

Cvl;;Patient Name: _____ Age: _____ DOB: _____

Date: _____

PLEASE READ CAREFULLY AND ANSWER EACH QUESTION, DO NOT LEAVE ANY QUESTIONS UN-ANSWERED:

1. Has any of your contact information changed since your last visit? ____ Yes ____ No

If Yes, what changed? _____

2. Has your insurance changed since your last visit? ____ Yes ____ No

If Yes, what changed? _____

3. What is your NUMBER ONE complaint for today's visit? (What area of your body hurts the most, pick one)

4. Have you participated in Physical Therapy or Chiropractic manipulations since your last visit? ____ Yes ____ No

If yes, Where: _____ When _____

5. Have you had any IMAGING such as X-ray, MRI, or CT scans since your LAST visit? ____ Yes ____ No

If yes, where: _____ Phone Number (**REQUIRED**) _____

Please call and have them fax the results to 770-370-8358. We DO NOT accept disc!

6. Did you have any Neck, Back, Knee, Hip, or Other injections since your last visit (here or elsewhere)? ____ Yes ____ No

If Yes, What percentage of relief did you get from the injection? _____ date of procedure: _____

7. Have you been treated for any INFECTIONS since your last visit? ____ Yes ____ No

What were you treated for? _____ Where: _____ When: _____

8. Have you been admitted to a hospital or been to an ER since your last visit? ____ Yes ____ No

What were you treated for? _____ Where: _____ When: _____

On a scale of 1 to 10, with 1 being the least amount and 10 being the greatest amount...WRITE ONE NUMBER ONLY!!!

9. What is your CURRENT pain score? _____

10. What is your Average day-to-day Pain score? _____

11. What is your pain score AFTER you have taken your medication? _____

Circle any of the following NSAIDS you are ALLERGIC to... Aspirin Motrin Advil Aleve Ibuprofen

Patient Signature: _____ **Printed Name:** _____

-----**For Office Use Only**-----

BP1: ____/____ BP2: ____/____ HR: ____ O2: ____ Temp: ____ HT: ____ WT: ____

UDS Positive for: THC, COC, AMP, OPI, MAMP, PCP, BAR, BZO, MTD, MDMA, OXY, BUP NEGATIVE

URGENT Symptoms: Chest Pain ____ Headache ____ Dizziness ____ N/V ____ Shortness of Breath ____ Blurry Vision ____

Patient Questionnaire

Please Check Yes or No

Frequency of urination?	☐ YES	☐ NO
Urgency of urination?	☐ YES	☐ NO
Pain or burning when passing urine?	☐ YES	☐ NO
Unable to empty bladder/ pass urine?	☐ YES	☐ NO
Constant feeling that you have to urinate?	☐ YES	☐ NO
Do you have bloody or cloudy urine?	☐ YES	☐ NO
Pain in low back, sides, or flanks?	☐ YES	☐ NO
Pain or pressure in lower abdomen/pelvic area?	☐ YES	☐ NO
Sores/Bumps around your genitals, thighs, or butt?	☐ YES	☐ NO
Weird discharge from your vagina or penis?	☐ YES	☐ NO
Itching, pain, swelling, or irritation near male/female parts	☐ YES	☐ NO
Do you have any flu like symptoms (body aches, fatigue)?	☐ YES	☐ NO
Have you been told by a sex partner that they have an STD?	☐ YES	☐ NO
Unprotected sex?	☐ YES	☐ NO
Multiple sexual partners?	☐ YES	☐ NO

Patient Name: _____

Patient Signature: _____

DATE: _____

Patient Disclosures, Waivers, and Acknowledgements

1. I shall come to my appointment on time and, from time to time, I should expect delays in the office, which may be longer than normal. I shall arrive no earlier than 10 minutes before, and no later than 15 minutes of the time of the appointment.
2. I shall not be rude or disrespectful to other patients or employees of the clinic.
3. I shall update my contact, address, and insurance information with the clinic, ASAP if there are any changes.
4. I shall pay any amounts due on my account that the insurance has not paid. I understand that I WILL NOT be seen by the doctor if I continue to have an outstanding balance without making payment arrangements. I am personally responsible for financial matters related to receiving care from this clinic.
5. I shall pay my co-pay, co-insurance, and deductibles at the time of check-in.
6. I am aware that I must notify the clinic at least 24 hours in advance if I cancel my scheduled appointment, otherwise I must pay a \$45. no show fee.
7. I shall ask questions related to my pain only during my office visit, not by phone or email after leaving the office as the response will be delayed.
8. I expect the office to return my inquiry within 24-48 hours after the initial call and I must not call repeatedly for the same subject. I authorize the clinic to communicate with me by phone, text and or email. I must update my phone number and email if they change.
9. I will follow the instructions and course of treatment as prescribed to me by the doctor.
10. I understand that if I do not follow the instructions given to me, I may be discharged from the clinic or be denied care.
11. I agree that all communication will be conducted with me via text message or email in Tebra or any medical records system that the clinic may utilize. It's my responsibility to update my contact information, including, my emergency contacts.
12. I agree, know and am responsible to notify the doctor if I have been in an accident, that could or would potentially impact my health, if I have retained an attorney for any accidents, if I am pregnant, if I am receiving pain treatments elsewhere, and I shall notify my insurer if I have a personal injury case for which a lawyer or law firm has been retained.
13. I am responsible for getting medical office visits approved from my insurance carrier.
14. If I am accompanied by anyone under the age of 18, I assume full responsibility for their behavior and safety while in the clinic.

Patient Name: _____

Patient Signature: _____

Date: _____

OPIOD RISK TOOL

ATTENTION !!! ATTENTION!!!

Circle Each Number That Applies	I'm A Female	I'm A Male
Family History of Substance Abuse		
Alcohol	1	3
Illegal Drugs	2	3
Prescription Drugs	4	4
Personal History of Substance Abuse		
Alcohol	3	3
Illegal Drugs	4	4
Prescription Drugs	5	5
Age Between 16-45 years	1	1
History of Preadolescent Sexual Abuse	3	0
Psychological Disease		
ADD, OCD, Bipolar, Schizophrenia	2	2
Depression	1	1
Scoring Totals		

PATIENT NAME: _____ DATE : _____