CAPITOL PAIN INSTITUTE

Name:
DOB:

Confidential Patient Database

Patient Information

Last name _____ First name _____ MI _____ Sex : ☐ M ☐ F

Age _____ Date of Birth _____ Social Security Number _____

Home Address _____

City _____ State _____ Zip _____

Mobile phone _____ Home phone _____ Work phone _____

Email address to reach you: _____

Race _____ Ethnicity _____ Language _____

Emergency contact _____ Phone _____ Relationship _____

The pharmacy you usually use _____ Phone _____

Primary Care Physician _____ Phone _____

Are you currently seeing or have you seen a pain management health care provider in the last 3 years? ☐ Yes ☐ No

If yes, name of pain management provider _____

Address _____ Provider's number _____

Insurance & Guarantor Information

☐ Medicare ☐ Medicare Advantage ☐ Commercial (Aetna, BCBS, Cigna, UHC, etc.) ☐ WC ☐ No Insurance

Insurance company name _____

Subscriber's name _____ Date of Birth _____

Relationship to patient _____ Social Security Number _____

Member ID Number _____ Group Number _____

If Worker's Comp:

Company name _____ Claimant Number _____

Adjuster name _____ DOI _____ Phone Number _____

Referred by:

☐ Primary Care Physician ☐ Other Physician ☐ Friend ☐ Insurance list ☐ Internet ☐ Other

Have you or any of your family members been seen as patients in this Practice? ☐ Yes ☐ No

If yes, name of patient _____

Physician who referred you to our practice _____ Phone _____

If referred by Other, please specify _____

*Please be sure to include first and last name of your physicians

CAPITOL PAIN INSTITUTE

Name:
DOB:

Summary of Notice of Privacy Policy

Effective Date: **June 10**, 2020

THIS NOTICE SERVES AS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES ("NOTICE"). THE NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY CAPITOL PAIN INSTITUTE ("CPI") AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

A full copy of our Notice is located on our website and can also be found in our waiting area. **We strongly encourage you to take the time to read the entire Notice** so you are aware of your individual rights and how your health information is used. If you have questions about our Notice, contact: Lauren Bantau, Privacy Officer at 512-467-7246.

Once you have received the Notice or we have made a good-faith effort to provide it to you, we can use your health information for the following purposes:

1. Treatment;
2. Payment; and
3. Healthcare operations.

We may use your health information according to federal and state laws without your consent or authorization for items such as the following:

- As required or permitted by law
- Organ and tissue donation
- Public health activities
- To avoid a serious threat to health or safety
- Military, national security, or law enforcement
- Health oversight activities

Your rights concerning your personal health information are as follows:

1. You may inspect and obtain a copy of your health information.
2. You may request to correct your health information.
3. You may request to amend your health information
4. You may request an accounting disclosures of your health information.
5. You may request restrictions on certain uses and disclosures.
6. You may receive confidential communication of health information.
7. You may revoke an authorization that you have executed in the past.
8. You may obtain a paper copy our Notice.

If you believe your privacy rights have been violated, you may file a complaint with CPI or, with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with CPI contact the Privacy Officer at: 512-467-7246. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services,
Region VI, Office for Civil Rights, U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing. ***You will NOT be penalized for filing a complaint.***

Initials_____

CAPITOL PAIN INSTITUTE

Name:
DOB:

Risks of medication use

All medications have side effects, some of them serious. Almost all medications can be fatal if used inappropriately. Almost every medication could cause sleepiness or insomnia, dizziness, confusion, hallucinations, anxiety, panic, constipation or diarrhea, headache, chest pain, and nausea or vomiting. Any of these side effects could predispose the patient to injury (e.g. dizziness could cause the patient to fall down stairs). Many of the medications can cause a drop in blood pressure, which could cause fainting, dizziness, stroke, or other problems. Some of the medications can lead to liver damage including the remote possibility of liver failure. Opioid-based pain medications significantly increase the risk of asthma attacks or other lung problems and can produce respiratory insufficiency or failure, even at low doses. Medications react differently in different people. Remember that ANY MEDICATION can cause ANY REACTION in the body, even if it never happened before and even if it is not listed among the drug side effects. Some medications used in this practice have not been in existence long enough to determine potential short term or long-term side effects. Rarely, a medication can cause the opposite effect of what was intended. This is called a paradoxical reaction and is not predictable. Medications may also worsen your condition or cause an entirely new medical condition to arise.

