

**REFERRAL FORM – Help us by letting us know how you heard about Integrated Orthopedics.**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

\_\_\_\_\_\_ Doctor Referral

If so what doctor referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Internet Search (Google, Bing, Yahoo, Etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Our Blog

\_\_\_\_\_\_ Our Integrated Orthopedics Website

\_\_\_\_\_\_ PRP Procedure Information from our website

\_\_\_\_\_\_ Social Media (Facebook, Pinterest, YouTube, Other?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Our Monthly Newsletter

\_\_\_\_\_\_ Postcard / info I picked up at a local venue or Health Expo. Tell us Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Referral from a friend or family member

\_\_\_\_\_\_ I am a former / returning patient

\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Integrated Orthopedics, PLLC

# **PATIENT REGISTRATION/DEMOGRAPHICS**

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| Section A. - PLEASE PRINT AND COMPLETE ALL ENTRIES | | | | | | | | | | | | | | | | |
| PATIENT NAME: PATIENT DATE OF BIRTH: | | | | | | | | | | | | | | | | |
| ADDRESS, CITY, STATE: | | | | | | | | | | | | | | | ZIP: | |
| HOME/MESSAGE PHONE: | | | | | | | | CELL PHONE: | | | | | | | | |
| EMAIL ADDRESS: | | | | | | | | | RACE: | | | | | ETHNICITY: | | |
| PATIENT SSN: | | | SEX (circle one):  Male Female | | | | | | MARITAL STATUS (circle one):  Single Married Divorced Widowed Other | | | | | | | |
| PRIMARY CARE PHYSICIAN: | | | | | | | | | REFERRING DOCTOR OR PROVIDER: | | | | | | | |
| IN CASE OF EMERGENCY NAME AND CONTACT NUMBER: | | | | | | | | | | | | | RELATIONSHIP: | | | |
| INSURED/RESPONSIBLE PARTY INFORMATION(If different from the patient please fill out completely) | | | | | | | RELATION TO PATIENT: | | | | | | | | | |
| NAME | | | | | ADDRESS | | | | | | | | | | | |
| HOME PHONE | | WORK PHONE | | | SSN | | | | | BIRTH DATE | | EMPLOYER | | | | |
| COVERAGE INFORMATION | | | | | | | | | | | | | | | | |
| ***WHAT IS YOUR CURRENT MEDICAL COVERAGE? (IE SELF PAY, INSURANCE, LIEN, WORKERS COMPENSATION):*** | | | | | | | | | | | | | | | | |
| **1** **PRIMARY MEDICAL COVERAGE:** | | | | ADDRESS (street, city, state, zip) | | | | | | | | PHONE | | | | |
| GROUP NUMBER | | ID NUMBER | | | EMPLOYER | | | | | | EMPLOYER PHONE | | | | | |
| **2** **SECONDARY/SUPPLIMENTAL MEDICAL COVERAGE:** | | | | ADDRESS (street/city/state/zip) | | | | | | | | PHONE | | | | |
| GROUP NUMBER | | ID NUMBER | | | EMPLOYER | | | | | | EMPLOYER PHONE | | | | | |
|  | | | | | | | | | | | | | | | | |
| ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees. | | | | | | | | | | | | | | | | |
| **SIGNATURE (PATIENT OR IF MINOR SIGNATURE OF GUARDIAN):** | | | | | | | | | **DATE:** | | | | | | | |
| **Section B. - MEDICAL RECORDS RERELEASE**  **Authorization to release health information via fax/phone** | | | | | | | | | | | | | | | | |
| **Please list a facility or anyone in your personal life that Integrated Orthopedics is released to discuss your medical treatment.**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  hereby authorize (name, address, phone number, and fax number as applicable):  to discuss my treatment and/or release information to:  Integrated Orthopedics 20940 N Tatum Blvd, Suite B290, Phoenix Arizona 85050  Phone 602-734-1834 Fax 602-734-1835 | | | | | | | | | | | | | | | | |
| Dates of Service  from: to: | | | | | Authorization Expires (unless otherwise noted this authorization will remain in effect one year from the date signed)  ❑ Never Date: | | | | | | | | | | | |
| Release the following information: | | | | | | | | | | | | | | | | |
| ❑ All Records | | ❑ Chart Notes | | | | ❑Radiology | | | ❑ Operative Reports | | | | | | | ❑ History & Physicals |
|  | |  | | | |  | | |  | | | | | | |  |
| **Section C. - HIPPA REVIEW/AUTHERIZATION:**  **Please review and sign below** | | | | | | | | | | | | | | | | |
| I understand that: | | | | | | | | | | | | | | | | |
| ● | Once Integrated Orthopedics of Arizona discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information. | | | | | | | | | | | | | | | |
| ● | I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524). | | | | | | | | | | | | | | | |
| ● | My records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. The medical records to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases. | | | | | | | | | | | | | | | |
| ● | This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department (45 CFR 164.508(c)(2)(i)). | | | | | | | | | | | | | | | |
| **Signature of patient or legal representative:** | | | | | | | | | **Date:** | | | | | | | |
| If signed by legal representative, relationship to patient | | | | | | | | | Signature of witness (optional): | | | | | | | |

