ORTHOPEDIC
& WELLNESS

PATIENT DEMOGRAPHIC INFORMATION
PAIN MANAGEMENT

Appointment Date, Time:	
Referring Physician:	**Phone**:
	Fax:
Primary Care Physician:	**Phone**:
	Fax:
MRI: ☐ **Yes** ☐ **No** **Date/Location:**	

How did you hear about ORTHOPEDIC & WELLNESS (please select one): ☐ PCP, ☐ Social Media, ☐ Internet/Website, ☐ Family/Friend, ☐ Newspaper/Magazine, ☐ Other_____.

All information must be **Obtained**

Last Name:	First Name:	Middle Initial:
Address:		
City:	State:	Zip code:
(H) Phone:	(w) Phone:	(C) Phone:
Email:		
Social Security Number:	Preferred Language:	
Date of Birth:	Sex: ☐ F ☐ M	
Employer:		
Emergency Contact:	Phone:	
Primary Insurance Name:		
Policy Holder:	S.S.N:	DOB:
Insurance ID #:	Insurance Group #:	
Insurance Phone #:		
Secondary Insurance Name:		
Policy Holder:	S.S.N.	DOB:
Insurance ID #:	Insurance Group #:	
Insurance Phone #:		
Workers Comp / PIP:	DOI:	Claim #:
Ins Carrier:	Claim Address:	
Adjuster Name:	Phone:	

ORTHOPEDIC
& WELLNESS

HIPAA NOTICE OF PRIVACY
NOTICE OF PRIVACY PRACTICES

Name: _____ **DOB:** _____ **Date:** _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ORTHOPEDIC & WELLNESS including pain management physicians and orthopedic physicians, are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

General Authorization of Release of Medical Records that you sign authorizes your Medical Care Provider to disclose the information in your medical records to the extent needed for the following purposes:

1. For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other Health Care Providers who are treating you or consulting in your care.
2. For the purpose of arranging payment for your care. This may include, for example, your insurer or other third-party who is responsible for paying all or part of the cost of your care.
3. For the purpose of Provider's "Health Care Operations." This would include such things as internal quality assessment activities, contacting other Health Care Providers regarding treatment alternatives, evaluating provider performance, training Providers of care, legal and medical review of care provided, business planning and management, customer service, resolution of internal grievance and the provision of legal and auditing services.
4. For the purpose of other Health Care Provider's "Health Care Operations", to the extent that they have a treatment relationship with you.

Specific Authorization for Release of Medical Records that you may sign authorizes the Provider to make a specific disclosure that is not covered under the section above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose your records.

1. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.
2. Provider may be required by law, in some cases, to make disclosures of your records that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by license agencies or the U.S. Department of Health and Human Services.
3. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
4. You have the following rights with respect to your medical records/information:

[continued]

- **a.** You have the right to request restrictions on the use and disclosure of your medical records/ information; however, Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
- **b.** You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
- **c.** You have the right to inspect and copy your medical records (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
- **d.** You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
- **e.** You have the right to receive an accounting (list) of disclosures of your medical records/information made by Provider (Except for those disclosures that are made to you or with your specific authorization that fall within the scope of Provider's "Health Care Operations," or disclosures made for payment or treatment purposes).
- **f.** You have the right to receive a paper copy of this notice.

In the event that **ORTHOPEDIC & WELLNESS** is sold or merged with another organization, your health information/records will become the property of the new owner.

Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate. If a patient believes that his or her privacy rights have been violated, the patient may complain to the Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to the Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

If you, as a patient or guardian, believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Compliance Contacts at 240.629.3998 or submit your complaint to: **ORTHOPEDIC & WELLNESS**, 1050 Key Pkwy, Ste 202, Frederick, MD 21702.

If you are not satisfied with the manner in which our office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Avenue, SW, Room 509F HHH Building, Washington, DC 20201. Or call 410.402.8000. www.medicare.gov/Ombudsman

Acknowledgement of Receipt of Notice

☐ I wish to restrict my Private Healthcare information: I have filed a Request of Restriction Form.

