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SYMPTOMS AND MEDICAL HISTORY

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Reason For Visit: (use body diagram to indicate location of problem) _____

How Long Have Symptoms Been Present? _____

What Makes The Symptoms Worse? _____

What Makes The Symptoms Better? _____

What Treatments Have You Tried? (medications, therapy, injections, surgeries, etc.)

_____

Other Medical Problems: _____

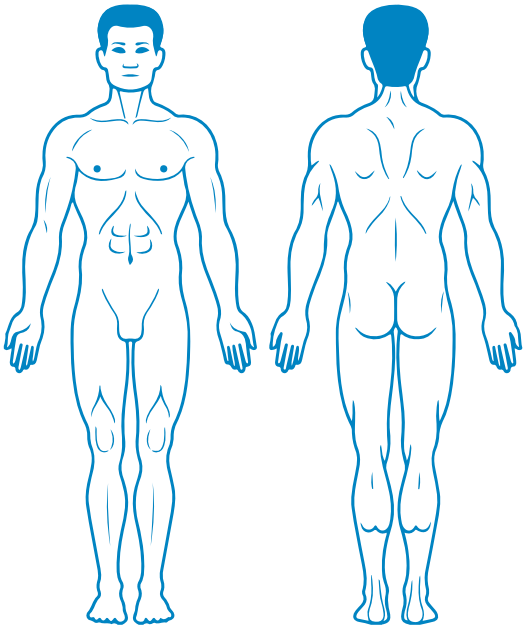
Previous Surgeries: _____

Medications/Supplements (name and dose): _____

_____

Allergies: _____

Family History of Medical Problems: _____



INDICATE WITH A CHECKMARK IF YOU HAVE A HISTORY OF:

- ☐ Smoking - If so, how much? _____
- ☐ Alcohol use - If so, how much? _____
- ☐ Non-prescription drug use - Which drug? _____
- ☐ Current use of blood thinning medication – Which medication? _____

- ☐ Recent infection
- ☐ HIV/AIDS
- ☐ Rheumatoid arthritis
- ☐ Autoimmune disease
- ☐ Cancer
- ☐ Vasculitis
- ☐ Blood clots
- ☐ Transfusion reaction

REVIEW OF SYMPTOMS - PLEASE CHECK ANY AND ALL THAT APPLY:

- ☐ Pregnant or may become pregnant
- ☐ Fevers
- ☐ Rashes
- ☐ Bruising
- ☐ Headaches
- ☐ Blurred vision
- ☐ Sore throat
- ☐ Weight loss
- ☐ Weight gain
- ☐ Anxiety
- ☐ Depression
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Seizures
- ☐ Dizziness
- ☐ Memory loss
- ☐ Difficult with speech
- ☐ Chest pain
- ☐ Palpitations
- ☐ Rapid heart beat
- ☐ Murmur
- ☐ Blood clots
- ☐ Cough
- ☐ Shortness of breath
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Incontinence
- ☐ Blood in stool
- ☐ Blood in the urine

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QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

***Please read carefully:**

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ Worst possible pain

0 1 (2) 3 4 (5) 6 7 (8) 9 10

1 - What is your pain RIGHT NOW?

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2 - What is your TYPICAL or AVERAGE pain?

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4 - What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

_____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

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PROVIDER NOTE

Patient Name: _____ **Date of Birth:** _____

Signature

Date

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PATIENT INFORMATION

Name (Last, First)

Gender

Male ☐ Female ☐

Preferred Name

Date of Birth (MM/DD/YYYY)

Age

E-mail

Home Phone

Cell Phone

Street Address

City

State

Zip Code

PRIMARY CARE PHYSICIAN

Name

Office Phone

Fax

PREFERRED PHARMACY

Name

Phone Number

Street Address

City

State

Zip Code

EMERGENCY CONTACT

Name

Relationship

Phone Number

_____

Patient Signature

_____

Date

RENEW MEDICAL
NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treatment area discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid an investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Gayle at (513) 561-2273. If you are not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201

RENEW MEDICAL NOTICE REGARDING YOUR RIGHT TO PRIVACY *continued...*

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____
Patient's Name	DOB
_____	_____
Patient's Signature	Date
_____	_____
Witness	Date