Date_____ Home Phone_____ Cell Phone_____ Email_____
Patient Last Name_____ First Name_____ Initial_____
Street Address_____
City_____ State_____ Zip_____
Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Social Security #_____ Driver's License #_____
Insured Name_____ How and where did you learn about this clinic?_____
Last Name First Name Initial
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City_____ State_____ Zip_____ Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate_____ SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____ Phone_____ Occupation_____ City_____ State_____ Zip_____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

Supreme Court Upholds Patient's Bill Of Rights (ACA)

Affordable Care Act (ACA) Discount Disclosure:

ACA Discount Protects You from Medical Bankruptcies

You and Your Loved Ones No Longer Have To Skip or Delay Needed Healthcare

ACA Discount Is Similar to, But Much Better Than PPO Discount

Dear Patient:

We are very excited to share with you on the most exciting and important Supreme Court decision on the Patient Protection and Affordable Care Act (PPACA, in short, ACA). On June 28, 2012, Supreme Court upheld the constitutionality of Patient Protection and Affordable Care Act (ACA). ACA is also known as Patient's Bill of Rights, a new federal health reform law went into effect on March 23, 2010. ACA now authorizes your health provider, as your Authorized Representative, to appeal all of the improperly denied or delayed healthcare claims by your health plan, and protects your constitutional rights to ACA Accessibility and Affordability Discount and Savings, which are not available to you before.

We offer an Affordable Care Act Discount (ACA Discount) under our Corporate Compliance Policy to anyone who qualifies, on a case by case basis. You only pay what you can afford or are willing to pay for your deductible and co-insurance, as outlined in your plan cost-sharing obligations, only based on your medical need, in relation to your income at the time of the service. Most people may qualify and your satisfaction is guaranteed.

This timely Supreme Court's ACA decision will protect you, your loved ones of your family from medical bankruptcies or having to skip or delay the timely sensitive healthcare, even with PPO discount but still can't afford to pay for high deductible & co-insurance, because PPO discount fails to protect most patients, who can't afford to pay high deductible and co-insurance after having paid for higher premiums, at the critical time when the medical care is needed the most.

According to the AMA and Kaiser reports in June 2012, "Even among people who make $90,000 or more per year, nearly 40% skipped or delayed care because of cost", even after more than 95% of insured people have received PPO discount.

"Harvard researchers say 62% of all personal bankruptcies in the U.S. in 2007 were caused by health problems-and 78% of those filers had insurance".

About 77% of insured Americans paid for first-class, high quality out-of-network coverage with guaranteed Freedom of Choice of Providers, but are unable to receive the actual care they paid for when they need it the most. Only less than 5% out-of-network claims were filed each year in America, because PPO discount failed to protect patient's rights to choose.

While most people in America don't make more than $90,000 per year, every American is entitled to the constitutional ACA protections, discount and savings, as constitutionally ruled by Supreme Court on June 28, 2012.

Many provisions of the ACA are designed to improve access and affordability to health care and health insurance. Our ACA Discount Protections are offered to you under HHS and OIG Guidance (http://archive.hhs.gov/news/press/2004pres/20040219.html), and CMS FAQ for Medicare and non-Medicare patients (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf).

While you may still receive letters from your plan telling you about the limited savings from PPO discount, Supreme Court on June 28, 2012 upholds your constitutional rights under ACA for all ACA protections, discount & savings, and rights to Freedom of Choice of Providers, so that you No longer have to pay for the First-Class Seats but Being Forced to sit in the PPO Economy in the back on a healthcare flight when you and loved ones needed the quality care the most.

Now that Congress promised, President endorsed and Supreme Court decided for your constitutional rights to the improved choice, access and affordability to health care, we are honored to actually deliver the first-class, high quality care with all ACA protections, discount and savings, to avoid any medical bankruptcies and to keep your cash in your bank. Under PPACA, we are dedicated to helping patients keep cash in your banks with your constitutional ACA Discount, because the Supreme Court ACA decision protects patient's rights to freedom of choice of providers for the first-class, quality care from both in-network and out-of-network without healthcare bankruptcies, after you already paid for it.