Patient Name: _____ Patient Signature: _____ Date: _____

ORTHOPEDIC
& WELLNESS

PATIENT BILL OF RIGHTS

As a patient being treated in our office you have a right to:

- To have consideration of your privacy concerning your own medical care.
- To know the name of all physicians and/or staff directly assisting in your care.
- To have medical records pertaining to your medical care treated as confidential (except as required by law or third party contracted agreement).
- To know what rules and regulations in our practice apply to your conduct as a patient.
- To expect emergency procedures to be implemented without delay; if there is a need to transfer you to another facility the responsible person and facility will be notified of your condition prior to your arrival.
- To have good quality care and high professional standards that are continually maintained and reviewed.
- To have full information in layman's terms concerning diagnosis, treatment, prognosis and possible complications.
- To give an informed consent to the physician prior to the procedure.
- To be advised of participation in a medical care research program or donor program (You will be asked to give your informed consent prior to participation in such a program and you may refuse to continue in a program that you may have previously given informed consent to participate in).
- To refuse drugs or procedures and have a physician explain the medical consequences of your refusal.
- To be given medical and nursing services without discrimination based upon age, race, color, religion, national origin, handicap, disability or source of payment.
- To have access to an interpreter whenever possible.
- To have access to all information contained in your medical record unless access is prohibited by law.
- To expect good management techniques to be implemented that consider effective use of your time and avoid unnecessary discomfort.
- To be able to examine and receive a detailed evaluation of your bill.
- To be informed at your request of your provider's credentials.
- To exercise your rights without discrimination or reprisal.
- To voice grievances.
- To designate power of attorney to exercise rights on your behalf.
- To receive care in a safe setting.
- To be free from abuse/harassment.

We recognize that you have a choice for healthcare services, and we are grateful that you have chosen us as your provider.

For more information or to report a problem, please contact Corporate Management at 240.629.3998, or State of Maryland DHMH, Office Healthcare Quality (www.dhmh.maryland.gov/ohcq) Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228, OR call 1.800.492.6005 or http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Patient Name: _____ Patient Signature: _____ Date: _____

ORTHOPEDIC
& WELLNESS

PATIENT RESPONSIBILITY STATEMENT

The patient has the responsibility to:

- Provide the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- Participate in health care decisions and for the following the treatment plan outlined by the practitioner responsible for his/her care.
  - This includes following instructions of the physicians, nurses, and other health care personnel carrying out the plan of care and enforcing rules and regulations.
- For assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible, and in the case of financial difficulty, making all reasonable efforts to meet any agreed upon financial payment plan.
- Responsibility for his/her actions if he/she refuses treatment or is non-compliant in following a plan of treatment recommended by his/her physician.
- To know the rules and regulations of ORTHOPEDIC & WELLNESS affecting his care and conduct, and for following those ORTHOPEDIC & WELLNESS rules and regulations.
- For being considerate of the rights of other ORTHOPEDIC & WELLNESS patients and ORTHOPEDIC & WELLNESS personnel, and for assisting in the control of noise and the non-smoking policy of the ORTHOPEDIC & WELLNESS.
- For being respectful of the property of other persons and of ORTHOPEDIC & WELLNESS.
- To make known to his/her physician, attending nurse, or other health care personnel, any concerns or complaints he/she may have.
- To make sure he/she understands all information regarding the implications of his symptoms, his/her surgery or procedure (if applicable) and any risks related to having or declining such surgery or procedure, the expected outcomes of the plan of care outlined by this physician, and his responsibilities in regards to that plan of care.
- To be made aware of advanced directives, living wills and the limitations if any to comply with such request.
- To refuse any drug regimen he /she does not feel is necessary and assume the risks involved with such refusal.
- To change providers at any time or gather a second opinion from another provider.
- To provide urine sample for purposes of drug screening and adhere to the opioid agreement.
- To provide transport and a responsible caregiver after any procedure if directed to do so by the provider or physician.

We recognize that your have a choice for healthcare services, and we are grateful that you have chosen us as your provider.

For more information or to report a problem, please contact Corporate Management 240.629.3998, or State of Maryland DHMH, Office Healthcare Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228, OR call 1.800.492.6005

Patient Name: _____ Patient Signature: _____ Date: _____

ORTHOPEDIC
& WELLNESS

OFFICE POLICIES

CONSENT AND INSURANCE AUTHORIZATION FOR TREATMENT AND BILLING

Patient Name: _____ **DOB:** _____ **Date:** _____

BILLING NOTICE

I hereby authorize the Physicians at ORTHOPEDIC & WELLNESS, to provide medical treatment, release information pertaining to treatment deemed necessary by my insurance companies, attorney or referring Physician, and to receive direct payments for professional treatment otherwise payable to me for service rendered. My insurance carrier or I may revoke this authorization at any time in writing. **Initial:** _____

