. Supplemental or secondary insurances to Medicare will not cover services denied by Medicare. We recommend checking with your insurance carrier prior to treatment if you are concerned about these issues.

### MISSED & CANCELLED APPOINTMENTS

The office is open 7:30am to 5:30pm, Monday through Friday. We require at least 24 business hours' notice if you must cancel an appointment. Failure to do so will result in a cancellation/ no show fee of \$25.00 for office visits, \$100.00 for EMG appointments or \$100.00 for procedure visits. If you miss three appointments without providing the required 24 hours' notice for cancellation, we may exercise the right to discharge you from the practice.

**COLLECTION OF CO-PAYS AND DEDUCTIBLES AND OTHER BALANCES**

You are expected to pay your co-payment, any co-insurance, deductible amounts, and any outstanding balances in full at the time of service. If you are insured with a high deductible insurance plan and have not met your deductible, we will collect the estimated contracted rate for services rendered at the time of service. If you are unable to pay the full amount due prior to your next appointment, please request to speak with our billing manager to create an acceptable payment arrangement to satisfy your balance before your next visit. We do not accept payment plans.

**RETURNED CHECKS**

We do not accept checks as form of payment in the office. If you mail in a payment on services rendered in the form of a check to our billing department and the check is returned, you will be assessed a return check fee of \$35.00 and will need to resubmit your original payment by either cash or credit card. If this occurs, mailed check payments will no longer be accepted for any future account balances.

**FINANCIAL RESPONSIBILITY**

I understand that Virginia iSpine Physicians, PC, as a courtesy, will file my insurance claims with insurance companies that the Practice participates with; however, I am ultimately responsible for the full payment of all charges. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient’s responsible party, understands that Virginia iSpine Physicians, PC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient’s responsible party, understands and agrees to pay all collection fees in the amount up to thirty-three and one-third percent (33 1/3%) of the total unpaid balance due. I understand and agree that should Virginia iSpine Physicians, PC be awarded judgement relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half (1 ½%) per month, eighteen (18%) per annum, beginning on the date of the judgment.

All patient balances are billed immediately upon receipt of your insurance plan’s Explanation of Benefits. Your remittance is due within 10 business days of your receipt of your bill. If there is a balance on your account and previous arrangements have not been made with our billing department, any account balance outstanding longer than 90 days will be forwarded to a collection’s agency. Any patient account balance over 90 days past due, that does not have a financial payment contract or credit card on file, will be turned over to an outside collection agency. ***This also includes any patient account balances that have defaulted from their financial payment contract.***

**CONSENT FOR THE RELEASE OF MEDICAL RECORDS**

I authorize Virginia iSpine Physicians, PC to release necessary medical information to my insurance company, its agents or any third-party payer in order for payable benefits for these services to be determined.

If you would like to request copies of your medical record, there will be an administrative Search Fee of \$10.00. Pages 1–50 \$0.50 per page, pages 51+ \$0.25 per pages under Virginia Consent for Release of Medical Records. A separate CONSENT FOR THE RELEASE OF MEDICAL RECORDS form must be completed before your request can be honored.

**OVERPAYMENTS/REFUNDS**

Once ALL insurance and patient payments for all dates of service completed have been received and it is deemed the carrier and/or patient have made an overpayment, Virginia iSpine Physicians, P.C. will refund the overpayment to the appropriate party, in a prompt fashion.

**I have read and I understand Virginia iSpine Physician PC’s financial policies and understand that I am bound by the above terms. I accept responsibility for the payment of any fees associated with my care.**

**I acknowledge that Virginia iSpine Physicians, PC will scan this document and destroy the original, and agree that the scanned document is the same as the original.**

\_\_\_\_\_  
*Signature of Patient or Responsible Party*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Signature*

\_\_\_\_\_  
*Relationship to Patient*

**Patient Portal Authorization Form**

Patient Name: \_\_\_\_\_

Responsible Party Name (if Patient is a Minor):  
\_\_\_\_\_

Email Address / Account Holder (please print clearly):  
\_\_\_\_\_



(Please supply the personal email address of the person who will be using the PATIENT PORTAL)

**Purpose of this Form:**

The PATIENT PORTAL offers patients of **Virginia iSpine Physicians, P.C.** a secure way to view parts of your electronic health record and communicate with our staff. Secure messaging is a valuable communication tool for our practice, but it has certain limitations and guidelines. Please read this form thoroughly before signing.