Integrated Orthopedics, PLLC

20940 N. Tatum Blvd., Suite B-290, Phoenix, AZ 85050- 602-734-1834

**THIS AGREEMENT STATES THAT THE RESPONSIBLE PARTY AGREES TO TERMS STATED BELOW,**

**We will bill primary and secondary insurances. You are responsible for deductible, coinsurance, copays, uncovered service, plus any supplies purchased and not covered by the insurance. If you are covered by Medicare, we will bill Medicare as your primary insurance. We will bill any secondary insurance also. You are responsible for deductible, coinsurance, copays, uncovered service, plus any supplies purchased and not covered by the insurance. You may be asked to sign an ABN (Advanced Benefit Notice) for services that are non-covered by Medicare.**

This financial agreement is based on information quoted by your insurance carrier via telephone, because your

Insurance carrier may misquote your benefits to us, we strongly encourage all patients to verify their own benefit coverage, including co-pay amounts, remaining deductibles. **THIS FINANCIAL AGREEMENT IS BASED ON BENEFITS QUOTED BY YOUR INSURANCE CARRIER AND IS EFFECTIVE THROUGH THE CALENDAR OR FISCAL YEAR, WHICH EVER CORRESPONDS TO YOUR INSURANCE POLICY.**

If reimbursement is to be received due to a personal injury, all adjustments are null and void and full balance without negotiation will be due at the time of settlement.

All co-pays and co-insurance payments are due **prior to treatment.** We accept cash, check, or credit card.

**Should you be unable to keep a scheduled appointment, you must call at least 24 hours prior to your appointment. Patient’s, who fail to do so, will be charged a $35 fee. These charges will be the patient’s responsibility as insurance carriers will not pay for them.**

Your insurance coverage is an agreement between you (the patient) and your insurance carrier. Integrated Orthopedics will, as a courtesy, submit all eligible charges to your insurance carrier for payment. Please remember that you are ultimately financially responsible for all charges incurred during your course of treatment. A statement of charges showing patient responsible charges (those charges that are not covered by your insurance carrier) will be sent out monthly. A patient who has not patient responsible charges will not receive a statement until their course of treatment is completed. Upon completion of treatment, all patient’s will receive a statement showing all pending charges, adjustments and pending insurance payments. Any charges, which are the patient’s responsibility, are due immediately.

**If, after 90 days from your discharge date, we have not received payment in full from the Insurance Carrier, all outstanding charges will become the responsibility of the patient and are due immediately.** We strongly encourage you to contact your insurance carrier, during this 90-day period, to check on the status of your claims. Please feel free to contact us if your insurance carrier needs additional information from us to process your claims.

**I understand that I am financially responsible for all charges incurred. Should this matter be turned over to our collection attorney all costs, including reasonable collection fees (35%-50%) and any court costs incurred by Integrated Orthopedics or our attorneys, shall be the responsibility of the patient or responsible party.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

Integrated Orthopedics, PLLC

20940 N. Tatum Blvd., Suite B-290, Phoenix, AZ 85050- 602-734-1834

**NOTICE TO PATIENTS**

State law, A.R.S. 32-1401 (25) (ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. (I/We) support this law because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services that (I/We) have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

* SurgCenter at Pima Crossing
* Desert Ridge Surgery Center
* Insight Pharmacy

THESE SERVICES ARE AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS:

* Paradise Valley Hospital
* John C. Lincoln North Mountain
* Scottsdale Healthcare Thompson Peak

The law provides for the acknowledgment of your having read and understood these disclosures by dating and signing this form in the spaces provided below.

**ACKNOWLEDGMENT**

(I/We) have read this Notice to Patients, and (I/We) understand the disclosures that it contains.

