Initial Evaluation

Name _____ DOB _____

Address: _____ Phone _____

_____ SS# _____

Email _____ Insurance _____

Referring Physician: _____

History

1. Chief complaint:
2. Describe activities which aggravate or worsen your symptoms/pain:

3. Describe activities which decrease your symptoms/pain:

4. What treatments have you received?

0 Anti-inflammatory medications	0 Pain medications	0 Narcotics
0 Oral/injected steroids,	0 Acupunc/chiropractor	0 Physical therapy
0 Brace	0 TENS/ultrasound,	0 Other

5. Do medications help?

0 No 0 Somewhat (1/3 better) 0 Moderately (1/3-2/3 better) 0 Greatly better

6. What studies have been performed

0 X-ray	0 CT	0 Myelogram	0MRI	0 Discogram
0 bone scan	0 Spectroscopy	0 EMG/NCS	0 Other	

Disability and Litigation	Yes	No
1. SSI/SSDI?	0	0
2. Workers comp?	0	0
3. Have you retained a lawyer?	0	0

PMH Do you have any of the following? Circle or specify any condition **(please specify)**

Heart- CAD, Afib, valvular HD_____

High blood pressure _____
Lung- asthma, bronchitis _____
Diabetes - insulin dependent _____
GI- ulcer, gastritis, diverticulitis_____
Kidney or liver disease _____
Anemia or blood disease _____
Cancer- Breast Lung prostate _____
Depression _____
Arthritis-rheumatoid, fibromyalgia _____
Osteoporosis _____
Back/Neck problems _____
Other (please specify) _____

Allergies _____

ROS	Have you experienced any of the following symptoms?	No	Yes	detail
1. General	Fever, chills, night sweats, weight loss	0		_____
2. Skin	rash, sores	0	0	_____
3. Neurologic	headache, LOC, balance difficulties, Sz	0	0	_____
4. Eyes/ears	visual or hearing problems	0	0	_____
5. Nose/throat	discharge, pain, soreness, swelling, sinusitis	0	0	_____
6. Chest	cough, asthma, bronchitis	0	0	_____
7. Cardiac	chest pain, SOB, difficulty breathing,	0	0	_____
8. GI	ulcer, GI bleeding, diverticulosis	0	0	_____
9. Urinary	stones, infection, frequent urination	0	0	_____
10. MuSk	arthritis, swelling, pain, fracture, weakness	0	0	_____
11. Heme	anemia, bleeding disorders, DVT	0	0	_____
12. Psychiatric	depression, bipolar, mood swings	0	0	_____

Surgical Describe

1. Heart_ _/_ _/_ _____
2. Abdominal_ _/_ _/_____
3. Spine_ _/_ _/_ _____
4. Orthopedic_ _/_ _/_____
5. Other _/_ _/_ _____

Medications Name Dose Reason

1. _____ 6. _____

2. _____ 7. _____
3._____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Females

1. Are your menstrual cycles regular? 0 Yes 0 No 3. Previous Pregnancies:
2. Menopause? 0 Yes 0 No 4. Currently Pregnant? 0 Yes 0 No