Patient Protection & Advocacy Policy

Affordable Care Act (ACA) Discount Disclosure
You Are Protected From Any Unexpected Costs And Bills

Dear Patient:

1. As your Patient Advocate (PA), we offer the highest care quality and safety possible at the **most affordable cost to you**, no matter if you are covered by an in-network or out-of-network health plan.
2. We offer an **Affordable Care Act Discount (ACA Discount)** under our Corporate Compliance Policy to anyone who qualifies, on a case by case basis. **You only pay what you can afford or are willing to pay** for your deductible and co-insurance, as outlined in your plan cost-sharing obligations, based on your medical need. Most people may qualify and **your satisfaction is guaranteed**.
3. Our Affordable Care Act (ACA) Discount is **similar to or even much better than all PPO discounts**, as our **ACA Discount is available from both in-network and out-of-network providers and facilities**.
4. Once you qualify, **you will NOT receive ANY unexpected invoices, bills or collection letters FROM US**, even if your insurance denies your claims.
5. As your Patient Advocate and Authorized Representative, and under the new federal health reform law PPACA (Patient Protection and Affordable Care Act, or ACA), we may appeal all of the claim denials or delays on your behalf, which is strictly in compliance with the new federal health reform law, PPACA.
6. As your Patient Advocate, **your best interest is our best interest**. To ensure that you also get this kind of ACA Discount from other providers known to us or affiliated with us, we will inform you of these facilities and/or providers, **so you may also receive the best care possible along with the ACA Discounts and Savings.**
7. With your informed choice, we will refer you to a provider who may also offer a compliant ACA Discount and ensure that **you are always protected from any unexpected costs and bills** under the new federal health reform law (PPACA).
8. As your Patient Advocate, we want **you to be fully protected from any unexpected costs and bills from any providers, unless otherwise authorized by you.**
9. You always have freedom of choice to receive healthcare from any provider you choose. However, we cannot speak for or guarantee anything on behalf of other providers we don't know or are not affiliated with regarding their discount or collection policies. You are advised to contact them directly before scheduling your next appointment(s) or medical procedure(s).
10. **If you are willing to be protected from any unexpected costs and bills,** feel free to apply for our Affordable Care Act Discount under our Corporate PPACA Indigency Policy. "*Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount*". Your satisfaction is guaranteed.

I have read and fully understand this Patient Protection & Advocacy Policy. My questions are fully answered.

X _____ _____ _____

Patient Name (print) | Signature of Patient | Date

FINANCIAL POLICY

Thank you for choosing us as your medical care facility. Our goal is to provide you with highest quality medical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER OR REDUCTION OF DEDUCTIBLES, CO-PAYS AND CO-INSURANCE) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON CASE TO CASE BASIS.
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE.
- WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, AND AMERICAN EXPRESS CARD.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Dishonored checks will be charged back to the patient's account with a service fee of $25.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor for collection.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeon's office. However, you will be personally responsible for your account balance regardless whether or not if you're insurance will pay for your total balance of your claims, unless you're eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event, we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due, if your insurance company/employee benefits plan has not paid your account in full within 45 days or has determined your claims to be your responsibility for the reasons of annual deductible, co-payment, non-covered services and not medically necessary.

If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as a self-pay.

Regarding Discount

We may offer discounts, reduction or waiver of deductibles, coinsurance and co-pay to any eligible patients based on medical needs and ability to pay on a case-by-case basis under our Corporate Indigency Policy in accordance with applicable federal and state laws. You may apply for financial indigency discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as clearly as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist, diagnostic labs, radiologists, pathologists, and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post-surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

The charges only include the stated date of services at this facility and do not include any other date of services from us or other providers and facilities.

