PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Date of Birth_____ Preferred Name (if different from above): _____

Address: _____ Social Security #: _____

City, State, Zip: _____Cell #:_____ Home or Other #:_____

Primary Physician First and Last Name _____ Primary Physician Phone #:_____

Referring Physician's First and Last Name (if different than above): _____

Patient E-Mail Address:_____How did you hear about us? _____

Gender: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Gender category not listed _____
☐ Choose not to disclose

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Choose not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Korean ☐ French ☐ Arabic ☐ Other not listed _____

Pharmacy Name: _____Phone number: _____

Address: _____

RESPONSIBLE PARTY INFORMATION- COMPLETE BELOW IF NOT SELF

Responsible Party: ☐ Parent ☐ Guardian ☐ Other _____ ☐ Check here if address and telephone information is same as patient

(if patient is a minor, the responsible party cannot be anyone other than the person completing this form.)

Responsible Party Name: (Last)_____(First)_____(MI) _____

Date of Birth: _____ Phone Number: _____ Gender: ☐ Female ☐ Male

Address:_____ City, State, Zip: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

Primary insurance: _____ **Subscriber Name:** _____ **ID:** _____ **Group:** _____

Secondary insurance: _____ **Subscriber Name:** _____ **ID:** _____ **Group:** _____

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____Emergency contact relationship to patient:_____

Is your visit today related to an injury that occurred while at work? NO YES I Don't Know

Is your visit today related to an auto, motorcycle or ATV accident? NO YES I Don't Know

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____ Date: _____

Printed name of patient or personal representative:_____ Relationship to patient: _____

Notice of Privacy Practice

_____(**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

_____(**Patient/Representative initials)** Some messages relevant to your visit may be sent regardless of explicit consent, including instructions or communications directly related to your care. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. For other types of communications, I consent to receiving, by telephone call, text message, or voicemail transmission, communications by or on behalf of the practice/clinic at the email, telephone number or text address I have provided in my patient record. I also consent to receiving such communications to any email, text address or telephone number forwarded or transferred from that address or telephone number. Other healthcare communications may include, but are not limited to, healthcare communications to family or designated representatives regarding my treatment or condition, reminder messages to me regarding appointments for medical care, communications regarding insurance or billing or requests for feedback about my visit via satisfaction surveys and/or public-facing reviews. I authorize and acknowledge that these instructions and other communications may be transmitted using an automated system for the selection or dialing of telephone numbers or the playing of prerecorded messages and may be made by the practice/clinic or someone calling on their behalf even if my phone number is listed on any federal or state "do not call" registry. To the extent these instructions and other communications could be deemed telephonic sales calls, solicitations or advertisements, I consent to receiving them. I understand that I am not required to consent directly or indirectly to communications in order to receive healthcare services.

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship. My consent to access the location's Electronic Health Record's Patient Portal shall be considered separate and apart from the consent in this form *(section: Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications).*

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and

protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written

authorization from me or my legal representative unless otherwise permitted or required by law.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Financial Agreement

I acknowledge, that as a courtesy, Texas Joint Institute, PLLC (practice), may bill my insurance company for services provided to me. I agree to pay for services not covered or covered charges not paid in full including but not limited to, any copayment, co-insurance and/or deductible, or charges not covered by insurance. **Third Party Collection.** I acknowledge the practice may use the services of a third-party business associate or affiliated entity a Central Billing Office (CBO) for medical account billing and servicing. **Assignment of Benefits**. I hereby assign to the practice any insurance or third party benefits available for healthcare services provided to me. I understand the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Texas Joint Institute, PLLC by the Medicare or Medicaid program.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____ Date: _____

Printed name of patient or personal representative:_____ Relationship to patient: _____

NOTICES TO PATIENTS

Physician's Assistant Certified/Nurse Practitioner Consent- This practice is proud to employ Certified Physician Assistants and Nurse Practitioners, collectively known as Advanced Practice Professionals, or APPs that assist the surgeons with the delivery of orthopedic medical care. I acknowledge a Non-Physician Practitioners is not a physician. The state medical board licenses APPs, under the supervision of a physician, to diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care and assist during surgery. "Supervision" does NOT require the constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. **Texas Joint Institute**, its employees, affiliates, or designated business associate may bill your insurer or plan administrator fiduciary separately to obtain payment. A list of services may be provided that are within the scope of practice for APPs upon request. I acknowledge the above information and consent to the services of APPs for my health care needs. I understand that at any given time, I can request to see the physician instead of the APP.