Confession of Judgment: I hereby acknowledge and agree that I am responsible for any portion of this claim that for any reason is not covered by my insurance. In the event that my account is past due more than sixty (60) days, I understand that ORTHOPEDIC & WELLNESS will exercise its rights and remedies under the law to enforce such payment, including, but not limited to, institution of legal proceedings against me to recover the above amount. I irrevocably authorize any attorney to appear in any court of competent jurisdiction and confess a judgment without process in favor of the creditor for such amount as may then appear unpaid hereon, and consent to immediate execution upon such judgment. I understand and agree that I will be responsible for all costs incurred by ORTHOPEDIC & WELLNESS to enforce such payment, including attorneys' fees. **Initial:** _____

For Worker's Compensation Cases: It is your responsibility to make sure that your accident insurance company has authorized your procedure. If your insurance company does not pay for the visit, you will be held accountable for the entire charge. **Initial:** _____

Waiver: If I am a member of a HMO insurance and the Physicians at ORTHOPEDIC & WELLNESS, are not participating members or I choose to be treated without a referral or authorization, I acknowledge that I am fully responsible for any and all charges incurred as a result of my decision to be treated by ORTHOPEDIC & WELLNESS. I understand and agree that I am financially responsible to ORTHOPEDIC & WELLNESS for co-pays, deductibles and non-covered items as outlined in my insurance policy contract. I hereby certify that the information above is correct. **Initial:** _____

For Health Insurance Cases: It is your responsibility to adhere to all of the regulations and requirements of your health plan, in or out of network. If your health insurance plan requires you to obtain a written referral and/or authorization number from your Primary Care Physician for your office visit or procedure, you must supply us with the referral/auth number. If you do not, you will be responsible for the entire charge for that date of service. This is a rule of the Health Plan that you selected. **Initial:** _____

Statements that you are expected to receive: Be advised that ORTHOPEDIC & WELLNESS and our associated ambulatory surgery centers function under different Tax ID numbers and therefore insurance participation may vary. Depending on the location of your choice, surgeries, procedures, and injections may take place under APSC, ASSC, FMH (Frederick Memorial Hospital), Adventist Hospitals and you should expect a separate statement from that facility. **Initial:** _____

OWNERSHIP NOTICE

ORTHOPEDIC & WELLNESS is a health care facility owned by Dr. Ojedapo Ojeyemi, Dr. Matthew Roh and Khalid Kahloon, J.D. Pursuant to federal and state regulations, the above individuals hereby notify you that they maintain ownership and financial interest in ORTHOPEDIC & WELLNESS. You have the option to seek treatment at a health care service provider of your own choice. **Initial:** _____

ORTHOPEDIC & WELLNESS

ACKNOWLEDGEMENT OF OWNERSHIP

I acknowledge that I am aware of the ownership and financial interests held by Dr. Ojedapo Ojeyemi, Dr. Matthew Roh and Khalid Kahloon, J.D. in ORTHOPEDIC & WELLNESS, and further, I am aware that I may request that my treatments be performed elsewhere. It is my choice to be treated at ORTHOPEDIC & WELLNESS. **Initial:** _____

CRISP NOTICE

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1.877.952.7477 or completing and submitting on Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. **Initial:** _____

MISSED/LATE ARRIVAL APPOINTMENT POLICY

All patients are required to give a **24 hour notice if unable to keep a scheduled appointment**. A **$35.00 fee** will be collected for any non-compliance with our policy. Repeated late cancellations and/or missed appointments will result in the discontinuation of your treatment with ORTHOPEDIC & WELLNESS. At ORTHOPEDIC & WELLNESS, we value your time and in turn, we strive to maintain a time-conscious schedule. Our Physicians and Staff work together to keep the schedule on time. We ask that our patients help us by arriving at least 30 minutes early for each appointment in order to be ready to be seen at their scheduled appointment time. Our Physicians are rotationally "on call" which can sometimes impinge the promptness of an appointment; we apologize for any inconvenience but ask for your support and understanding. If a patient arrives after their scheduled appointment time, ORTHOPEDIC & WELLNESS has the right to ask that patient to reschedule their appointment if there is no available time for the patient to be seen.