Signature of Patient or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

# Integrated Orthopedics, PLLC

# **PATIENT MEDICAL HISTORY**

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| PLEASE PRINT AND COMPLETE | | | | | | | |
| PATIENT NAME: DATE OF BIRTH:  HEIGHT: WEIGHT: | | | | | | | |
| \*\*\* Preferred Pharmacy and Pharmacy phone number\*\*\*: | | | | | | | |
| ALLERIGES (Please list all allergies or if no known allergies please indicate) | | | | | | | |
| **❑** NONE/No Known Allergies | | | | | | | |
| FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following. | | | | | | | |
|  | MOTHER | | FATHER | | | | SIBLING (Please indicate brother or sister) |
| Anesthesia Problems |  | |  | | | |  |
| Arthritis |  | |  | | | |  |
| Cancer |  | |  | | | |  |
| Diabetes |  | |  | | | |  |
| Heart Problems |  | |  | | | |  |
| Hypertension |  | |  | | | |  |
| Stroke |  | |  | | | |  |
| Thyroid Disorder |  | |  | | | |  |
| **SOCIAL HISTORY** | | | | | | | |
| Marital status: 🞎 Single 🞎 Married 🞎 Divorced 🞎 Widowed 🞎 Separated | | | | | | | |
| Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Retired 🞎 Disabled (reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | | | | | | | |
| 🞎Yes 🞎No - Do you drink alcohol? 🞎 Daily 🞎Weekly 🞎Infrequently 🞎 Recovering Alcoholic | | | | | | | |
| 🞎Yes 🞎No - Do you use tobacco? 🞎 Smoke ( \_\_\_ packs per day) 🞎 Chew | | | | | | | |
| **SURGICAL HISTORY:** Please list any hospitalizations, surgeries, fractures or major illnesses you have had. | | | | | | | |
| TYPE OF SURGERY | | | | YEAR or DATE | | DOCTOR | |
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| **MEDICAL HISTORY:**  **Have you EVER had any of the following? Circle or mark only those that apply.**  None of the Below    Infection/Infectious Disease  Blood Clots HIV/AIDS Thyroid Disease  Diabetes Hepatitis Seizures  High Blood Pressure Stomach Ulcer Stroke  Heart Attack Liver Disease Congestive Heart Failure  Heart Disease Heart Palpitations Asthma  Pacemaker Arthritis Depression  Headaches Heart Surgery Osteoporosis  Kidney Stones Chest Pain/Angina Tuberculosis  Kidney Disease Cancer Peripheral Vascular Disease    Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **REVIEW OF SYSTEMS (circle only those that currently apply):**  GENERAL MENTAL HEALTH ENT  Chills Anxiety Bleeding Gums  Dizziness Loss of Interest Blurred Vision  Fainting Depression Crossed Eyes  Fever Difficulty Swallowing  Night Sweats SKIN Double Vision  Sleeping Problems Dry/Sensitive Skin Earaches  Thirst – Excessive Hives Ear Discharge  Weight Gain Rash Hay Fever  Weight Loss Scars Hoarseness  Bruises Easily Sinus Problems  GASTROINTESTINAL Hearing Loss  Bowel Changes GENITOURINARY Nose-Bleeds  Constipation Lack of Bladder Control Persistent Cough  Diarrhea Blood in Urine Persistent Runny Nose  Vomiting Painful Urination Ringing in Ears  Nausea Frequent Urination Recurring Sore Throat    NEUROLOGICAL CARDIOVASCULAR RESPIRATORY  Coordination Problems Chest Pains Coughing  Learning Disabilities Swelling of Ankles Coughing up Blood  Speech Problems Rapid Heart Beat Shortness of Breath  Convulsions Irregular Heart Beat Wheezing  Seizures Circulation Problems  Light-headedness Varicose Veins  Memory Loss Heart Palpitations  Numbness / Tingling  Paralysis  Tremors  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
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| **Current Medications:** List any medications you are currently taking, please include over the counter medications:  **PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE** | | | | | | | |
| MEDICATION | | DOSAGE | | | PERSCRIBING DOCTOR | | |
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Integrated Orthopedics, PLLC Intake Form

Please fill out the following injury report as thoroughly as possible.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old are you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you right or left handed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What body part are you being treated for today (please choose ONLY one per office visit consultation)?

Upper Extremity:

\_\_\_\_\_\_\_\_Right Shoulder \_\_\_\_\_\_\_Left Shoulder

\_\_\_\_\_\_\_\_Right Elbow \_\_\_\_\_\_\_Left Elbow

\_\_\_\_\_\_\_\_Right Wrist/Hand \_\_\_\_\_\_\_Left Wrist/Hand

Lower Extremity:

\_\_\_\_\_\_\_\_Right Hip \_\_\_\_\_\_\_Left Hip

\_\_\_\_\_\_\_\_Right Knee \_\_\_\_\_\_\_Left Knee

\_\_\_\_\_\_\_\_Right Ankle \_\_\_\_\_\_\_Left Ankle

Other (please note what ONE area of the body hurts if not listed above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your pain on a scale of 1-10?

Not Painful 1 2 3 4 5 6 7 8 9 10 Severe Pain

What date did this begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe the injury and location of the injury? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous treatment for this problem? Yes No

If yes please describe the treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had and X-ray? Yes No If Yes; Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had an MRI? Yes No If Yes; Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had an Injection treatment? Yes No

Have you done physical therapy for this problem? Yes No

Please describe your pain (i.e. dull, sharp, burning, aching, catching, locking, giving way, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain feel worse (i.e. specific activities, positions, motions, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain feel better (i.e. rest, ice, Tylenol, Ibuprofen, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_