DISCLOSURE OF PHYSICIAN OWNERSHIP - To better serve you, some of the physicians at Texas Joint Institute have ownership interests in various healthcare facilities in North Texas. These facilities and our physicians are committed to providing clinical services to our patients in a safe, high-quality environment. Their ownership interest in these facilities provides them with a voice in administration and in clinical operational policies. This involvement helps ensure the highest level of patient care and customer service. **As our patient, you always have the option of utilizing an alternate health care facility. Please ask one of our representatives for a list of alternate facilities. The physicians of Texas Joint Institute welcome any questions regarding this aspect of their patient's care.**

The following is a current list of facilities (individually a 'Facility') with whom one or more of our surgeons have an ownership or financial interest:

- Baylor Scott & White Surgical Hospital Sherman, Eminent Medical Center, Medical City Orthopedic & Spine Surgery Center Dallas, Baylor Scott & White Uptown, Live Oak Surgery Center, Medical City Dallas Surgery Center, Texas Health Surgery Center Addison, Medical City Surgery Center Allen.

As many of our surgeons are renowned for their skill and outcomes, they are frequently sought out by medical device manufactures and other healthcare companies to participate in research, development and education initiatives. These organizations realize that physicians are important contributors to the ongoing advancements in healthcare. As such, these companies sometimes offer consulting, teaching and investment opportunities, which is a common industry practice. Some of these healthcare companies may be used in your medical treatment and may be out-of-network with your insurance plan. Please review Texas Senate Bill 1264 (SB 1264) for your rights regarding balance billing. This practice adheres to SB 1264. However, a physician's decision as to which product, device or provider, if any, to be used in your treatment and care is made upon the physician's clinical judgement and what is in your best medical interest.

The following is a current list of healthcare-related organizations (individually a 'Company') with whom one or more of our surgeons have a consulting agreement or ownership interest:

- ZimmerBiomet, Stryker, Kyocera, Total Joint Orthopedics, Depuy Synthes, Smith & Nephew, Poleyn, Inc. Solenic Medical, Surgical Automations.

We hope this helps clarify the nature of our ownership with other healthcare companies in orthopedic care. We are very proud to be leaders in technological innovation that we believe ultimately will result in better patient care.

1. During the course of our physician/patient relationship, I may refer you to a Facility or one or more other physicians who provide specialized medical services or refer to the use of a Company product, device or provider.
2. I want to inform you that I am aware of the services, devices and/or products provided at a Facility or a Company when I have an ownership interest in it. Further, if I refer you to another physician for specialized medical services, that physician may also have an ownership or financial interest in a Facility or a Company.
3. I am providing this information to help you make an informed decision about your healthcare. You have the right to choose your health care provider. Therefore, you have the option to use a healthcare facility other than a Facility (previously defined) to whom I might refer you from time to time.
4. I will not be treating you differently if you choose to obtain healthcare at a facility other than a Facility and, if you desire, I will be happy to provide you information about alternative healthcare facilities.

If you have any questions, please do not hesitate to ask. We welcome you as a patient and we value our relationship with you. By signing below, you acknowledge that you have read and understand this notice and that you are aware of an ownership or financial interest in a Facility or a Company and that this notice was provided to you prior to any referral of you to a Facility, a Company or another physician.