Initial: _____

INSURANCE, BILLING AND PRIVACY NOTICE ACKNOWLEDGEMENT

I have received and read the above information in this packet, which includes the company's referral policy, the billing information, and the Notice of Privacy Practices. I have read and acknowledge the policies of ORTHOPEDIC & WELLNESS, as stated above. I understand failure to comply with these policies may result in the discontinuation of my treatment with the said facilities.

Patient Signature: _____ Date: _____

Guardian/Power of Attorney: _____ Date: _____

ADVANCE DIRECTIVES NOTICE

At your request, we can make available an Advance Medical Directives formulary for you to read, fill out, and sign at your discretion. Maryland law recognizes as valid "living wills" and advance medical directives allowing you to decide under certain circumstances, in advance, that in the event of an unexpected medical crisis such as cardiac or respiratory arrest, no attempt should be made to resuscitate you, and all life sustaining procedures should be withheld from you. Also, in the event that you are incapacitated and unable to make such a decision on your own behalf, medical decisions, including the decision to withhold or withdraw life support, may, under the same circumstances, be made for you by a "health care agent" previously designated by you, or by a "surrogate" decision maker, such as your adult child, parent or spouse. Because of the nature of our facilities, and recognizing that surgical services provided in these facilities are elective, we are unable to honor "do not resuscitate" orders or similar advance medical directives. In the event of a sudden life-threatening medical situation, we will immediately begin the administration of life-sustaining procedures, and transfer you to the nearest hospital as soon as possible.

•••Please read all options and write your initials on the ONE that applies to you***

- I am aware of Advance Directives. I have one but I do not have it with me **Initial:** _____
- I am aware of Advance Directives. I have one and it is on my file. **Initial:** _____
- I am aware of Advance Directives. I do not have one and do not require one. **Initial:** _____
- I am aware of Advance Directives. I do not have one and I want more information. **Initial:** _____

Patient Name: _____ Patient Signature: _____ Date: _____

Guardian/Power of Attorney: _____ Date: _____

ORTHOPEDIC
& WELLNESS

AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications and other information pertinent to our patient's care. In this event with your signed authorization, we would discuss such information to a person you designate. Please complete the section below:

I, hereby, authorize ORTHOPEDIC & WELLNESS to discuss any information required in the course of my examination or treatment (when I cannot be reached by phone) to the following designated person(s):

Name of Designee (1): _____

Relationship to Patient: _____

Name of Designee (2): _____

Relationship to Patient: _____

☐ No Designee

When a designee is not on file, family members, spouses or friends are not permitted to make or change a patient's appointment time.

I agree to all of the above.

Patient Name (PRINT)	Patient or Legal Guardian Signature	Date

This form shall expire one year from date of signature.

t 240.629.3944 **f** 240.629.3945
t 240.629.3952 **f** 240.629.3953

1050 Key Parkway, Suite 103, Frederick, MD 21702
12070 Old Line Center, Ste 205, Waldorf, MD 20602

ORTHOPEDIC & WELLNESS

PATIENT OPIOID AGREEMENT

Patient Name: _____ **Date:** _____

PLEASE INITIAL ALL STATEMENTS - Failure to comply with these guidelines will result in termination of treatment and your prescriptions will be revoked.

_____ You agree not to ask or to receive pain medication from any other Physician. Refusal to comply with this will result in discharge from ORTHOPEDIC & WELLNESS. Only your pain doctor will prescribe opioid medications for you.

_____ You agree to keep all scheduled appointments, not just with your Physician, but also with recommended therapists and psychological counselors.

_____ All patients receiving controlled substances must have a Primary Care Physician to attend to other medical needs that will arise. The Physicians at ORTHOPEDIC & WELLNESS will not assume the role of PCP.

_____ You agree to random urine screening. Any patient who refuses testing will not receive treatment and be discharged. (a) – Positive tests for illegal substances, opioids not prescribed by your pain doctor, or negative tests for prescribed opioids, will result in discontinuation of opioids and referral elsewhere.
(b) – If urine tests repeatedly show ethanol (alcohol), we will either reduce opioids and sedating medications to safe levels or discontinue opioids completely.

_____ All prescriptions are written for a 30 day supply. No prescriptions will be refilled early. You will follow up every 30 days for evaluation by your Pain Physician while being prescribed opioids. Prescriptions will not be written greater than 7 days in advance.

_____ Prescriptions for controlled substances are issued only during appointments. They will not be mailed or left for patients to pick up or called in to your pharmacy.

_____ Refills for non-narcotic medications are allowed, but can only be done or authorized during office hours with approval of your Pain Physician.