Many of the medications used in this practice are not FDA approved for the treatment of pain or headache. This means that although there is evidence to support their use in pain management, the medications were invented (and tested for the FDA) for other medical conditions. Using a medication to treat a non-FDA approved condition is known as off-label use. The use of medication off-label is legal, ethical, and appropriate based on medical research and is common in all fields of medicine, including pain management. If you have any questions about off-label use of medications, please ask your doctor.

Alcohol is not considered safe in conjunction with the medications typically prescribed by this practice. Illegal drugs are not considered safe in conjunction with the medications typically prescribed in this practice. Herbal supplements and Eastern (or non-traditional) medications may not be safe in conjunction with the medications typically prescribed by this practice. Medications may interfere with birth control methods. Some medications prescribed by this practice are unsafe during pregnancy and breast-feeding.

Because of potential harmful interactions, you must let each of your healthcare providers know about every medication and supplement (including over-the-counter products) that you use and every health condition you have been diagnosed with. Failure to do so may result in serious harm.

Initials_____

CAPITOL PAIN INSTITUTE

Name:
DOB:

Opioid-based Medications (Opiates):

If you have a chronic pain condition, you may be prescribed opioid-based pain medications. Opiates are very powerful medications for the treatment of pain and may have significant side effects even with normal use. Opioid medications are controlled substances, and possessors of these prescriptions are subject to the provisions set forth by the Texas legislature and the Department of Public Safety.

If you, as our patient, are prescribed opiates, it is up to you to maintain perfect responsibility for the medications. You MUST protect against loss, theft, or damage; you must keep them away from children, animals, and other persons. In order to justify the use of opiates, you should be able to report (1) improved pain control, (2) increased functional level, (3) no serious side effects, and (4) no episodes of running out of medications early, lost or stolen medications, or increasing intake without the approval of your physician. You agree to drug testing for both prescribed and illicit drugs at any time. The presence of illicit drugs may require the practice to make adjustments to your pain medication regimen, which may include the cessation of opiate medications. You specifically acknowledge that the use of illicit drugs could result in death or other severe harm. You agree to use one and only one physician for pain medication prescriptions, and one and only one pharmacy for pain medication dispensing. You understand that you may be called at any time to bring in all prescribed medication for a mandatory pill count within a specified time period (typically within 24 hours). You acknowledge that you are to bring medications prescribed by Capitol Pain Institute in the original bottles to every appointment, even when empty. Failure to comply with this section of the agreement may require the practice to make adjustments to your pain medication regimen, which may include the cessation of opiate medications.

There is a risk of addiction with the use of opiate medications. Several risk factors for addiction have been identified and may be used to determine whether or not you are a candidate for opiate medications. Unfortunately, no screening method is completely effective in selecting out patients that will misuse (or divert) opioid medications. The treating physician cannot guarantee that you will not become addicted to your medication. You freely agree to the use of the medication and understand that no guarantees regarding safety or addiction are stated or implied. Increasing your dose on your own, seeing multiple prescribing physicians, running out of medication early, or getting extra medication from friends and family are signs of addiction. Remember, it is not legal for the physician to provide early opioid refills if the patient continues to increase the dose on his or her own. If you are experiencing increased pain or more frequent pain (breakthrough pain) that is not being controlled by your medication, call your physician for instructions. Do NOT take extra pain medication beyond what is prescribed or attempt to acquire additional pain medications from other sources.