Print Name	Signature	Date

Texas Joint Institute – Office Policies

Appointments & Office Hours

- Our office hours are 8:00am to 12:00 pm and 1:30pm to 5:00pm Monday through Friday. The lobby may be closed at lunch depending on the location.
- For urgent matters after 5:00pm, please call our main phone number, 972-566-5255 to reach our answering service**. In an emergency, call 911 or go directly to the nearest emergency room**
- **We can only see you for one condition per visit due to increased regulated documentation requirements.**

Financial Policy

- ***Payment is due at time of service. We accept cash, Visa, MasterCard, American Express and Discover.***
- For patients with health insurance, co-payments, co-insurance and/or deductibles will be collected at the time services are rendered. Your insurance policy is a contract between you and your insurance company. In the event of denials, errors, service caps, policy exclusions or non-covered services, the patient is responsible for payment of all services rendered. ***It is the patient's responsibility to know whether our providers are in-network with their insurance plan*****.** Patient will be responsible for any charges incurred whether in or out of network. Please notify the office of any changes in insurance coverage before services are rendered.
- If you do not have insurance, the office staff can provide you with a cost for services which is due in full, at time of service.
- Any account balance you may have must be paid in full prior to scheduling surgery.
- We reserve the right to report any unpaid balances greater than 120 days old to a collection agency for payment recovery.
- If you have multiple primary insurance policies, you are responsible for coordinating primary vs. secondary with your insurance companies. Failure to do so will result in claim denials and refusal to pay.

Identity Verification

- If you would like us to bill your insurance carrier, you must present a valid insurance card AND identification prior to being seen at check-in **at every visit.**

Fees for Services

- Medical records requests are processed by a HIPAA-complaint third party vendor. We may ask for a $5 fee for your x-rays on disk.
- Disability, FMLA, employer-related or legal forms are $25.00. **(**Our physicians do NOT perform complete disability evaluations for military or worker's compensation MMI assessments.)**
- Other fees: Returned check fee: $35.00, Notarized Forms (including Temporary Handicap Placards): $10.00

Medication Refill & Narcotics Policy

- All requests for prescriptions must be made 48 hours in advance. For non-narcotic medications, please have your pharmacy call our office to request your refill. For narcotic or controlled substances, you will need to request refills via our refill line and allow us 48 hours to process. Medication refills are only addressed during office hours. **Narcotic prescriptions must be picked up in person or filled via e-prescribing and cannot be mailed or called in. Narcotic Prescriptions will only be written or submitted during normal business hours and we CANNOT accommodate walk-in requests.** Per compliance with State regulations, this practice verifies your prescription history against the Texas PMP database. By signing below, you are authorizing us to view your external Rx history.

I have read and understand the Office Policies and I agree to accept responsibility as described above. I also understand the Policy may be amended from time to time by the practice.

Printed Name	Signature	Date

Motor Vehicle Accident (MVA) Policy Acknowledgement

Are you here today because you were injured in an MVA? If no, you may skip this page.
If yes, please continue.

1. **I (Please circle) DO or DO NOT have or plan to have a legal claim involving my MVA.**

2. **I have (Please Circle One):**

MEDICARE INSURANCE COMMERCIAL INSURANCE NO INSURANCE I DON'T KNOW

You here today due to injuries sustained in a motor vehicle/cycle/ATV accident (MVA).

There are complex and challenging rules that insurance companies assign to MVA claims that often leave our doctors without any payment from insurance for providing care that is related to injuries sustained in an MVA. We realize this can be frustrating for you, the patient, when often times, you were injured through no fault of your own.

We need to share some important information about your financial responsibility for your MVA-related medical care at Texas Joint Institute. We do not recognize MVA or litigation claims, nor do we accept any letters of payment from a third party. We do not accept or bill auto/motorcycle/ATV insurance with medical payments coverage. We regret that we are not able to confer with attorneys or defer payment obligations while a case settles. We will provide you with receipts and the documentation you will need to submit for reimbursement**. If you have an active legal claim surrounding your MVA incident, *we can bill your insurance IF you provide your attorney with the information to verify that we are part of the subrogation. You will need to provide this information to us.***

If you do not have an attorney involved in your situation and you have commercial (non-government insurance) such as BCBS or Aetna, we will bill your insurance for your care. However, should they deny your claims for any reason you will be responsible for all charges and fees related to our care for you as a result of your MVA.

If you have MEDICARE, we will have you sign an Advanced Beneficiary Notice (ABN) form. This is your acknowledgement that should Medicare not pay us for the care we provided as a result of your MVA, you will be responsible for paying the charges. If when we verify your Medicare benefits, they have a third-party insurance policy (motor vehicle insurance) showing as primary, this means that they will not pay claims until all benefits for that 3rd party insurance are exhausted. If this is the case, we will collect up front today and for any future care related to this incident until MEDICARE releases the 3rd party liability claim. If we are eventually paid by insurance, we will refund any amounts due back to you.

