Center for Wellness and Pain Care New Patient Packet

1. Please enter your information.

First Name: _____ Last Name: _____ Date of Birth: _____ Gender: ○ Female ○ Male ○ N/A

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Preferred Phone: _____ Secondary Phone: _____ Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Email: _____

☐ By checking this box and supplying your mobile number and email you agree to receive SMS notifications and emails from the Center for Wellness and Pain Care of Las Vegas. Message frequency varies per user. Reply STOP to cancel. Msg & Data rates may apply.

Drivers License #/ State: _____ Social Security Number #: _____ Emergency Contact: _____

Phone: _____ Relationship: _____

Race:
☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Refuse to report

Ethnicity
☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Referral: Were you referred to our clinic by another physician? If so, whom?

_____

How did you hear about us?
☐ TV ☐ Magazine ☐ PCP ☐ Family ☐ Friend ☐ Internet ☐ YouTube ☐ Facebook ☐ Twitter ☐ Telephone Message
☐ www.cwpclv.com ☐ Other

Social Status
○ Married ○ Single ○ Divorced ○ Widowed ○ Other

2. Please Upload a clear photo of the front and back of your ID

3. Pharmacy and Insurance

Pharmacy Name _____ Pharmacy Phone Number _____

Pharmacy Address _____

Do you have a prescription drug card?
○ Yes ○ No

RX Drug Card Member #: _____ RX Card BIN #: _____ RX Card Group #: _____

Primary Insurance Payer (e.g. BC/BS): _____ Member ID#: _____

Plan: _____

Insurance Policy Holder _____

Policy Holder Name: _____ Policy Holder Gender _____

Date of Birth: | Social Security Number

Policy ID/Number: | Group Number #:

Secondary Insurance (If any) Payer: | Member ID #:

Plan:

Insurance Policy Holder

Policy Holder Name | Policy Holder Gender

Date of Birth: | Social Security Number:

Policy ID/Number #: | Group Number #:

Workers Compensation Claim Information- Company Name: | State of Inquiry:

Agent Name: | Phone Number #: | Fax Number #:

Claim Number #: | Date of initial injury:

Injury Claim: Is your pain the result of a Personal Injury?
○ Yes ○ No

Law Firm: | Attorney Name:

4. Please upload a clear photo of the front and back of your Insurance Card.

5. Referrals or Medical Records

I certify that the above information is accurate, complete and true. I give my consent for CWPC to retrieve and review my medication history. I understand that this will become part of my medical record.

Signature | Date

Financial Policy

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms.

Appointments:

1. Co-payments. Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, The Center for Wellness and Pain Care of Las Vegas, Inc. reserves the right to reschedule your appointment until a time that you are able to make your copayments. Payment for any outstanding balance is due at your appointment.
2. Procedure Prepayment. The Center for Wellness and Pain Care of Las Vegas, Inc. collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy below. We reserve the right to reschedule your procedure until prepayments has been made.
3. Missed Appointments and Late Arrivals. If you are more than 12 minutes late, we may reschedule your appointment. If you are more than 60 minutes late, or if you do not show up for your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a $50 charge. Missed procedure, is subject to a $100 charge. These charges are

your responsibility and will not be billed to any insurance carrier.

Insurance Payments:

1. Financial Responsibility. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment in full for all medical services provided to you. Any charge not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.
2. Coverage Changes and Timely Submission. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time lime within which The Center for Wellness and Pain Care of Las Vegas, Inc. must submit a claim on your behalf to your insurer. If the Center for Wellness and Pain Care of Las Vegas, Inc. is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.
3. Self-Pay. If you do not have health insurance, or if your health insurance will not pay for services rendered by The Center for Wellness and Pain Care of Las Vegas, Inc., you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desks). Self-pay patients are expected to make payment in full at the time of service.

