



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



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 \_\_\_\_\_



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 \_\_\_\_\_



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 \_\_\_\_\_



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 3<sup>rd</sup> 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, 8015 Shoal Creek Blvd #103, Austin, Texas 78757.

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.



**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  
8015 Shoal Creek Blvd., Ste 103  
Austin, TX 78757  
Tel: 512-467-7246 Fax: 512-467-7247

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 8015 Shoal Creek Blvd., Ste 103, Austin, TX 78757.

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

Date:

\_\_\_\_\_



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? \_\_\_\_\_

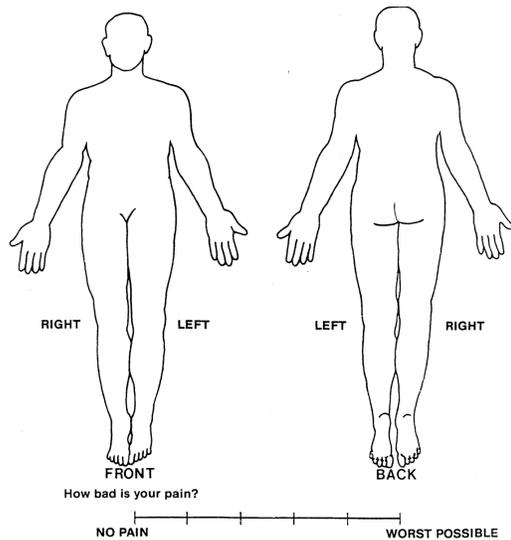
My pain is the result of an:  accident  illness  injury  other/unsure

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? \_\_\_\_\_



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? \_\_\_\_\_

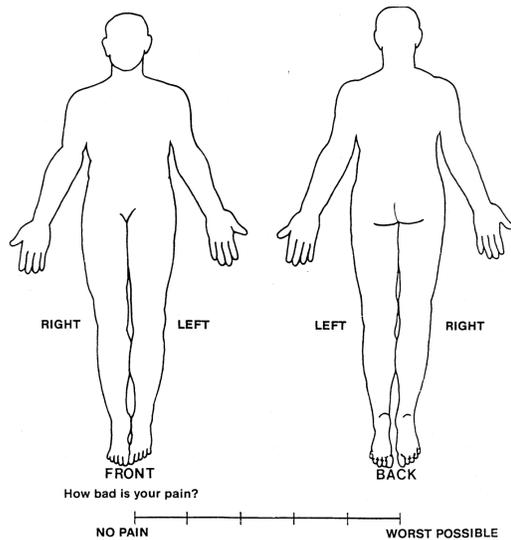
My pain is the result of an: accident, illness, injury, other/unsure

Please describe \_\_\_\_\_

Have you had any diagnostic testing or imaging?

- X-ray, MRI, CT scan, EMG/NCS

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? \_\_\_\_\_



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, Ebedal, Kadian, Morphabond, MS Contin)
 Oxycodone (Oxycontin, Percocet)
 Oxymorphone (Opana, Opana ER)
 Propoxyphene (Darvocet, Darvon)
 Tapentadol (Nucynta, Nucynta ER)
 Tramadol (Ultram, Ultram ER)

Muscle Relaxants

- Baclofen
 Carisoprodol (Soma)
 Chlorzoxazone (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)
 Duloxetine (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?

Table with 5 columns: Problem description, Not at all, Several days, More than half, Nearly every day. Rows 1-9 describing various symptoms like 'Little interest or pleasure in doing things'.



**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 \_\_\_\_\_



**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



Family Medical History

Please select all that apply.

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

Table with 7 columns (F, M, PGF, PGM, MGF, MGM) and 13 rows of medical conditions (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?
Do you live alone?
Do you have children?
Do you exercise regularly?
Do you have a high stress level?
Do you smoke?
Are you interested in quitting?
Do you use alcohol?
Do you use marijuana products?
Do you use drugs other than marijuana and tobacco?
Do you have a history of drug or alcohol abuse?

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