Please read and sign acknowledgement below.
I have read and understand this MVA-related financial policy. I further understand and agree that my failure to follow this Financial Policy may result in Texas Joint Institute terminating my patient-physician relationship.

Patient Signature (parent/guardian if patient under 18)	Patient Name (Please Print)	Date

Work-Related Injury

Did your injury occur on or near your office/jobsite or while working for your employer? If yes or you are unsure, be sure to formally notify your employer's HR department or your supervisor to inquire about creating a worker's compensation claim. If your claim is approved, you may be provided medical care for your injury, free of charge. If you wait too long to notify your employer about your injury, you may lose your ability to file a claim and receive benefits.

If you believe your injury may be eligible to be covered under your employer's workers compensation policy, it is your responsibility to notify us at your **first visit**. If you fail to notify our office at your first visit, *you will be responsible for paying for any related, previously billed charges and any further charges up to and if we obtain payment from the work comp insurance company.* If we receive payment from the workers' comp insurance company after you have paid for services, we will issue you a refund for the claim(s) paid.

I am here today due to injuries sustained at/or related to work. (please circle one) YES / NO / UNSURE

IF NO – Sign DECLINATION Below:
I have read and fully understand this form and by my signature, I am attesting that my current medical condition/injury did not happen while at work (place of employment) or while performing work-related duties.

_____	_____	_____
Patient Signature (parent/guardian if patient under 18)	Patient Name (Please Print)	Date

IF YES – Please sign and complete below.
My injury occurred while at my place of employment and/or performing work-related duties.

_____	_____	_____
Patient Signature (parent/guardian if patient under 18)	Patient Name (Please Print)	Date

If Yes, please complete below:

Employer: _____ Name of Supervisor/HR Director:_____
Supervisor/HR Phone: _____ Email: _____
What was the date your injury occurred? _____
Social Security # (Required if you are under worker's comp coverage): _____

Name of Worker's Compensation insurance Company (ask your employer): _____
Accident Claim #: _____ Adjuster's Name: _____
Adjuster's phone: _____ Adjuster's Email_____

What are we seeing you for today? _____ **Which side is affected?** Right Left Both

Was this the result of an accident/injury? No / Yes **If yes, please describe <u>in detail</u> what happened:**

_____

Date pain started/injury occurred? _____ *** **HEIGHT:** _____ **WEIGHT:**_____***

Have you had prior surgery at site of pain? No Yes **Type of surgery and when** _____

Have you had x-rays, MRI, CT or other imaging done for this issue? Yes/No If yes, where: _____

Are you having any of the following?:

- ○ Cracking/popping
- ○ Decreased mobility/range of motion
- ○ Instability/falls
- ○ Stiffness/locking/catching
- ○ Numbness
- ○ Night pain/awakening
- ○ Swelling
- ○ Weakness

What makes it worse?:

- ○ Bending (pain at the joint)
- ○ Kneeling (unable to apply weight/pressure on knees due to pain)
- ○ Stairs
- ○ Standing
- ○ Walking
- ○ Sitting
- ○ Lifting
- ○ Overhand reaching
- ○ Other: _____

The pain is…?:

- ○ Sharp
- ○ Dull
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Constant
- ○ Intermittant
- ○ Radiating

Are you here today due to a fracture or recent traumatic injury? Yes / No *****If yes, please skip to next page.*****

These next questions will help your provider formulate a treatment plan and could also help us when contacting your insurance company for authorizations/pre-certifications:

What activities are you limited in doing due to pain?