Benefits and Authorization

1. Insurance Plan Participation. We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.
2. Referrals. Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by The Center for Wellness and Pain Care of Las Vegas, Inc., it is your responsibility to be aware of this fact, and to obtain this referral.
3. Prior Authorization and Non-Covered Services. The Center for Wellness and Pain Care of Las Vegas, Inc. may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. The Center for Wellness and Pain Care of Las Vegas, Inc., as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and if so, whether or not prior authorization for treatment is required. If determine that a prior authorization is required, we will attempt to obtain such authorization on your behalf.
4. Out of Network Payments. If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to The Center for Wellness and Pain Care of Las Vegas, Inc., immediately.

Account Balances and Payments

1. Reassignment of Balances. If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non- payment issues. Balances are due within 30 days of receiving a statement.
2. Collection of Unpaid Accounts. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and /or an attorney, which may result in reporting to credit bureaus and /or legal action. The Center for Wellness and Pain Care of Las Vegas, Inc. reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay The Center for Wellness and Pain Care of Las Vegas, Inc. for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection cost.
3. Returned Checks. Returned checks will be subject to a $100 returned check fee.
4. Refunds. Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow for four to six weeks or your request to be processed. Send request to The Center for Wellness and Pain Care of Las Vegas, Inc., Attn Tashi Campbell, 311 North Buffalo Dr. Suttie A, Las Vegas, NV 89145.
5. Statements. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

Form Completion:

A charge of 40$ is due before the forms will be completed. (Disability, FMLA, Physician statements, etc.)

Workers Compensation/Auto Liability

1. Our office requires authorization prior to the initial visit. We will do our best to obtain the authorization prior to the visit. You are also required to provide us with Health Insurance coverage in case your workers' comp or auto denies the service. If you do not have health insurance, you may be asked to pay for the service advance. Any claims paid after we have received your payment will be refunded promptly.

Agreement and Assignment of Benefits: I have read and understand the financial policy of The Center for Wellness and Pain Care of Las Vegas, Inc., and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to The Center for Wellness and Pain Care of Las Vegas, Inc. I understand that I am financially responsible for all serviced I received from The Center for Wellness and Pain Care of Las Vegas, Inc. This financial policy is binding upon you and your estate, executor and /or administrators, if applicable.

Signature _____ Date _____

6. **Patient Authorization for Use and Disclosure of Protected Health Information: The Center for Wellness and Pain Care takes your privacy seriously. We will not disclose your medical records (Protected Heath Information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes The Center for Wellness and Pain Care to release your medical records to parties indicated. By signing below, I authorize The Center for Wellness and Pain Care, its agents and employee's ("Provider"), to use and /or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients")**

Name of Authorized Party: _____ Relationship: _____

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Name of Authorized Party: _____ Relationship: _____

Authorization to Disclose Protected Health Information Including HIV & AIDS Information: I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility of benefits on whether I sign this Authorization. In addition, I understand that Recipient may disclose the Records and that the Records may no longer be protected by the Federal Privacy Regulations. I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV related diseases and communicable disease related information. With respect to any communicable disease related information protected by State Confidentiality Rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law. Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal Confidentiality rules (42.C.F.R Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42.C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this

Patient Authorization for Use and Disclosure of Protected Health Information The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Right of Refusal I acknowledge that I have had the opportunity to review The Center for Wellness and Pain Care Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at The Center for Wellness and Pain Care. When my information is used, or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization. My written revocation must be submitted to the privacy officer whose address is listed below: Privacy Officer 6930 s. Cimarron Rd. Suite 260 Las Vegas, NV 89145 P: (702) 476-9700 F: (702)-476-9138

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original. Date of authorization expires (if any):

_____

_____

Signature _____ Date _____

Clinical Information

7. Clinical Information

Where is the worst area of your pain located, please list one area?

What is the main reason for your visit today?

Does the pain radiate? If yes, where?

Please list additional areas of pain:

Approximately, when did this pain begin?

What caused your current pain episode?