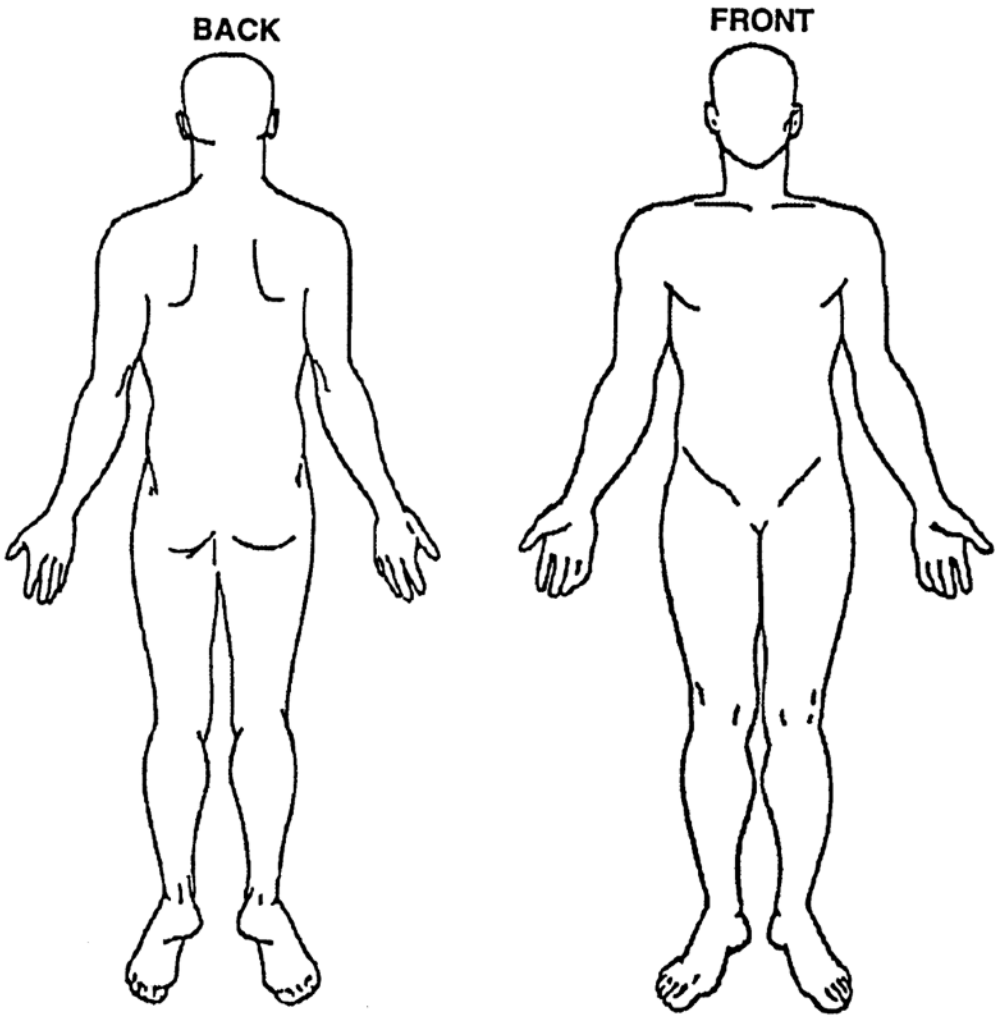
Social

1. Occupation _____
2. Type 0 Heavy labor 0 with restrictions 0 Mostly sitting 0 Sedentary
3. Have you changed your job because of your spine problem? 0 Yes 0 No
4. Education 0 High school 0 College 0 Graduate school
5. Smoking 0 Never 0 Quit ____ months ago 0 Smoke ___pack/day
6. Alcohol 0 Don't drink 0 Drink ___ days/week
7. Married 0 Yes (Children_____) 0 No
8. WCI/Auto Injury Hx: _____

Pain Diagram

Mark the areas on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Tingling 0000
Pain XXXX
Numbness IIII



Rate the severity of your pain on a scale of 0-10, 0 being no pain and q0 the greatest pain you've experienced

0_____10

HIPAA

Notice of Privacy Policies

This Notice of Privacy Practices describes how we may use, and disclose, your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for purposes required by law and describes your rights to access and control your protected health information. "Protected Information" is information about you, including demographic information, that may identify you as it relates to your past, present, future physical and mental health, or condition, and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff, and anyone outside of our office who are involved in your care, and treatment, for the purpose of providing health services to you, to pay your health care bills, to support the operation of the physician's practice, and other uses required by law.

Treatment. We will use, and disclose, your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination, or management, of your care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you; OR your protected health information may be provided to a physician to whom you have been referred to in order to ensure that the physician has the necessary information to diagnose or treat you.

Payment. Your protected health information will be used, as needed, to obtain payment for your care services. For example, obtaining approval for a medical procedure may require that your protected health care information be disclosed to the health insurance plan to establish medical necessity.

Healthcare Operations. We may use or disclose, as needed, your Protected Health Information in order to conduct the normal day to day operations of our practice which include, but are not limited to: Quality Control, Licensing, Employee Reviews, and Training of Medical Students.

For example, we may disclose your Protected Health Information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked your name and indicate your physician. We may also call you by name in the waiting room when the physician is ready to see you. We may use, or disclose, your Protected Health Information in the following situations without authorization, as required by law: Public Health Concerns, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donations, Research, Criminal Activity, Military Activity, National Security, Worker's Compensation, Inmates, Required User Disclosures, Under Lay.

We must make a disclosure to you when we are required by the Secretary of the Department of Health and Human Services to investigate, or determine, our compliance with the requirement of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with the consent, authorization, or opportunity to object, unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician, or the physician's practice, has taken an action in relation to the use, or disclosure, indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your Protected Health Information. If you have any objections to this form, please ask to speak with our privacy officer.

You have the right to inspect and copy your Protected Health Information. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of our Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information for the purpose of treatment, payment, or healthcare operations.

You may also request that any part of your Protected Health Information not be disclosed to family members, or friends, who may be involved in your care for notifications purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions, and which they apply. Your physician is not required to agree to a restriction that you may request. If your physician believes your restriction is unreasonable, and it is in your best interest to permit use and disclosure your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you have the right to use another Healthcare Professional.

You have the right to request, and receive, confidential communications from us by alternative means, or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically or by fax.

You may have the right to have our physician amend your Protected Health Information. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we subsequently submit a rebuttal to your statement we will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if an, of your Protected Health Information. We reserve the right to change the terms of this notice and will inform you by mail of any changes made. You then have the right to object, or withdraw, as provided in this notice.

Complaints

You may complain to the U.S. Department of Health and Human Services, 200 Independence Ave, S.W. Washington, D.C. 20201, if you believe your privacy rights have been violated by us you may file a complaint with us by notifying our HIPAA Privacy Officer. We will not retaliate against you for filing a complaint.

Law requires us to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to the Protected Health Information.

Signing below acknowledges you have received our Notice of Privacy Practices.

Print Name	Signature	Date

PATIENT FINANCIAL RESPONSIBIITY STATEMENT **ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.**

_____ _____ _____ Patient/Responsibility Party/
Guardian Date Date of Birth

_____
Witness

_____ _____ _____ Patient/Responsibility Party/
Guardian Date Date of Birth

_____
Witness

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____
Signature of Patient or Guardian Date