**How the PATIENT PORTAL Works:**

A secure WEB PORTAL is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site. Once you are logged into the portal you will have access to only your records or those for whom you are legally responsible. Via the PATIENT PORTAL you will be able to:

- ✓ Use the message function to communicate with our staff
- ✓ Schedule, confirm, cancel or reschedule an appointment
- ✓ Communicate about billing questions and pay your bill online
- ✓ Request a medication refill
- ✓ View health summary information in your electronic chart and send staff requests to update information
- ✓ Print or save an electronic copy of the health summary using the continuity of care record (CCR) format

**How to Participate in the PATIENT PORTAL:**

Once this form is agreed to and signed, you will receive a link to the patient portal via your personal email account. Check your spam and junk folders if you do not find our email confirmation. You will need to click this link to set up your password and security question. Once this is complete, you will be able to access the patient portal via our website at [www.vaispine.com](http://www.vaispine.com). You will want to accept our website as Trusted Site.

**Protecting Your Private Health Information and Risks:**

This method of communicating and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two important factors, we need you to make sure we have your correct email address and you **MUST** inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address as this information might be available to your employer.

**Conditions of Participating in the PATIENT PORTAL:**

We understand the importance of privacy with regard to your health care, and will continue to protect the privacy of your medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices. Access to this secure web portal is an optional service and we may suspend or terminate it at any time for any reason. As a user of the patient portal and by signing this form you agree to:

1. Not transmit any electronic information that violates the rights or privacy of any party.
2. Use the WEB PORTAL in any way that would violate local, state or federal laws.
3. Not transmit materials that are obscene, defamatory, abusive, slanderous or otherwise likely to result in harm to others.
4. Intentionally distribute viruses code or take any other action that could compromise the security of our computer system.

**Patient / Guardian Acknowledgement:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please send or fax back to the office at:

Virginia iSpine Physicians, P.C.  
9020 Stony Point Parkway, Suite 140  
Richmond, Virginia 23235  
Fax (804) 327-1677



**HIPAA Authorization to release information**

Patient Rights:

- I have the right to revoke this authorization any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

By signing this form, you only give your consent to discuss your medical and billing information with the family members indicated below.

1. Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

2. Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

3. Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**Authorization to leave messages with Household Members / Cell Phone / Answering Machine.**

Occasionally it is necessary for the staff of Virginia iSpine Physicians to leave messages for our patients. The purpose of these messages varies and may include reminders to patients of their upcoming appointments or other messages to return our calls. At no time will a representative of Virginia iSpine Physicians discuss your medical condition without your consent.

By signing this form, you give consent for VISP to leave messages with members of your household, your personal cell phone, or answering machine. **Please check all that apply:**

I authorize VISP to leave a detailed message on my home or cell number regarding appointments.

I authorize VISP to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

I authorize VISP to leave a message with anyone who answers the phone.

Messages may only be left with \_\_\_\_\_

Please Note: There is a separate form to fill out for Medical Record Request.