How did your pain episode begin?
○ Gradually ○ Suddenly

Since your pain began, how has it changed?
○ Decreased ○ Increased ○ Stayed the same

Weight:

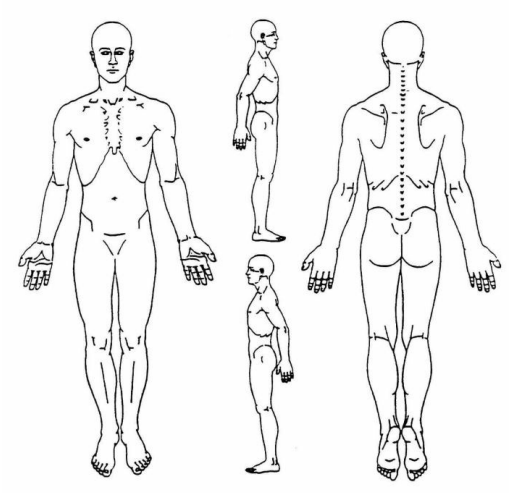
Height:

Do you Smoke?
○ Yes ○ No

Do you Drink?
○ Yes ○ No

8. USE THIS DIAGRAM TO INDICATE THE LOCATION AND TYPE OF YOUR PAIN

0 - Numbness 1 - Stabbing 2 - Burning 3 - Pins and Needles 4 - Aching



Mark the drawing with the following that best describe your symptoms.

9. Pain Description- Check all of the Following that describe your pain.

- ☐ Aching
- ☐ Throbbing
- ☐ Shock-Like
- ☐ Dull
- ☐ Tingling/Pins and Needlies
- ☐ Numbness
- ☐ Stabbing/Sharp
- ☐ Squeezing
- ☐ Tiring/Exhausting
- ☐ Spasming
- ☐ Cramping
- ☐ Hot/Burning
- ☐ Shooting

10. Pain Frequency

What word best describes the frequency of your pain?
○ Constant ○ Intermittent

When is the pain at its worst?
☐ Mornings ☐ During the Day ☐ Evenings ☐ Middle of the Night

11. In the Past Three Months have you developed any new:

☐ Balance Problems _____
☐ Bladder Incontinence _____
☐ Bowel Incontinence _____
☐ Chills _____
☐ Vomitting _____
☐ Difficulty Walking _____
☐ Fevers _____
☐ Nausea _____
☐ Numbness or Tingling? Where? _____
☐ Weakness? Where? _____

12. Diagnostic Tests, Imaging and Treatment

MRI of the _____	Date: _____	Facility: _____
X-Ray of the _____	Date: _____	Facility: _____
CT scan of the _____	Date: _____	Facility _____
EMG/VCV study of the _____	Date: _____	Facility: _____
Ultrasound of the _____	Date: _____	Facility: _____

Other Diagnostic Testing:
_____

○ I have not had any diagnostic test performed for my current pain complaints

Mark any of the following pain treatments you have undergone prior to today's visit
☐ Chiropractic ☐ Physical Therapy ☐ Spine Surgery ☐ Trigger Point Injections

If yes to any of the above, where?
_____

Epidural Steroid Injections: Check all levels that apply
☐ Cervical ☐ Thoracic ☐ Lumbar

Medical Branch Blocks or Facet Injections: Check all levels that apply
☐ Cervical ☐ Thoracic ☐ Lumbar

Radiofrequency Ablation: Check all levels that apply
☐ Cervical ☐ Thoracic ☐ Lumbar

Spinal Column Stimulator: Check One:
☐ Trial Only ☐ Permanent Implant

Other Treatments:
_____

☐ I have not had any prior treatments for my current pain complaints

13. Please list any prescribed medications you take:

	Name	Dosage	How long?
1			
2			
3			
4			

14. Medications Cont.

Are you taking a prescribed blood-thinner medication?
☐ Yes ☐ No

If yes, please check which one:
☐ Aggrenox ☐ Coumadin ☐ Effient ☐ Eliquis ☐ Lovenox ☐ Plavix ☐ Pletal ☐ Pradaxa ☐ Ticlid ☐ Warfarin ☐ Xarelto