_____ You will only use one pharmacy for refilling opioids. Should the need arise to change pharmacies, our office must be notified.

_____ No prescriptions will be refilled if you lose, destroy, or have any of your medication stolen. You agree to keep all opioid medications locked up and in a safe place. A written explanation is required for all thefts and lost medications, plus a police report for all thefts.

_____ No medication adjustments are permitted without prior approval from your Pain Physician. Development of another painful condition does not justify increased use of your medication without permission from ORTHOPEDIC & WELLNESS. Controlled substances will NOT be refilled early due to misuse.

_____ You agree not to share or sell your medications. You acknowledge that we will contact Drug Enforcement Agency and/or the Police if you violate the Federal Law regarding opioid medications.

_____ You agree to comply fully with all aspects of your treatment program including behavioral medicine (psychology/psychiatry) and physical therapy, if recommended. Failure to do so may lead to discontinuation of your medication and referral to another provider or treatment center.

_____ Successful pain management entails employing multiple interventions, including active participation in regular physical exercise, appropriate procedures, other treatment options and the use of psychological coping strategies. A pattern of passive reliance on medications, resistance to more active physical treatments, and repeated failure to demonstrate the implementation of psychologically based coping strategies that have been taught to you may lead to discontinuation of medications and/or referral to another provider or treatment center.

_____ Disruptive, threatening or violent behavior, and persistent noncompliance with the prescribed pain treatment plan will lead to patient dismissal from our practice.

ORTHOPEDIC & WELLNESS

We understand that emergencies can occur and under some circumstances, exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

ACKNOWLEDGEMENT OF OPIOID WARNINGS AND SIDE EFFECTS

Opioids may cause drowsiness that can be worsened with alcohol, benzodiazepines, and other sedating medications. We absolutely do not recommend driving an automobile or operating machinery while taking any opioid medication because they may alter judgment resulting in serious injury or death to you or anyone involved in an accident with you. Furthermore, an overdose caused by opioids can cause severe side effects, such as respirator depression and even death. Opioids can alter hormonal levels leading to impotence, changes in personality and behavior, lowering of bone strength and increase tooth decay. Other common, usually temporary, side effects include nausea, itching, and sweating. Psychological depression and lowered testosterone levels may also occur. Sleep apnea, if present, may be worsened by opioids. Constipation commonly occurs, and often does not improve with time. It is impossible to predict opioid side effects in any individual patient. Having side effects on one opioid does not necessarily mean there will be side effects on another opioid.

You must take opioids only as directed. Federal law prohibits giving this medication to anyone else. Physical dependence will develop with regular use, but does not by itself indicate addiction; this means that a withdrawal syndrome will develop if you stop your medication abruptly. Tolerance may develop to the pain relieving effects of opioids; this means that the pain relief may decrease over time, but in chronic pain states this usually occurs slowly, if at all. Not all pain conditions respond to opioids. Some pain may only be partially responsive to opioid therapy. Total elimination of pain is an unrealistic goal. Escalating dosages may indicate that opioids are not effective or that there is an underlying problem with addiction or psychological dependence. Discontinuation of opioid medications may need to be done under these circumstances: not enough pain relief, persistent side effects, not achieving goals of opioid treatment (such as improvement in function), problematic dose escalation, or inability to comply with the treatment agreement.

I, the undersigned, agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. I give permission to my pain doctor to contact any of my other healthcare providers, for the purposes of sharing information concerning my situation, as is deemed necessary for coordinated, high quality care. If I do not follow these guidelines fully, my doctor may taper and stop opioid treatment and refer me elsewhere for care.

A copy of this document has been given to me.

Patient Name: _____ Patient Signature: _____ Date: _____

Physician Name: _____ Physician Signature: _____ Date: _____

PHARMACY AND PCP INFORMATION MUST BE COMPLETED.