**Signing below means that you have received and understand this notice.**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

***YOU HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING AT ANY TIME. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL YOU REVOKE IT IN WRITING.***

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## Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

\*Copy of our privacy practices can be provided to you via email, or in office upon request\*

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**PLEASE COMPLETE THIS ENTIRE FORM**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**How were you referred to Virginia iSpine Physicians?**

- Physician: \_\_\_\_\_  Relative  Friend  
 TV Ad: Channel-\_\_\_\_\_  Other - \_\_\_\_\_

**Tell us why you are here today:**

- Lower Back Pain (Axial Lumbosacral pain)  Neck Pain (Axial Neck Pain)  
 Mid Back pain (Axial Thoracic Pain)  Shoulder/Arm Pain (Cervical Radic Pain)  
 Hip and Leg Pain (L-S Radic Pain)  Other: \_\_\_\_\_

**Are you allergic to any of the following?** (Describe type of reaction)

- a. Shellfish  Yes  No \_\_\_\_\_  
b. Contrast Dye  Yes  No \_\_\_\_\_  
c. Local anesthetic  Yes  No \_\_\_\_\_  
d. Medications  Yes  No \_\_\_\_\_

If 'Yes,' indicate which medications: \_\_\_\_\_

**What Medications are you CURRENTLY taking?** (attach a separate piece of paper if needed)

<b>Medication Name</b>	<b>Dose (#mg)</b>	<b>Times Taken Per Day</b>

**What Medications did you PREVIOUSLY take for your pain?**

Medication Name	Dose (#mg)	Times Taken Per Day

**Is your pain?**

- Electrical    Stabbing    Dull    Achy

**Is your injury/condition work related?**       Yes      W/C case number: \_\_\_\_\_      No

**How long have you had this pain (enter a number)?** \_\_\_ Days    \_\_\_ Weeks    \_\_\_ Months    \_\_\_ years

**What seemed to cause your current pain condition:**

- Unknown                                       Lifting       Athletic Activity       A Fall  
 Auto Accident: date \_\_\_/\_\_\_/\_\_\_       Other Trauma

**What activities increase and decrease your pain:**

ACTIVITY	INCREASES PAIN	DECREASES PAIN
Sitting		
Standing		
Walking		

**Please indicate if you have received any of the following treatments for your pain condition, when the treatment occurred, and whether the outcome was positive (+) or negative (-)**

Treatment	Approximate Month & Year	Treatment
Surgery		
Physical Therapy		
Chiropractic Treatment		
Trigger Point Injections		

CONTINUED:		
Treatment	Approximate Month & Year	Treatment
Injections Guided by X-Ray <ul style="list-style-type: none"> <li><input type="checkbox"/> Epidural Steroid Injection</li> <li><input type="checkbox"/> Facet Joint Injection</li> <li><input type="checkbox"/> Sacroiliac (SI) Joint Injection</li> <li><input type="checkbox"/> Hip Joint Injection</li> <li><input type="checkbox"/> Other</li> </ul>		

**Have you had any diagnostic imaging such as (MRI, CT, X-Ray,) within the past 6 months,**  
 If so, when? \_\_\_\_\_ where? \_\_\_\_\_

**Have you had any diagnostic testing such as DEXA (bone density or bone scan) done in the past?**  
 If so, when? \_\_\_\_\_ where? \_\_\_\_\_

**Please check (✓) any of the following symptoms or problems that you have experienced during the last six (6) months**

<p style="text-align: center;"><b>CONSTITUTIONAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Weight gain</li> <li><input type="checkbox"/> Weight loss</li> <li><input type="checkbox"/> Marked fatigue</li> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Sweats</li> <li><input type="checkbox"/> Excessive thirst</li> <li><input type="checkbox"/> Heat/Cold intolerance</li> <li><input type="checkbox"/> Depression or other emotional changes</li> </ul>	<p style="text-align: center;"><b>CARDIOVASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest pain / pressure/ tightness</li> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Rapid heart rate</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Poor circulation</li> </ul>	<p style="text-align: center;"><b>GASTROINTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Persistent/recurring stomach pain</li> <li><input type="checkbox"/> Loss of bowel control</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Blood in stool</li> <li><input type="checkbox"/> Heartburn or indigestion</li> <li><input type="checkbox"/> Nausea/vomiting</li> <li><input type="checkbox"/> Yellow jaundice</li> </ul>
<p style="text-align: center;"><b>MUSCULOSKELETAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Joint pain</li> <li><input type="checkbox"/> Joint stiffness</li> <li><input type="checkbox"/> Joint redness or swelling</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Cramps</li> </ul>	<p style="text-align: center;"><b>NEUROLOGICAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Blackouts/Fainting</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Memory loss</li> </ul>	<p style="text-align: center;"><b>RESPIRATORY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Coughing up blood</li> <li><input type="checkbox"/> Wheezing</li> </ul>