All patients receiving opiate prescriptions will be closely monitored for signs of abuse, addiction, or diversion. Patients receiving schedule II opioids (morphine, OxyContin, etc.) will have at least 1 monthly appointment to receive their prescriptions. Patients receiving schedule III (tramadol, etc) or IV (darvocet) opioids may have refills authorized for up to 3 months at the discretion of their treating physician. No refill authorizations or medication changes will be made over the phone, after-hours, or on weekends.

Patient's Signature_____

Physician's Signature_____

CAPITOL PAIN INSTITUTE

Name:
DOB:

Financial agreement, assignment of benefit, consent to treat, and exchange of information

I hereby assign to and authorize payment of all benefits due to me under any insurance policy, worker's compensation plan, auto insurance policy, Medicare, Medicaid, or any other 3rd party payor for any and all services provided by Capitol Pain Institute, P.A. ("CPI") or any of its individual practitioners directly to CPI or its individual practitioners.

I authorize CPI to disclose to, or obtain from, to the extent allowed by law, my medical and financial record to: (a) any insurance company, attorney, insurance adjuster, employer, or their representatives, agents, or employees that may be responsible for all or part of the payments due for services rendered to the patient; (b) any physician, clinic, hospital, or other healthcare provider who has provided services for me in the past or who may be providing future services (e.g. a consulting physician or a facility at which a procedure is to be performed); (c) the Centers for Medicare and Medicaid Services or any other government agency as required by local, state, or federal law; (d) any person or entity to provide quality and/or utilization review. This authorization can be revoked by submitting a request in writing to CPI,3841 Ruckriegel Pkwy #104 Louisville, KY 40299.

I understand and agree that all payments for services rendered are due at the time they are performed. I further understand and agree that I am financially responsible for all charges, including all fees assessed under this paragraph, whether or not my insurance provider accepts or denies any claim for payment, and agree to pay all sums due to CPI and/or its individual practitioners at the usual and customary charge for CPI. I understand and agree that there is a $25 fee for all missed office visits and a $100 fee for all missed surgical procedures that are not cancelled at least 24 hours in advance. I understand and agree that there is a $25 service fee for any returned checks regardless of reason. I further understand that I must leave a credit card on file with CPI if I wish to pay my bill by personal check. I authorize CPI to charge my credit card for the full balance owed plus applicable service charges if my check is returned for any reason whatsoever. I understand and agree that there is a 1.5% monthly finance charge for all past-due balances on my account. I certify that I am the patient and/or I am financially responsible for the services rendered and do hereby unconditionally guaranty the payment of all amount when and as due.

I consent to all examination procedures and/or treatments prescribed by my physician and his assistants or designees as is necessary by his judgment.

A photocopy or electronic copy (i.e scan) of this agreement shall be considered effective and valid as the original.

_____ _____

Patient or Guarantor Date

After-hours and emergencies:

If you are experiencing an emergency, you should call 911 and report your emergency immediately. If you have a non-emergent situation or question call the office directly. After-hours or on weekends, please follow instructions to reach the on-call doctor. The on-call doctor will respond to you as soon as possible. Please note that medication adjustments or refill requests cannot be handled after-hours or on weekends.

Name:
DOB:

CAPITOL PAIN INSTITUTE

Authorization for use and disclosure of Protected Health Information

Patient Identification

Name: _____

SS#: _____

DOB: _____

Address: _____

Telephone: _____

Request: Please fax the patient's pain management records, including radiology.