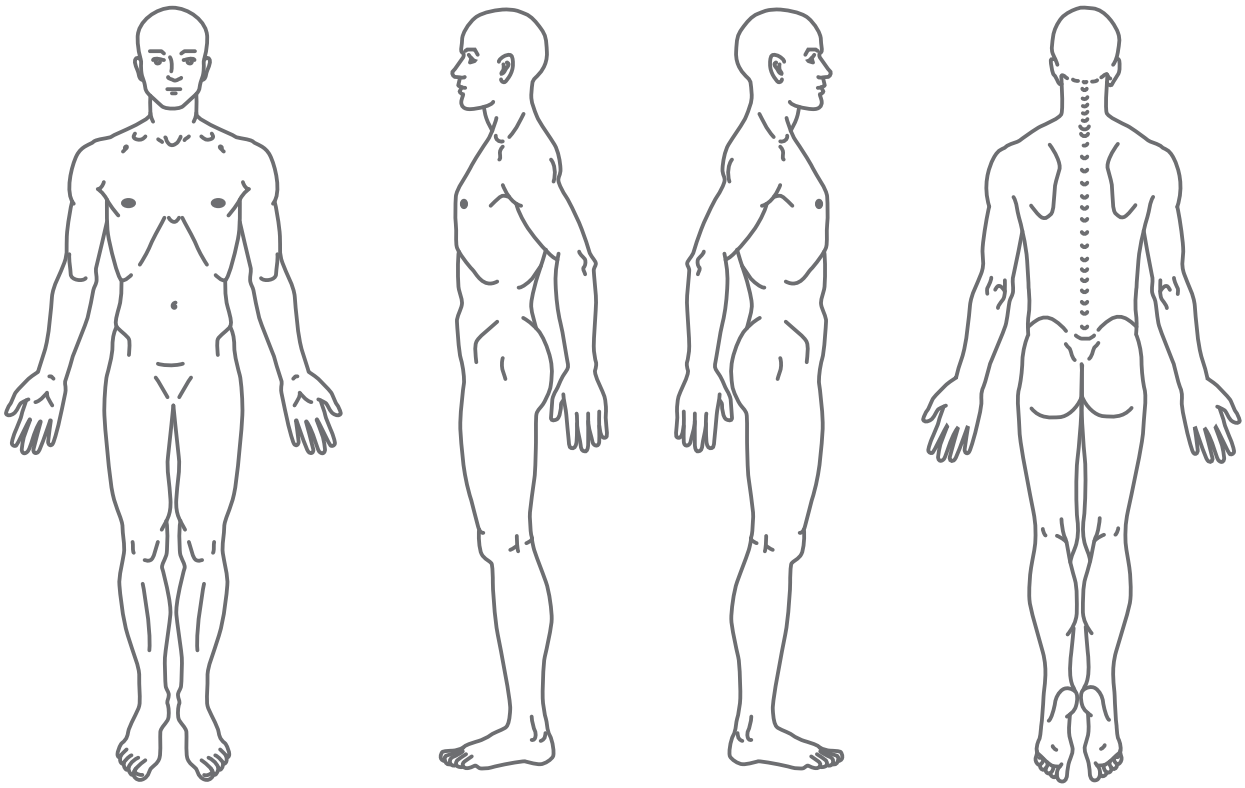
NAME OF PHARMACY	NAME OF PRIMARY CARE PHYSICIAN
ADDRESS	ADDRESS
PHONE NUMBER	PHONE NUMBER

ORTHOPEDIC & WELLNESS

HISTORY AND PHYSICAL

Patient Name: _____ **DOB:** _____ **Date:** _____

Please mark the area(s) in which your pain is located:



About Your Pain

Pain Location #1 (Refer to one pain location in this section, use page 2 if you have another pain issue):

Location of pain: _____ When did your pain begin? _____

What was the injury or the cause of the pain? _____

How often do you experience this pain? (Mark one) ☐ **Constantly** ☐ **Frequently** ☐ **Occasionally** ☐ **Rarely**

Check off your current pain intensity with "1" representing no pain and "10" representing the most severe pain.

What is your pain score right now?	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
What is your usual pain score?	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
What is your pain score during a flare-up?	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

FOR STAFF ONLY

Wt: _____ **Ht:** _____ **Temp(F):** _____ **BP:** _____ /_____ **Pulse:** _____ **RR:** _____ **SatO2:** _____ **%**

ORTHOPEDIC & WELLNESS

Patient Name: _____ **DOB:** _____

Please check the one(s) that apply to Pain #1:

Location of Pain	Radiation of Pain	Quality	Aggravated by	Relieved by
☐ Upper Back ☐ Mid Back ☐ Lower Back ☐ Gluteal Area ☐ Left Flank ☐ Right Flank ☐ Arms ☐ Legs ☐ Neck ☐ Thighs	☐ Back ☐ None ☐ Left Ankle ☐ Right Ankle ☐ Left Arm ☐ Right Arm ☐ Left Calf ☐ Right Calf ☐ Left Foot ☐ Right Foot ☐ Left Thigh ☐ Right Thigh	☐ Aching ☐ Burning ☐ Deep ☐ Diffuse ☐ Discomforting ☐ Dull ☐ Localized ☐ Numbness ☐ Piercing ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Superficial ☐ Throbbing ☐ Other: _____	☐ Nothing ☐ Ascending Stairs ☐ Bending ☐ Changing Positions ☐ Coughing ☐ Daily Activities ☐ Descending Stairs ☐ Extension ☐ Flexion ☐ Jumping ☐ Lifting ☐ Lying/Rest ☐ Rolling over in bed ☐ Pushing ☐ Running ☐ Sitting ☐ Sneezing ☐ Standing ☐ Twisting ☐ Walking	☐ Nothing ☐ Exercise ☐ Heat ☐ Ice ☐ Lying Down ☐ Injections ☐ Massage ☐ Movement ☐ OTC Medication ☐ Pain Medication ☐ Physical Therapy ☐ Spontaneously ☐ Stretching ☐ Rest ☐ Sitting

Pain Location #2 (If Not Applicable, then skip to next page):

Location of pain: _____ When did your pain begin? _____

What was the injury or the cause of the pain? _____

How often do you experience this pain? (Mark one) ☐ **Constantly** ☐ **Frequently** ☐ **Occasionally** ☐ **Rarely**

Check off your current pain intensity with "1" representing no pain and "10" representing the most severe pain

What is your pain score right now?	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
What is your usual pain score?	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
What is your pain score during a flare-up?	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

Please check the one(s) that apply to Pain #2:

Location of Pain	Radiation of Pain	Quality	Aggravated by	Relieved by
☐ Upper Back ☐ Mid Back ☐ Lower Back ☐ Gluteal Area ☐ Left Flank ☐ Right Flank ☐ Arms ☐ Legs ☐ Neck ☐ Thighs	☐ Back ☐ None ☐ Left Ankle ☐ Right Ankle ☐ Left Arm ☐ Right Arm ☐ Left Calf ☐ Right Calf ☐ Left Foot ☐ Right Foot ☐ Left Thigh ☐ Right Thigh	☐ Aching ☐ Burning ☐ Deep ☐ Diffuse ☐ Discomforting ☐ Dull ☐ Localized ☐ Numbness ☐ Piercing ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Superficial ☐ Throbbing ☐ Other: _____	☐ Nothing ☐ Ascending Stairs ☐ Bending ☐ Changing Positions ☐ Coughing ☐ Daily Activities ☐ Descending Stairs ☐ Extension ☐ Flexion ☐ Jumping ☐ Lifting ☐ Lying/rest ☐ Rolling over in bed ☐ Pushing ☐ Running ☐ Sitting ☐ Sneezing ☐ Standing ☐ Twisting ☐ Walking	☐ Nothing ☐ Exercise ☐ Heat ☐ Ice ☐ Lying Down ☐ Injections ☐ Massage ☐ Movement ☐ OTC Medication ☐ Pain Medication ☐ Physical Therapy ☐ Spontaneously ☐ Stretching ☐ Rest ☐ Sitting

ORTHOPEDIC & WELLNESS

Patient Name: _____ **DOB:** _____

REVIEW OF SYSTEMS only check the one(s) that apply

CONSTITUTIONAL	YES	NO	GASTROINTESTINAL	YES	NO	METABOLIC/ENDOCRINE	YES	NO
Change in Appetite			Abdominal Mass			Abnormal Habitus		
Chills/Rigors			Abdominal Pain			Abnormal Hair Distribution		
Fatigue			Constipation			Chronically Overweight		
Fever			Fecal Incontinence			Chronically Underweight		
Insomnia			Heartburn			Goiter		
Irritability			Hemorrhoids			Gynecomastia		
Lethargy			Melana			Heat intolerance		
Night Sweats			Nausea			Polyuria		
Weight Gain			Vomiting			**GENITOURINARY**	**YES**	**NO**
Weight Loss			Stomach Ulcer			Decreased Urine Stream		
CONSTITUTIONAL	**YES**	**NO**	**DERMATOLOGIC**	**YES**	**NO**	Decreased Urine Output		
Dizziness			Frequent Skin Infections			Frequent Urination		
Gait Disturbance			Rash			Hematuria		
Incontinence			Shingles			Nocturia		
Loss of Consciousness			**RESPIRATORY**	**YES**	**NO**	Polyuria		
Memory Impairment			Accelerated Respirations			Urinary Incontinence		
Near Syncope			Cough			**HEMATOLOGIC**	**YES**	**NO**
Seizures			Cyanosis			Easy Bleeding		
Tremors			Dyspnea			Easy Bruising		
Vertigo			Hemoptysis			Thromboembolic Events		
CARDIOVASCULAR	**YES**	**NO**	Wheezing			**MUSCULOSKELETAL**	**YES**	**NO**
Chest Pain			Frequent Upper Respiratory			Back Pain		
IMMUNOLOGICAL	**YES**	**NO**	Infection			Bone /Joint Symptoms		
Asthma			Known TB Exposure			Myalgias		
Contact Dermatitis			**PSYCHIATRIC**	**YES**	**NO**	Muscle Weakness		
Food Allergies			Difficulty Concentrating			Neck Stiffness		
			Psychiatric Emotional			Rheumatologic Manifestations		