<p><b>EARS, NOSE &amp; THROAT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Loss of hearing</li> <li><input type="checkbox"/> Vertigo/Dizziness</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Sinus problems</li> </ul>	<p><b>SKIN</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Frequent bruising</li> <li><input type="checkbox"/> Rash</li> <li><input type="checkbox"/> Nail or hair changes</li> <li><input type="checkbox"/> Hives</li> <li><input type="checkbox"/> Sores that don't heal</li> </ul>	<p><b>EYES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blurred vision</li> <li><input type="checkbox"/> Double vision</li> <li><input type="checkbox"/> Eye pain</li> </ul>
<p><b>GENITOURINARY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Painful urination</li> <li><input type="checkbox"/> Urgency to urinate</li> <li><input type="checkbox"/> Loss of bladder control</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Difficulty urinating</li> </ul>	<p><b>MEN ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Penis discharge</li> <li><input type="checkbox"/> Sore on penis</li> <li><input type="checkbox"/> Lump on testicle</li> <li><input type="checkbox"/> Other: _____</li> </ul>	<p><b>WOMEN ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Extreme menstrual pain</li> <li><input type="checkbox"/> Vaginal discharge</li> <li><input type="checkbox"/> Painful intercourse</li> <li><input type="checkbox"/> Breast pain</li> <li><input type="checkbox"/> Nipple discharge</li> <li><input type="checkbox"/> Breast lump - if yes, date of last mammogram _____</li> </ul>

**Medical History - Check (√) any of the following conditions or problems that you have faced at any time in your life.**

<ul style="list-style-type: none"> <li><input type="radio"/> AIDS</li> <li><input type="radio"/> Alcoholism</li> <li><input type="radio"/> Anorexia/Bulimia</li> <li><input type="radio"/> Arthritis</li> <li><input type="radio"/> Asthma/COPD</li> <li><input type="radio"/> Bleeding Disorder</li> <li><input type="radio"/> Cataracts</li> <li><input type="radio"/> Cancer Type: _____</li> <li><input type="radio"/> Chicken pox</li> <li><input type="radio"/> Diabetes - Type: _____</li> <li><input type="radio"/> Drug Dependency</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Emphysema</li> <li><input type="radio"/> Glaucoma</li> <li><input type="radio"/> Heart Disease</li> <li><input type="radio"/> Hepatitis Type: _____</li> <li><input type="radio"/> Hernia</li> <li><input type="radio"/> HIV Positive</li> <li><input type="radio"/> Hypertension</li> <li><input type="radio"/> Kidney Disease</li> <li><input type="radio"/> Liver Disease</li> <li><input type="radio"/> Measles</li> <li><input type="radio"/> Migraine Headaches</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Mononucleosis</li> <li><input type="radio"/> Multiple Sclerosis</li> <li><input type="radio"/> Mumps</li> <li><input type="radio"/> Pacemaker Implant</li> <li><input type="radio"/> Pneumonia</li> <li><input type="radio"/> Polio</li> <li><input type="radio"/> Prostate Problems</li> <li><input type="radio"/> Psychiatric Conditions</li> <li><input type="radio"/> Rheumatic Fever</li> <li><input type="radio"/> Stomach Ulcer</li> <li><input type="radio"/> Stroke</li> <li><input type="radio"/> Thyroid Condition</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Tuberculosis</li> <li><input type="radio"/> Typhoid Fever</li> <li><input type="radio"/> Vascular Disease</li> <li><input type="radio"/> Other (list) _____ _____ _____ _____</li> </ul>
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**Surgical History - Please list any previous surgeries and their respective dates**