- ○ Dressing
- ○ Walking more than 25 feet
- ○ Using stairs
- ○ Housework
- ○ Exercise
- ○ Getting up from a seated position
- ○ Driving
- ○ Outdoor activities
- ○ Sports
- ○ Raising arms

For the issue you are being seen for today:

Have you had cortisone injections? Yes No

If yes, when was last injection and did it help? _____

Have you had a gel or hyaluronic acid injection? Yes No

If yes, when was last injection and did it help? _____

Have you tried physical therapy? Yes / No

If yes, for how long? _____

Have you tried a home exercise program? Yes No
If yes, for how long? _____

Have you tried braces/assistive devices (cane, walker, etc.)? Yes / No
If yes, what kind? _____

For this specific issue, have you tried pain and/or anti-inflammatory medications? Yes / No. What meds? _____

Medications:

- ○ Check Here if you are not currently taking any medications

Medication	Dosage	Directions/How Taken:

Surgical History:

- ○ Check Here if NO surgical history

Surgery	Date or Year

Immediate Family History:

- ○ Check here if there is NO contributory family history

Condition	Please circle if applicable
Diabetes	Mother / Father / Brother or Sister / Grandparents
Stroke	Mother / Father / Brother or Sister / Grandparents
Lung Disease	Mother / Father / Brother or Sister / Grandparents
Hemophilia	Mother / Father / Brother or Sister / Grandparents
Cancer: What kind _____	Mother / Father / Brother or Sister / Grandparents
Malignant Hyperthermia	Mother / Father / Brother or Sister / Grandparents
Heart Disease	Mother / Father / Brother or Sister / Grandparents
Hypertension (High blood pressure)	Mother / Father / Brother or Sister / Grandparents

Allergies:

- ○ Check here if NO allergies

Environmental Allergies	Drug Allergies	Food Allergies
○ Latex		
○ Adhesives		
○ Metals: which?		

Have you ever had or currently have any of the following (mark all that apply)?

- ○ **Check here if you have no medical history**

- ○ **HIV**
- ○ **Tuberculosis**
- ○ **Hepatitis**
- ○ Alcoholism
- ○ Alzheimer
- ○ Anemia
- ○ Angina
- ○ Asthma
- ○ **Atrial Fibrillation (A Fib)**
- ○ **Autoimmune Disorder**
- ○ Benign Prostatic Hypertrophy
- ○ Cancer
- ○ **Congestive Heart Failure**
- ○ COPD
- ○ **Coronary Artery Disease**
- ○ Crohn's Disease
- ○ Cystic Fibrosis
- ○ Depression
- ○ Diabetes

- ○ Blood Clot/Clotting Disorder
- ○ Fibromyalgia
- ○ Gallbladder Disease
- ○ GERD
- ○ Gout
- ○ **Heart Attack**
- ○ **Heart Murmur**
- ○ High Cholesterol
- ○ **High Blood Pressure**
- ○ Ulcerative Colitis
- ○ Juvenile Rheumatoid Arthritis
- ○ **Kidney Disease**
- ○ **Liver Disease**
- ○ Lyme Disease
- ○ Migraine Headaches
- ○ Multiple Sclerosis
- ○ **Obesity**
- ○ Osteoarthritis
- ○ Drug Abuse (illegal or Rx)

- ○ Osteoporosis
- ○ Parkinson Disease
- ○ Peptic Ulcer Disease
- ○ Psoriasis
- ○ Peripheral Vascular Disease
- ○ Rheumatoid Arthritis
- ○ Scoliosis
- ○ Seizure Disorder
- ○ **Sleep Apnea**
- ○ Stroke
- ○ Systemic Lupus Erythematous
- ○ Spinal Stenosis
- ○ Spondyloarthropathy
- ○ Traumatic Arthritis
- ○ Thyroid Disease
- ○ Valvular Disease
- ○ Other:

Social History:

Are you currently residing in an assisted-living, skilled-nursing or inpatient rehab facility? Yes / No

Any chance you may be pregnant? Yes / No / N/A

Have you fallen in the last year? Yes / No If yes, did you break a bone? Yes / No

Are you currently under the care of a pain management physician? Yes /No

Are you currently under hospice care? Yes / No

Have you had your flu shot in the past year? Yes / No

Do you have an advance directive? Yes / No

Females, have you had a mammogram in the past year? Yes / No

Activity Level: Low / Moderate / Active Do you live: alone / with family

Never Smoked / Current Smoker / Former Smoker How long ago did you quit? _____

Do you consume alcohol? Yes / No Frequency? Daily / Weekly / Socially

Have you used illegal drugs? Yes / No Type: _ _ _ _ _ _ _ _ _ _ _ _ Use currently? Yes / No