Other:

_____

Who Prescribes your blood thinner medication? Name and Phone Number:

_____

15. Any allergies to medications? If yes, please specify below.

	Name of the drug	Type of reaction
1		
2		
3		

16. Other allergies or sensitivities (foods, pollen, animals, chemicals, latex, iodine, tape, shellfish, peanuts etc.):

_____

_____

_____

_____

17. Past Surgical History: Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

☐ I have never had any surgical procedures done

Gallbladder Removal _____ Appendectomy _____

Disectomy (Levels) _____ Laminectomy _____

Spinal Fusion (Levels) _____ Heart- Valve Replacement _____

Heart- Aneurysm Repair _____ Heart- Stent Placement _____

Joint- Shoulder _____ Joint- Hip _____

Joint- Knee _____ Vascular Surgery _____

Hemorrhoid Surgery _____ Hernia Repair _____

Thyroidectomy _____ Cesarean Section (Female) _____

Hysterectomy (Female) _____ Tonsillectomy _____

Laparoscopy (Female) _____ Ovarian (Female) _____

Please list any other Surgeries and Date:

_____

18. Mark all appropriate diagnosis as they pertain to your biological mother and father only

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizurues	S
Mother													
Father													

19. Health history - Gastrointestinal/Reproductive system

- ☐ Bowel Incontinence
- ☐ Acid Reflux (GERD)
- ☐ Gastrointestinal Bleeding
- ☐ Constipation
- ☐ Endometriosis
- ☐ Pelvic inflammatory disease
- ☐ PMS
- ☐ Menopause
- ☐ Fertility concerns
- ☐ Prostrate concerns
- ☐ Hysterectomy

If "other", please specify

_____

20. Health history - Head/Eyes/Ears/Nose/Throat

- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Migraines
- ☐ Other

If "other", please specify

_____

21. Health history - Cardiovascular/Hematologic

- ☐ Anemia/Bleeding Disorders
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Murmur
- ☐ Pacemaker/Defribillator
- ☐ Poor Circulation
- ☐ Stroke
- ☐ Other

If "other", please specify

_____

22. Health history - Circulatory and respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Valley Fever
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Night sweats
- ☐ Swollen ankles
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ High blood pressure
- ☐ Low blood pressure

If "other", please specify

_____

23. Health history - Musculo-skeletal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Broken/fractured bones
- ☐ Back pain
- ☐ Hip pain
- ☐ Leg pain
- ☐ Problems walking
- ☐ Chest, ribs, abdominal pain
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Bone or joint disease
- ☐ Other
- ☐ Amputation
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Joint Injury
- ☐ Osteoarthritis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid Arthritis
- ☐ Vertebral Compression

If "other", please specify

_____

24. Health history - Genitourinary/Nephrology

- ☐ Diabetes
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Bladder Infection(s)
- ☐ Dialysis
- ☐ Kidney Infection(s)
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Other

If "other", please specify

_____

25. Health history - Hepatic

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other

Please indicate if (active, inactive, unsure)

_____

26. Health history - Nervous system/Neuropsychologiical

- ☐ Spinal cord injury
- ☐ Chronic fatigue syndrome
- ☐ Numbness/tingling
- ☐ Twitching of face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral palsy
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Parkinson's disease
- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ CRPS/Reflex Sympathetic Dystrophy

If "other", please specify

_____

27. Have you received a pneumonia vaccination?

○ Yes ○ No

If yes, when?

_____

28. Activity

Do you exercise?
○ Yes ○ No

If yes, how many days per week?