This information is to be released to:

Capitol Pain Institute
3841 Ruckriegel Pkwy #104
Louisville, KY 40299
Tel: 502-791-8700 Fax: 502-742-8523

I authorize CPI to disclose to, or obtain from, to the extent allowed by law, my medical and financial record to: (a) any insurance company, attorney, insurance adjuster, employer, or their representatives, agents, or employees that may be responsible for all or part of the payments due for services rendered to the patient; (b) any physician, clinic, hospital, or other healthcare provider who has provided services for me in the past or who may be providing future services (e.g. a consulting physician or a facility at which a procedure is to be performed); (c) the Centers for Medicare and Medicaid Services or any other government agency as required by local, state, or federal law; (d) any person or entity to provide quality and/or utilization review. At any time I can revoke this authorization by submitting a notice in writing to Capitol Pain Institute 3841 Ruckriegel Pkwy #104 Louisville, KY 40299

Signature: _____ Date: _____

CAPITOL PAIN INSTITUTE

Name:
DOB:

Pain Description

Pain Area #1

Where is your worst pain located? _____ Average Pain Score (0-10) _____

Please check the word(s) that best describe your pain:

☐ aching ☐ burning ☐ constant ☐ deep ☐ dull ☐ electric ☐ intermittent ☐ itching ☐ nagging ☐ numbing ☐ pins & needles
☐ pressure ☐ radiating ☐ sharp ☐ sore ☐ spasms ☐ stabbing ☐ stiff ☐ stinging ☐ tight ☐ tingling ☐ throbbing
☐ other _____

Please check the word(s) that make your pain **better**:

☐ heat ☐ ice ☐ inactivity ☐ injections ☐ laying down ☐ movement ☐ NSAIDs ☐ pain medications ☐ physical therapy ☐ rest
☐ sitting ☐ standing ☐ stretching ☐ other _____

Please check the word(s) that make your pain **worse**:

☐ activity ☐ bending ☐ inactivity ☐ laying down ☐ lifting ☐ looking up and down ☐ movement ☐ sitting for long periods
☐ standing for long periods ☐ stress ☐ twisting ☐ use ☐ walking for long periods ☐ weather changes
☐ other _____

When did your pain start? _____

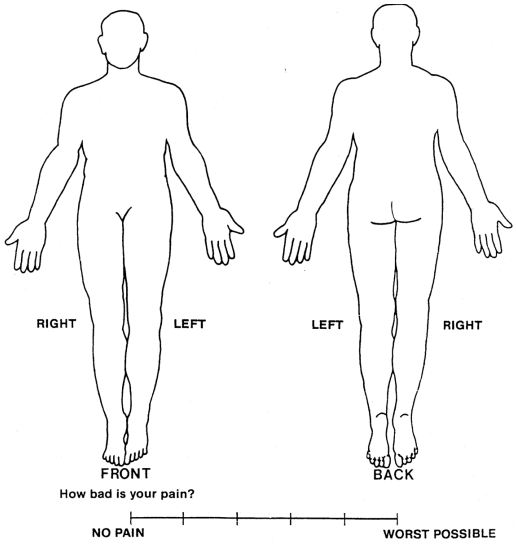
My pain is the result of an: ☐ accident ☐ illness ☐ injury ☐ other/unsure

Please describe _____

Have you had any diagnostic testing or imaging?

☐ X-ray Where/When? _____ ☐ MRI Where/When? _____
☐ CT scan Where/When? _____ ☐ EMG/NCS Where/When? _____

Please indicate the location of your pain in the diagram below by shading in the area:



Previous treatments tried: ☐ acupuncture ☐ chiropractor ☐ injections ☐ physical therapy ☐ surgery

If so, when and how much relief did it provide? _____

Have you ever been recommended for surgery? ☐ Yes ☐ No

If so, what surgery and by whom? _____

CAPITOL PAIN INSTITUTE

Name:
DOB:

Pain Description Continued

Pain Area #2

Where is your second worst pain located? _____ Average Pain Score (0-10) _____

Please check the word(s) that best describe your pain:

☐ aching ☐ burning ☐ constant ☐ deep ☐ dull ☐ electric ☐ intermittent ☐ itching ☐ nagging ☐ numbing ☐ pins & needles

☐ pressure ☐ radiating ☐ sharp ☐ sore ☐ spasms ☐ stabbing ☐ stiff ☐ stinging ☐ tight ☐ tingling ☐ throbbing