Date	Surgery

**Family History - Please (√) any conditions experienced by your parents, children, or siblings:**

		Parents	Siblings	Children
	High Blood Pressure			
	Diabetes			
	Cancer			
	Heart Disease			
	Stroke			
	Back/Neck Pain			
	Rheumatoid Arthritis			

**Social / Vocational / Work History**

Do you smoke cigarettes?       Yes       No

If 'No,' did you ever smoke?       Yes       No

If 'Yes,' indicate how much you smoke/smoked per day by checking one of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Less than ¼ pack per day             | <input type="checkbox"/> About ¾ pack per day (15 cigarettes) |
| <input type="checkbox"/> About ¼ pack per day (5 cigarettes)  | <input type="checkbox"/> About 1 pack per day (20 cigarettes) |
| <input type="checkbox"/> About ½ pack per day (10 cigarettes) | <input type="checkbox"/> More than 1 pack per day             |

Do you have a history of alcohol or drug abuse?       Yes       No

**Marital Status**     Single     Married     Separated     Divorced     Widowed

**Employment Status**     Unemployed     Employed    \_\_\_ Full Time    \_\_\_ Part Time

Employer Name: \_\_\_\_\_

If unemployed right now, indicate the last date worked: \_\_\_/\_\_\_/\_\_\_

If out of work, what was your reason for leaving?     Due to pain problem     Not due to pain