Regarding PPO and HMO Network Participation

As you may know, you may have choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing highest quality care to every patient; however, we have no power to change your insurance coverage or network limitations. Most health care plan or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

At this time, we don't participate in any managed care networks other than Medicare Fee-for-Service Plans (Medicare Part B). Most health plans or Insurance Policies may have coverage for out-of-network providers or facilities, but at different or lower percentage or level of reimbursement rates.

We will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your surgery.

Please understand that all insurance verification is not a guarantee of insurance payment.

Compliance & Disclosure under California Business and Professions Code

In compliance with California Business and Professions Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to any significant beneficial interest and have advised me that I may choose any organization for the purpose of obtaining the services ordered or requested by my attending physician, in connection with my choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the California Business and Professions Code.

Doctor or Facility with significant beneficial interest: Bay City Surgery Center

You're Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse check to our office within five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

We are committed to serving you with highest quality care possible at affordable cost. Every staff at our office is ready to help you at all time. If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your co-operation.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ Signature of Patient or Responsible Party _____ Patient Name (print) _____ Date

X _____ Signature of Co-Responsible Party _____ Your Name (print) _____ Date

Spalding Surgical Compliance Alert, 2013(A)(a)
PPACA Patient Advocacy for Freedom of Choice Disclosure and Compliance with California Business and Professions Code and California Health & Safety. Code § 1323(c)

Dear Provider of Patient Advocacy:

In compliance with new health care reform laws, PPACA, and all applicable federal and California laws, and as a long-standing patient advocacy practice for patient freedom of choice of healthcare providers solely based on the healthcare quality, safety, provider's reputation and patient satisfaction, we are excited to share with you on our 2013 compliance and advocacy updates.

According to the latest DOL Report in Dec 2012, about 74% of all insured private industry workers participated in PPO plans that "Allow non-emergency services outside Network". In order to advocate for patient PPACA rights for freedom of choice of providers, Spalding Surgical adopted the following new policies: (http://stats.bls.gov/ncs/ebs/detailedprovisions/2011/ownership/private/table02a.pdf)

Effective July 1, 2013, every healthcare provider must submit documents demonstrating your full and proper disclosures in compliance with federal and state laws, especially California Business and Professions Code and Cal. Health & Safety Code § 1323(c), as well as your managed-care network requirements, when scheduling for an appointment with Spalding Surgical.

You may fax or email the documents to Spalding Surgical 24 hours in advance of scheduling patient appointment, or any time for urgent care cases.

It is important that every provider must comply with both *public policies* in applicable federal and state laws and in *private agreement* with managed-care networks in advocating patient rights for freedom of choice. The documents submitted shall include specific Network Disclosure Forms, if any, under your PPO participating agreement, and any forms of your choice demonstrating full and proper compliance with all applicable federal and state laws.

It is also important to understand that California State law mandates for full and proper disclosures for any and all permissible self-referrals, regardless of in-network or out-of-network referrals, for both Medicare or non-Medicare patients, in addition to Medicare Stark Prohibitions and Anti-Kickback Statutes.

California Business and Professions Code and Cal. Health & Safety Code § 1323(c) laws prohibit referrals to other health facilities in which the health facility has a significant beneficial interest unless written disclosure that patient may choose another facility.

As you are well aware that Spalding Surgical has been fully dedicated to the patient advocacy for the quality care and patient choice through compliance, we have always shared with you on our compliance initiatives in protecting your practice and your own financial safety in the course of advocating patient rights.

We'll keep you updated on our forthcoming compliance and patient advocacy meetings and training programs.

If you have any questions regarding this compliance alert, please do not hesitate to contact our representative.

Respectively,
ERISA & PPACA Compliance Specialist

2573-B Pacific Coast Highway
Torrance, CA 90505

Neil Ghodadra, MD

Tel: (877) 339-0054
Fax: (818) 804-3469

Patient Information

Name: _____ Gender: M/F Age: _____ Date of Birth : _____

How did you hear about us? ☐ Doctor Referral _____ ☐ Family _____ ☐ Friend _____ ☐ Yelp
☐ Other online source _____ ☐ Other _____

Chief Complaint

Chief Complaint/What brings you here today?: _____
When did this problem start (date of injury)? Have you experienced this problem previously? If yes, how long ago?