_____

What type of exercise do you perform?
☐ Bicycle ☐ Cardio ☐ Strength ☐ Swimming ☐ Walking ☐ Other

Other: _____ How many times a day _____

Have you had two or more falls in the past year?
○ Yes ○ No

29. Social History

Are you capable of becoming pregnant?
○ Yes ○ No

If yes, are you currently pregnant?
○ Yes ○ No

Highest level of education obtained?
○ Grammar School ○ High School ○ College ○ Post-Graduate

Drug Use:
☐ A. Denies any illegal drug use. ☐ B. Currently using someone else's prescription medication.
☐ C. Formerly used illegal drugs (not currently using)

If yes to B. or C. above please list below:

_____

Have you ever abused narcotic or prescription medications?
○ Yes ○ No

Which ones:

_____

Are you working?
☐ Yes ☐ No ☐ Student ☐ Retired

Are you on disability?
○ Yes ○ No

30. Pain Level: For each question, please indicate your response by selecting a number from 0 to 10.

My Current Pain is::
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

During the past week, the best my pain has been is:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

During the past week, the worst my pain has been is:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

During the past week, my average pain has been:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

During the past 3 months, my average pain has been:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

31. Your Feelings: (During the past week I have felt)

Afraid:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Depressed:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Tired:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Anxious:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Stressed:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

32. Your clinical outcomes: (During the past week I have felt)

I have trouble sleeping:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

I have trouble feeling comfortable:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

I was less independent:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

I was unable to work (or perform normal tasks)
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

I needed to take more medication:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

33. Your activities: (During the past week I was NOT able to)

Go to the store:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Do chores in my home:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Enjoy my friends and family:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Exercise (include walking):
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Participate in my favorited hobbies:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

34. Review of Symptoms

Constitutional:
☐ Chills ☐ Difficulty Sleeping ☐ Easy Bruising ☐ Excessive Sweating ☐ Excessive Thirst ☐ Fatigue ☐ Fevers ☐ Low Sex Drive
☐ Night Sweats ☐ Tremors ☐ Unexplained Weight Gain ☐ Unexplained Weight Loss ☐ Weakness

Eyes:
☐ Visual Changes ☐ Blurry Vision ☐ Vision Loss

Ears/Nose/Throat/Neck:
☐ Dental Problems ☐ Difficulty Hearing ☐ Earaches ☐ Hay Fever/Allergies ☐ Nosebleeds ☐ Recurrent Sore Throats
☐ Ringing in Ears ☐ Sinus Problems

Cardiovascular/Respiratory:
☐ Bleeding Disorder ☐ Chest Pain ☐ Deep Vain Thrombosis ☐ Fainting ☐ High blood Pressure ☐ Irregular Heartbeat
☐ Lightheadedness ☐ Shortness of breath ☐ Swelling in the feet ☐ ☐ Cough ☐ Wheezing ☐ Shortness of breath Exertion/Effort
☐ Shortness of Breath at Rest

Gastrointestinal:
☐ Abdominal Cramps ☐ Acid Reflux ☐ Constipation (Less than 3 bowel movements a week) ☐ Epigastric Pain
☐ Coffee Ground Appearance in vomit ☐ Dark and Tarry Stools ☐ Diarrhea ☐ Hernia ☐ Vomiting

Musculoskeletal:
☐ Back Pain ☐ Joint Pain ☐ Joint Stiffness ☐ Neck Pain ☐ Myalgia ☐ Muscle Weakness ☐ Shoulder Pain

Neurological:
☐ Headache ☐ Dizziness ☐ Fainting ☐ Instability when walking ☐ Numbness/Tingling ☐ Tremors ☐ Seizures

Psychiatric:
☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems ☐ Suicidal Thoughts ☐ Suicidal Planning

Genitourinary/Nephrology
☐ Blood in Urine ☐ Decrease Urine (flow, frequency, volume) ☐ Flank Pain ☐ Painful Urination

I certify that the above information is accurate, complete, and true. I authorize CWPC and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for CWPC to retrieve my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review CWPC's Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I authorize the CWPC to release my Protected Health Information (medical records) in accordance with it's Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also Authorize CWPC to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that CWPC will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website. In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make a payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both agency fees and attorney fees will increase the balance you owe.

Signature _____ Date _____