**Patient Signature:** \_\_\_\_\_

**Date** \_\_\_\_\_

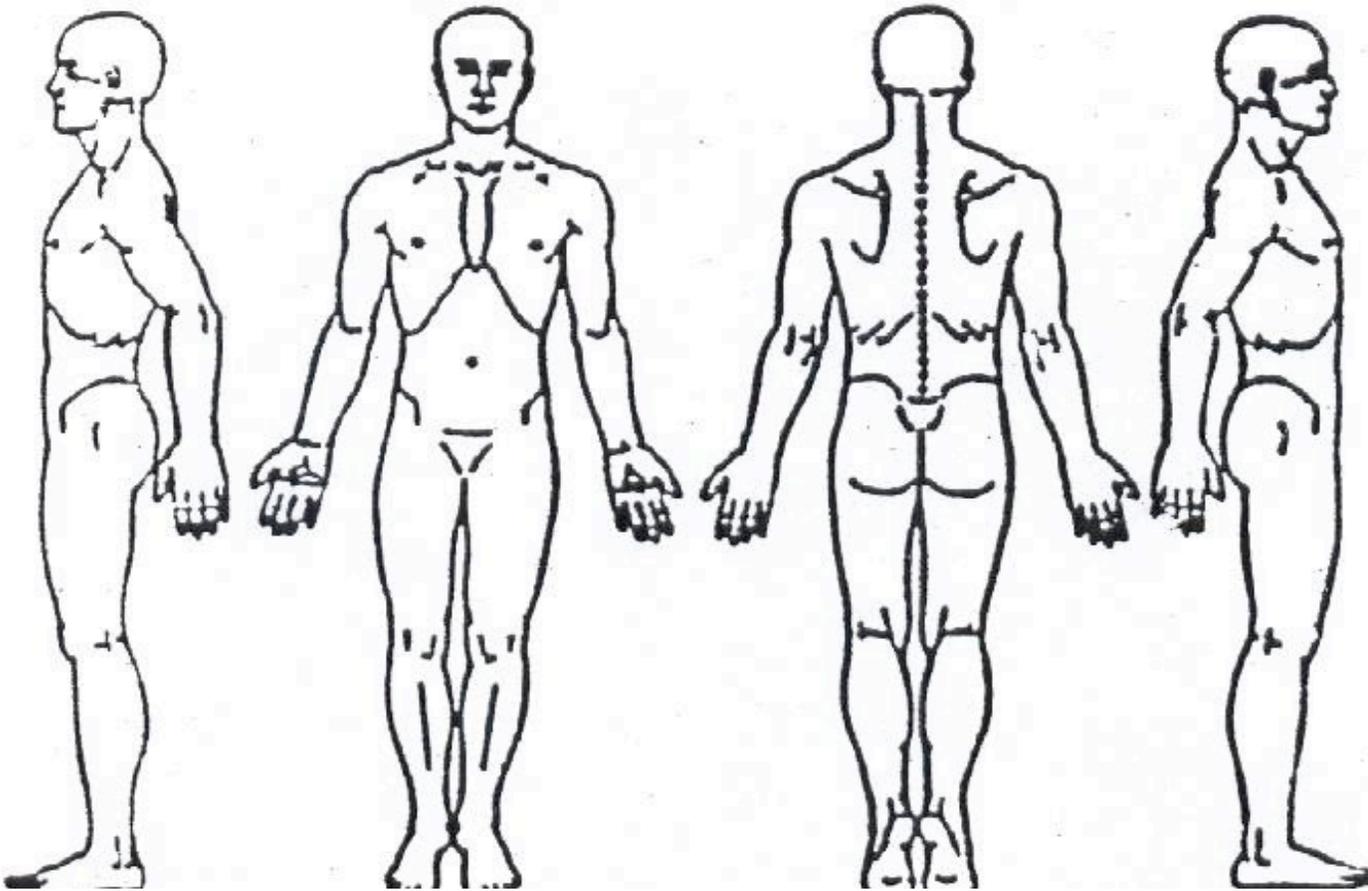
## PAIN DIAGRAM

Name: \_\_\_\_\_

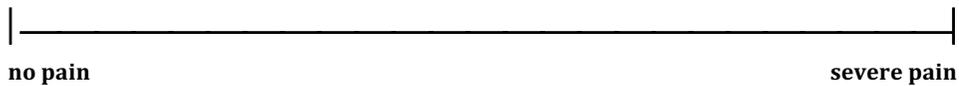
Date: \_\_\_\_\_

Draw the location of your pain on the body outlines & mark how severe it is on the pain line at the bottom of the page. Use a red pen if available.

Aching	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^	=>=>=>	000000	*****	/////	xxxx
^^^	=>=>=>	000000	*****	/////	xxxx



**PAIN LINE** Draw a perpendicular line or arrow to indicate your usual level of pain.



PI:	Patient Initials: _____ <i>First Middle Last</i>	Patient Number
<b>Oswestry Disability Questionnaire</b>	Date of Assessment: ____/____/____ <i>Month/Day/Year</i>	

VISIT TYPE:	<input type="checkbox"/> Baseline	<input type="checkbox"/>				
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This questionnaire has been designed to give us information as to how your back/leg/hip/knee pain has affected your ability to manage in everyday life. Please answer every question by checking **one box in each section** that best describes your condition today. We realize you may feel that two or more statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