_____

_____

How do you think your problem began? Please be as detailed as possible.

_____

_____

How often do you experience your symptoms?

_____

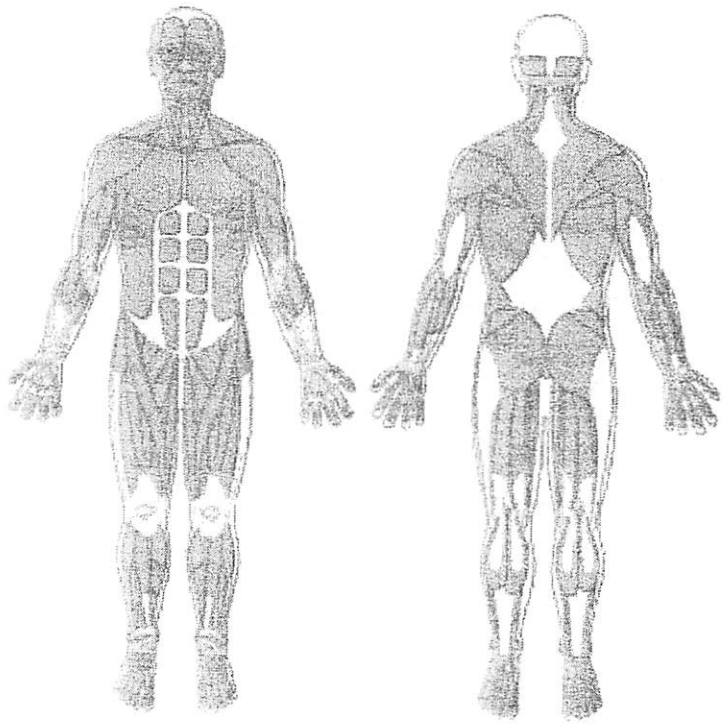
_____

When is your pain at its worst? Please check all that apply.

☐ Mornings ☐ Daytime ☐ Evenings ☐ Middle of the night ☐ Always the same

Draw the appropriate symbol(s) in the area of pain.

Burning	= = = = =
Dull/Aching	0 0 0 0 0 0
Sharp/Stabbing	x x x x x x
Throbbing	Δ Δ Δ Δ Δ
Tingling/Pins/Needles	~ ~ ~ ~ ~



If "0" is no pain and "10 is the worst pain you can imagine, how would you rate your pain?

Right now _____ At its Best _____ At its Worst _____

Does the pain radiate anywhere in your body? ☐ Yes ☐ No

If yes, where does it radiate? _____

How are your symptoms changing with time?

☐ Getting better ☐ Not changing ☐ Worse

Who else have you seen for this problem? Please check all that apply.

☐ Chiropractor ☐ Pain Management ☐ Neurologist ☐ Primary Care Physician

☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ Other _____

Please mark the effect each action listed below effects your **pain level.**

	Increase	Decrease		Increase	Decrease
Sitting	☐	☐	Coughing/Sneezing	☐	☐
Rising from sitting	☐	☐	Household chores	☐	☐
Standing	☐	☐	Lifting objects	☐	☐
Walking	☐	☐	Reaching overhead	☐	☐
Lying down	☐	☐	Showering or Bathing	☐	☐
Bending forward	☐	☐	Looking side to side	☐	☐
Bending backward	☐	☐	Looking Up	☐	☐
Driving	☐	☐	Looking Downward	☐	☐
Twisting	☐	☐	Changing Positions	☐	☐

Please mark the treatments you have used.