☐ other _____

Please check the word(s) that make your pain **better**:

☐ heat ☐ ice ☐ inactivity ☐ injections ☐ laying down ☐ movement ☐ NSAIDs ☐ pain medications ☐ physical therapy ☐ rest

☐ sitting ☐ standing ☐ stretching ☐ other _____

Please check the word(s) that make your pain **worse**:

☐ activity ☐ bending ☐ inactivity ☐ laying down ☐ lifting ☐ looking up and down ☐ movement ☐ sitting for long periods

☐ standing for long periods ☐ stress ☐ twisting ☐ use ☐ walking for long periods ☐ weather changes

☐ other _____

When did your pain start? _____

My pain is the result of an: ☐ accident ☐ illness ☐ injury ☐ other/unsure

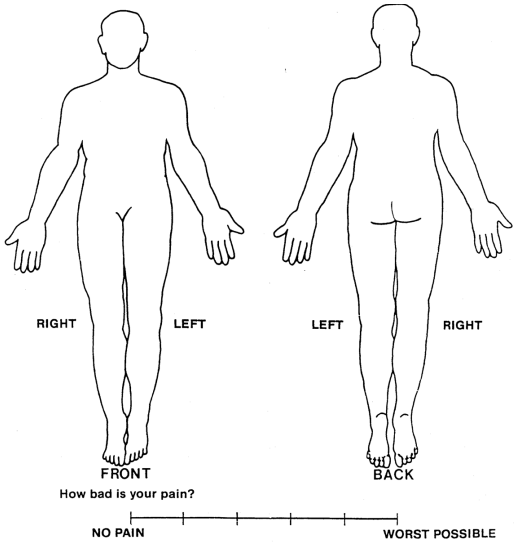
Please describe _____

Have you had any diagnostic testing or imaging?

☐ X-ray Where/When? _____ ☐ MRI Where/When? _____

☐ CT scan Where/When? _____ ☐ EMG/NCS Where/When? _____

Please indicate the location of your pain in the diagram below by shading in the area:



Previous treatments tried: ☐ acupuncture ☐ chiropractor ☐ injections ☐ physical therapy ☐ surgery

If so, when and how much relief did it provide? _____

Have you ever been recommended for surgery? ☐ Yes ☐ No

If so, what surgery and by whom? _____

CAPITOL PAIN INSTITUTE

Name:
DOB:

Previous Medications Tried

Opioid
☐ Buprenorphine (Belbuca, Butrans patch, Suboxone, Subutex)
☐ Codeine
☐ Demerol
☐ Fentanyl (Actiq, Duragesic, Fentora, Subsys)
☐ Hydrocodone (Lortab, Norco, Vicodin, Vicoprofen)
☐ Hydromorphone (Dilaudid, Exalgo)
☐ Methadone
☐ Morphine (Avinza, Ebeda, Kadian, Morphabond, MS Contin)
☐ Oxycodone (Oxycontin, Percocet)
☐ Oxymorphone (Opana, Opana ER)
☐ Propoxphene (Darvocet, Darvon)
☐ Tapentadol (Nucynta, Nucynta ER)
☐ Tramadol (Ultram, Ultram ER)

Muscle Relaxants
☐ Baclofen
☐ Carisoprodol (Soma)
☐ Chloroxazone (Lorzone, Parafon)
☐ Cyclobenzaprine (Amrix, Flexeril)
☐ Methocarbamol (Robaxin)
☐ Metaxalone (Skelaxin)
☐ Tizanidine (Zanaflex)
☐ Other _____

Other
☐ Lidoderm Patch (Lidocaine)
☐ Pregabalin (Lyrica)
☐ Neurontin (Gabapentin)
☐ Topiramate (Topamax)
☐ Other _____