<p><b>Section 1- Pain Intensity</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no pain at the moment.</li> <li><input type="checkbox"/> The pain is very mild at the moment.</li> <li><input type="checkbox"/> The pain is moderate at the moment.</li> <li><input type="checkbox"/> The pain is fairly severe at the moment.</li> <li><input type="checkbox"/> The pain is very severe at the moment.</li> <li><input type="checkbox"/> The pain is the worst imaginable at the moment.</li> </ul> <p><b>Section 2- Personal Care (e.g., Washing, Dressing)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can look after myself normally without causing extra pain.</li> <li><input type="checkbox"/> I can look after myself normally but it causes extra pain.</li> <li><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</li> <li><input type="checkbox"/> I need some help but manage most of my personal care.</li> <li><input type="checkbox"/> I need help every day in most aspects of self-care.</li> <li><input type="checkbox"/> I do not get dressed, wash with difficulty, and stay in bed.</li> </ul> <p><b>Section 3- Lifting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without extra pain.</li> <li><input type="checkbox"/> I can lift heavy weights, but it gives me extra pain.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</li> <li><input type="checkbox"/> I can lift only very light weights.</li> <li><input type="checkbox"/> I cannot lift or carry anything at all.</li> </ul> <p><b>Section 4- Walking</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me walking any distance.</li> <li><input type="checkbox"/> Pain prevents me walking more than 1 mile.</li> <li><input type="checkbox"/> Pain prevents me walking more than a quarter of a mile.</li> <li><input type="checkbox"/> Pain prevents me walking more than 100 yards.</li> <li><input type="checkbox"/> I can only walk using a cane or crutches.</li> <li><input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.</li> </ul> <p><b>Section 5- Sitting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can sit in any chair as long as I like.</li> <li><input type="checkbox"/> I can only sit in my favorite chair as long as I like.</li> <li><input type="checkbox"/> Pain prevents me sitting more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me sitting more than half an hour.</li> <li><input type="checkbox"/> Pain prevents me sitting more than 10 minutes.</li> <li><input type="checkbox"/> Pain prevents me from sitting at all.</li> </ul>	<p><b>Section 6-Standing</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can stand as long as I like without extra pain.</li> <li><input type="checkbox"/> I can only stand as long as I like but it gives me extra pain.</li> <li><input type="checkbox"/> Pain prevents me standing more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me standing more than half an hour.</li> <li><input type="checkbox"/> Pain prevents me standing more than 10 minutes.</li> <li><input type="checkbox"/> Pain prevents me from standing at all.</li> </ul> <p><b>Section 7- Sleeping</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My sleep is never disturbed by pain.</li> <li><input type="checkbox"/> My sleep is occasionally disturbed by pain.</li> <li><input type="checkbox"/> Because of pain I have less than 6 hours sleep.</li> <li><input type="checkbox"/> Because of pain I have less than 4 hours sleep.</li> <li><input type="checkbox"/> Because of pain I have less than 2 hours sleep.</li> <li><input type="checkbox"/> Pain prevents me from sleeping at all.</li> </ul> <p><b>Section 8- Sex Life (if applicable)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My sex life is normal and causes no extra pain.</li> <li><input type="checkbox"/> My sex life is normal but causes some extra pain.</li> <li><input type="checkbox"/> My sex life is nearly normal but is very painful.</li> <li><input type="checkbox"/> My sex life is severely restricted by pain.</li> <li><input type="checkbox"/> My sex life is nearly absent because of pain.</li> <li><input type="checkbox"/> Pain prevents me any sex life at all.</li> </ul> <p><b>Section 9- Social Life</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My social life is normal and causes me no extra pain.</li> <li><input type="checkbox"/> My social life is normal but increased the degree of pain.</li> <li><input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests e.g sport, etc.</li> <li><input type="checkbox"/> Pain has restricted my social life and I do not go out as often.</li> <li><input type="checkbox"/> Pain has restricted my social life to my home.</li> <li><input type="checkbox"/> I have no social life because of pain.</li> </ul> <p><b>Section 10- Traveling</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can travel anywhere without pain.</li> <li><input type="checkbox"/> I can travel anywhere, but it gives me extra pain.</li> <li><input type="checkbox"/> Pain is bad, but I manage journeys over 2 hours.</li> <li><input type="checkbox"/> Pain restricts me to journeys of less than 1 hours.</li> <li><input type="checkbox"/> Pain restricts me to short necessary journeys under 30 minutes.</li> <li><input type="checkbox"/> Pain prevents me from traveling except to receive treatment.</li> </ul>
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## Neck Disability Index

The questionnaire is designed to help us better understand how your neck/shoulder/arm pain affects your ability to manage everyday life activities. Please mark in each section the **one statement** that best applies.