Past Medical History

Do you have any of the following conditions?

	YES	NO		YES	NO		YES	NO
Anemia			COPD			Migraine Headaches		
Angina			Coronary Artery Disease			Multiple Sclerosis		
Arrhythmia			Diabetes			Parkinson's Disorder		
Asthma			Fibromyalgia			Peripheral Nerve Disorder		
Atrial Fibrillation			Hepatitis C			Renal Disease		
Blood Clots			HIV/AIDS			Rheumatoid Arthritis		
Brain Tumor			Hyperlipidemia			Seizure Disorder		
Cerebrovascular Accident			Hypertension			Spinal Cord Tumor		
Cirrhosis			Kidney Failure			Thyroid Disease		
Colon Cancer			Liver Disease			Tremor		
Congestive Heart Failure			Lung Cancer			Stomach Ulcers		

ORTHOPEDIC & WELLNESS

Patient Name: _____ **DOB:** _____

Past Surgical History

SURGERY	YEAR

Family History

Diagnosis	Mother	Father	Other	Diagnosis	Mother	Father	Other
ADD/ADHD				Hearing Deficiency			
Alcoholism				Hyperlipidemia			
Allergies				Hypertension			
Alzheimer's Disease				Irritable Bowel Syndrome			
Asthma				Learning Disability			
Blood Disease				Mental Illness			
CAD				Migraines			
CAD – Premature				Obesity			
Cancer				Osteoporosis			
CVA (Stroke)				PVD			
Depression				Renal Disease			
Developmental Delay				Seizure Disorder			
Diabetes				Other: _____			
Eczema				Other: _____			

Social History

EMPLOYER NAME	
Phone	
Occupation	
Employment Status (Circle One)	☐FULL-TIME ☐PART-TIME ☐RETIRED ☐DISABLED
Last Day Of Work	

Marital Status (Check one): ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated
Hand Dominance (Check one): ☐Right ☐Left ☐Ambidextrous
Activity Level (Check one): ☐Sedentary ☐Moderate ☐Vigorous

Have you ever filed any legal claims related to your pain problem? ☐No ☐Yes (please explain): _____

Have you ever had psychiatric, psychological, or social work evaluations or treatment for any problem, including your current pain? ☐No ☐Yes (please explain): _____

ORTHOPEDIC & WELLNESS

Patient Name: _____ **DOB:** _____

Are you suffering from or do you have a history of alcoholism? ☐No ☐Yes

Do you or did you ever smoke cigarettes or use tobacco? ☐No ☐Yes

Have you had any change in sleep patterns? ☐No ☐Yes (please explain): _____

Current Medications

List all your medications, dosages, how often you take them every day, and name of prescribing Physician.

	NAME	DOSAGE	DIRECTION	PRESCRIBING PHYSICIAN
1				
2				
3				
4				
5				
6				
7				
8				

Are you taking any blood thinners? ☐No ☐Yes

Drug Allergies

	MEDICATION NAME	REACTION
1		
2		
3		

Do you have any symptom such as red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

☐ Dye
☐ Iodine
☐ Shellfish
☐ Foods: _____
☐ Latex
☐ Rubber (band-aids, tape, spandex, balloons)
☐ Strawberries, Kiwis, Chestnuts.
☐ No Known Allergies

Please list any previously taken pain medications that you stopped taking and the reason for stopping:

_____

_____

_____