	Helped	Worsened	Same		Helped	Worsened	Same
Medications	☐	☐	☐	Massage therapy	☐	☐	☐
Physical Therapy	☐	☐	☐	Acupuncture	☐	☐	☐
Chiropractic	☐	☐	☐	Brace Support	☐	☐	☐
Electric Stim/TENS	☐	☐	☐	Cognitive Therapy	☐	☐	☐
Hot Packs	☐	☐	☐	Cold Packs/Ice	☐	☐	☐

Associated Symptoms

	Yes	No	Location/Comment
Numbness	☐	☐	
Weakness in arm	☐	☐	
Weakness in leg	☐	☐	
Bladder Incontinence	☐	☐	

Mark all of the following tests that you have had:

- ☐ X-ray of the: _____ Date: _____
- ☐ MRI of the: _____ Date: _____
- ☐ CT-Scan of the: _____ Date: _____
- ☐ Other Diagnostic Testing: _____ Date: _____
- ☐ I have not had ANY diagnostic tests done.

Past Medical and Health History

REVIEW OF SYSTEMS: Mark the following conditions/diseases/symptoms that you have been treated for:

Constitutional:
- ☐ Chills
- ☐ Difficulty sleeping
- ☐ Easy bruising
- ☐ Fatigue
- ☐ Fevers
- ☐ Low sex drive
- ☐ Weight gain
- ☐ Weight loss

Ears/Nose/Throat/Neck:
- ☐ Dental problems
- ☐ Earaches
- ☐ Hearing problems
- ☐ Nosebleeds
- ☐ Sinus problems

Eyes:
- ☐ Recent Visual Changes

Psychiatric:
- ☐ Depressed mood
- ☐ Feeling anxious
- ☐ Stress problems
- ☐ Suicidal thoughts
- ☐ Suicidal planning
- ☐ Thoughts of harming others

Genitourinary/Nephrology:
- ☐ Flank pain
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Decreased urine

Cardiovascular:
- ☐ Chest pain
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Fainting
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Low blood pressure

Gastrointestinal:
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Acid reflux
- ☐ Abdominal cramps

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Neurological:
- ☐ Dizziness
- ☐ Headaches
- ☐ Tremors
- ☐ Seizures
- ☐ Anxiety`
- ☐ Depression
- ☐ Pins & Needles

Musculoskeletal:
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Muscle spasms
- ☐ Scoliosis
- ☐ Neck pain
- ☐ Hip disorder
- ☐ Knee injuries
- ☐ Foot/Ankle pain
- ☐ Elbow/Wrist pain
- ☐ Poor posture

General:
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes

General Cont.:
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Hernia
- ☐ Herniated disk
- ☐ High Cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Metal implant
- ☐ Measles
- ☐ Migraines
- ☐ Mononucleosis
- ☐ M.S.
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pinched nerve
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Psychiatric patient
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Skin problem
- ☐ Thyroid problem
- ☐ Vaginal infection
- ☐ Venereal disease

Past Medical/Surgical History: Please list any other major illnesses, injuries or conditions not listed above:

_____

_____

_____

_____

Current Medications	Dose	Frequency

Allergies:

_____

_____

Family History

Mark all appropriate diagnoses as they pertain to your first-degree relatives (check all that apply):

☐ Cancer ☐ Arthritis ☐ Diabetes ☐ High Blood Pressure ☐ Osteoporosis
☐ No significant Family history ☐ Other Family History_____

Social History

Tobacco Use:

☐ Never used ☐ Current user ☐ Packs per day? ____ for ____ years? ☐Former user/Quit date: _____

Alcohol Use:

☐ Never used ☐ Social use ☐ History of alcoholism ☐ Current alcoholism ☐ Daily use of alcohol

Illegal Drugs Use:

☐ No illegal drug use ☐ Current illegal drug use ☐ Formerly used illegal drugs (not currently using)

Are you currently working? ☐ Full-time ☐ Part-time ☐ Retired ☐ On Disability ☐ Other

Occupation:_____

Do you currently have any active Workers Comp, Disability, or Personal Injury cases open? ☐ Yes ☐ No

The above information is accurate to the best of my knowledge.

_____ _____
Patient Signature *Date*

I have reviewed the above information with the Patient.

_____ _____
Doctor's Signature *Date*