Anti-inflammatories (NSAIDs) and Tylenol
☐ Acetaminophen (Tylenol)
☐ Aspirin
☐ Celecoxib (Celebrex)
☐ Diclofenac (Arthrotec, Flector patch, Pennsaid, Voltaren)
☐ Etodolac (Lodine)
☐ Ibuprofen (Advil, Motrin)
☐ Indomethacin (Indocin)
☐ Meloxicam (Mobic)
☐ Nabumetone (Relafen)
☐ Naproxen (Naprosyn)
☐ Oxaprozin (Daypro)
☐ Other _____

Antidepressants
☐ Amitriptyline (Elavil)
☐ Bupropion (Wellbutrin)
☐ Desvenlafaxine (Pristiq)
☐ Duloxitine (Cymbalta)
☐ Milnacipran (Savella)
☐ Nortriptyline (Pamelor)
☐ Venlafaxine (Effexor)
☐ Other _____

Sleep

Does your pain wake you up at night? ☐ Yes ☐ No
Are you taking any sleep medications? ☐ Yes ☐ No If yes, what medication? _____
How many hours of sleep do you average per night? _____

PHQ 9

Over the last 2 weeks how often have you been bothered by the following problems?

		Not at all	Several days	More than half	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself	0	1	2	3
7.	Trouble concentrating on things like reading or watching TV	0	1	2	3
8.	Moving or speaking slowly that others can notice. Or the opposite.	0	1	2	3
9.	Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

CAPITOL PAIN INSTITUTE

Name:
DOB:

Medical History

Cardiovascular
☐ Arrhythmia/Irregular heartbeat
Type? _____
☐ Artificial Heart Valve
☐ Congestive Heart Failure
☐ Heart Disease
☐ Heart Murmur
☐ Heart Attack or MI
When? _____
☐ High Blood Pressure/Hypertension
☐ Swollen Ankles
Do you have a Cardiologist?
☐ Yes ☐ No
Name _____
Phone _____

Endocrine
☐ Diabetes
☐ Polycystic Ovarian Syndrome
☐ Thyroid Disorders
Type?_____
☐ Hirsutism/Excessive Hair
Do you have an Endocrinologist?
☐ Yes ☐ No
Name _____
Phone _____

Gastrointestinal
☐ Liver Disease
☐ GI disease
Type?_____
☐ Reflux-GERD
☐ Ulcers
Do you have a Gastroenterologist?
☐ Yes ☐ No
Name _____
Phone _____

Hematology
☐ Abnormal Bleeding
☐ Anemia
☐ Bruise easily
☐ Blood Disease
☐ Blood Transfusion
☐ Clotting disorder
Type? _____
☐ Hemophilia
☐ Hepatitis
☐ Sickle Cell Disease
☐ Spider or Varicose Veins
☐ Deep Vein Thrombosis or blood clot
Do you have a Hematologist?
☐Yes ☐No
Name _____
Phone _____

Infections
☐ AIDS When? _____
☐ Hepatitis A/B/C
When? _____
☐ HIV + When? _____
☐ MRSA When? _____
☐ Rheumatic Fever
When? _____
☐ Shingles When? _____
☐ Tuberculosis
When? _____
☐ Sepsis When? _____

Musculoskeletal
☐ Arthritis
☐ Artificial Joints
Which? _____
Do you have an Orthopedist?
☐ Yes ☐ No
Name _____
Phone _____
Do you have a Neurosurgeon?
☐ Yes ☐ No
Name _____
Phone _____

Neurological
☐ Epilepsy/Seizures
When was your last seizure? _____
☐ Fainting/Dizzy Spells
Frequency? _____
☐ Frequent Headaches
☐ Stroke When?_____
☐ TIA or mini stroke When?_____
☐ Parkinson's Disease
☐ Other _____
Do you have a Neurologist?
☐ Yes ☐ No
Name _____
Phone _____

Oncology
☐ Cancer
Type? _____
When?_____
In remission?_____
☐ Chemotherapy When? _____
☐ Radiation therapy When? _____
Do you have an Oncologist?
☐ Yes ☐ No
Name _____
Phone _____