<p><b>Section 1 – Pain Intensity</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no pain at the moment.</li> <li><input type="checkbox"/> The pain is very mild at the moment.</li> <li><input type="checkbox"/> The pain is moderate at the moment.</li> <li><input type="checkbox"/> The pain is fairly severe at the moment.</li> <li><input type="checkbox"/> The pain is very severe at the moment.</li> <li><input type="checkbox"/> The pain is the worst imaginable at the moment.</li> </ul>	<p><b>Section 6 – Concentration</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</li> <li><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</li> <li><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to.</li> <li><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</li> <li><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to.</li> <li><input type="checkbox"/> I cannot concentrate at all.</li> </ul>
<p><b>Section 2 – Personal Care (washing, dressing, etc.)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can look after myself normally but it is very painful.</li> <li><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</li> <li><input type="checkbox"/> I need some help but manage most of my personal care.</li> <li><input type="checkbox"/> I need help every day in most aspects of my personal care.</li> <li><input type="checkbox"/> I need help every day in most aspects of self-care.</li> <li><input type="checkbox"/> I do not get dressed, wash with difficulty, and stay in bed.</li> </ul>	<p><b>Section 7 – Sleeping</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no trouble sleeping</li> <li><input type="checkbox"/> My sleep is slightly disturbed for less than an hour.</li> <li><input type="checkbox"/> My sleep is mildly disturbed for 1-2 hours.</li> <li><input type="checkbox"/> My sleep is moderately disturbed for 2-3 hours.</li> <li><input type="checkbox"/> My sleep is greatly disturbed for up to 3-5 hours.</li> <li><input type="checkbox"/> My sleep is completely disturbed for up to 5-7 hours</li> </ul>
<p><b>Section 3 - Lifting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without extra pain.</li> <li><input type="checkbox"/> I can lift heavy weights but it gives me extra pain.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</li> <li><input type="checkbox"/> I can lift only very light weights.</li> <li><input type="checkbox"/> I cannot lift or carry anything at all.</li> </ul>	<p><b>Section 8 – Driving</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can drive my car without neck pain.</li> <li><input type="checkbox"/> I can drive as long as I want with slight neck pain.</li> <li><input type="checkbox"/> I can drive as long as I want with moderate neck pain.</li> <li><input type="checkbox"/> I can't drive as long as I want because of moderate neck pain.</li> <li><input type="checkbox"/> I can hardly drive at all because of severe neck pain.</li> <li><input type="checkbox"/> I can't drive my car at all because of neck pain.</li> </ul>
<p><b>Section 4 – Work</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can do as much work as I want.</li> <li><input type="checkbox"/> I can do my usual work, but no more.</li> <li><input type="checkbox"/> I can do most of my usual work, but no more.</li> <li><input type="checkbox"/> I can't do my usual work.</li> <li><input type="checkbox"/> I can hardly do any work at all.</li> <li><input type="checkbox"/> I can't do any work at all.</li> </ul>	<p><b>Section 9 – Reading</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can read as much as I want with no neck pain.</li> <li><input type="checkbox"/> I can read as much as I want with slight neck pain.</li> <li><input type="checkbox"/> I can read as much as I want with moderate neck pain.</li> <li><input type="checkbox"/> I can't read as much as I want because of moderate neck pain.</li> <li><input type="checkbox"/> I can't read as much as I want because of severe neck pain.</li> <li><input type="checkbox"/> I can't read at all.</li> </ul>
<p><b>Section 5 – Headaches</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no headaches at all.</li> <li><input type="checkbox"/> I have slight headaches that come infrequently.</li> <li><input type="checkbox"/> I have moderate headaches that come infrequently.</li> <li><input type="checkbox"/> I have moderate headaches that come frequently.</li> <li><input type="checkbox"/> I have severe headaches that come frequently.</li> <li><input type="checkbox"/> I have a headache almost all the time.</li> </ul>	<p><b>Section 10 – Recreation</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no neck pain during all recreational activities.</li> <li><input type="checkbox"/> I have some neck pain with all recreational activities.</li> <li><input type="checkbox"/> I have some neck pain with a few recreational activities.</li> <li><input type="checkbox"/> I have neck pain with most recreational activities.</li> <li><input type="checkbox"/> I can do hardly do recreational activities due to neck pain.</li> <li><input type="checkbox"/> I can't do any recreational activities due to neck pain.</li> </ul>

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Score: \_\_\_\_\_ [50] Benchmark -5 =: \_\_\_\_\_