Psychology
☐ Anxiety
☐ Depression
☐ Bipolar
☐ Schizophrenia
Do you have a Psychologist or Psychiatrist? ☐ Yes ☐ No
Name _____
Phone _____

Renal
☐ Dialysis
Type? _____
Start date? _____
What days? _____
☐ Renal Disease
Stage?
_____
Do you have a Nephrologist? ☐ Yes ☐ No
Name _____
Phone _____

Respiratory
☐ Asthma
☐ Chronic Cough
☐ COPD
☐ Difficulty Breathing
☐ Emphysema
☐ Insomnia
☐ Respiratory Distress Syndrome (ARDS)
☐ Sleep Apnea
Do you use? ☐ CPAP ☐ BiPAP
Do you have a Pulmonologist?
☐ Yes ☐ No
Name _____
Phone _____

Rheumatology
☐ Fibromyalgia
☐ Joint Pain
☐ Lupus
☐ Rheumatoid Arthritis
☐ Sjogrens
Do you have a Rheumatologist?
☐ Yes ☐ No
Name _____
Phone _____

CAPITOL PAIN INSTITUTE

Name:
DOB:

Current Medications

Please list all prescription medications you are taking.

Name of Medication	Dosage (mg)	Frequency

Please list all over-the-counter medications, vitamins, or herbal supplements you are taking.

Name of Medication	Dosage (mg)	Frequency

Allergies

Please list the medication(s) and its adverse reactions. Include allergies to latex and/or surgical tap, if any.

Allergies	Reactions

Hospitalization and Surgical History

Please select any of the following that you have currently implant.

CARDIO: ☐ Defibrillator ☐ ICD ☐ Pacemaker
PAIN: ☐ Intrathecal Pump ☐ Spinal Cord Stimulator ☐ Peripheral Nerve Stimulator

Please list all surgeries and/or hospitalizations you have undergone.

Surgery/Procedure	Performing Physician	Date

CAPITOL PAIN INSTITUTE

Name:
DOB:

Family Medical History

Please select all that apply.

(F) Father (M) Mother (PGF) Paternal Grandfather (PGM) Paternal Grandmother (MGF) Maternal Grandfather (MGM) Maternal Grandmother

	F	M	PGF	PGM	MGF	MGM
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐

Social History

Please select what applies.

Are you employed? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you have a high stress level? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If yes, how many per day? _____

Are you interested in quitting? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No

If yes, how often? _____

Do you use marijuana products? ☐ Yes ☐ No

Do you use drugs other than marijuana and tobacco? ☐ Yes ☐ No

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

Review of Systems

Please select all that apply.

Constitutional:
☐ insomnia ☐ fatigue ☐ night sweats ☐ weight loss

Eyes:
☐ double vision ☐ visual changes ☐ other vision problems

Endocrine:
☐ cold intolerance ☐ frequent urination ☐ hair loss ☐ heat intolerance

Respiratory:
☐ cough ☐ shortness of breath ☐ wheezing

Cardiovascular:
☐ chest pain ☐ exercise intolerance
☐ heart palpitations ☐ swelling in hands/feet

Gastrointestinal:
☐ abdominal pain ☐ indigestion ☐ constipation
☐ diarrhea ☐ nausea ☐ vomiting

Hematology:
☐ anemia ☐ bleeding problems ☐ easy bruising

Genitourinary:
☐ urinary incontinence ☐ difficulty urinating

Musculoskeletal:
☐ muscle spasms ☐ muscle tightness ☐ joint pain

Skin:
☐ wounds ☐ lesions ☐ itching ☐ rash

Neurologic:
☐ weakness ☐ balance difficulty ☐ difficulty speaking ☐ headaches ☐ numbness/tingling

Psychiatric:
☐ anxiety ☐ depression ☐ difficulty sleeping