

| |
|------------------|
| Preferred Office |
| Trevoze _____ |
| Chalfont _____ |
| Marlton NJ _____ |



DATE: _____ (PLEASE PRINT CLEARLY)

PATIENT NAME: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

GENDER: MALE FEMALE OTHER MARITAL STATUS: SINGLE MARRIED WIDOW DIVORCED SEPARATED

EMAIL ADDRESS: _____

PHONE #: _____ SECONDARY PHONE #: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

E-MAIL: _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

EMERGENCY CONTACT: _____

EMERGENCY CONTACT NUMBER: _____ RELATIONSHIP: _____

REFERRING PHYSICIAN: _____ PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER ID: _____ GROUP: _____

IF OTHER THAN THE PATIENT, PLEASE TELL US ABOUT THE POLICY HOLDER

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S PHONE #: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S EMPLOYER: _____ EMPLOYER PHONE #: _____

STREET ADDRESS OF POLICY HOLDER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER ID: _____ GROUP: _____

**IF YOU ARE RECEIVING WORKMANS' COMPENSATION BENEFITS OR AUTO BENEFITS, PLEASE COMPLETE BELOW
ALONG WITH YOUR PERSONAL INSURANCE ON PAGE 1**

WORKMAN'S COMPENSATION INFORMATION

NAME OF INSURANCE CO _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____

DATE OF INJURY _____ CLAIM NUMBER _____ ADJUSTER NAME AND # _____

NCP NUMBER _____ WCAIS DOCUMENT _____

CITY AND STATE WHERE INJURY OCCURED _____

EMPLOYER NAME AND ADDRESS _____

APPROVED INJURIES _____

YOU HAVE AN ATTORNEY YES _____ NO _____

PLEASE PROVIDE ATTORNEY INFORMATION _____ PHONE # _____

AUTO ACCIDENT INFORMATION

NAME OF INSURANCE CO _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____

DATE OF INJURY _____ CLAIM NUMBER _____

ADJUSTER NAME _____ PHONE # _____ FAX # _____

CITY AND STATE WHERE INJURY OCCURED _____

APPROVED INJURIES _____

ATTORNEY YES _____ NO _____ ATTORNEY NAME _____

ATTORNEY ADDRESS _____ PHONE # _____

INJURIES SUSTAINED AND APPROVED FOR REATMENT: _____

Signature Page for Financial Responsibility

I/WE UNDERSTAND THAT I/WE ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I/WE AGREE TO ACCEPT TOTAL RESPONSIBILITY FOR ALL DAMAGES AND AGREE TO PAY AT THE TIME SERVICES ARE RENDERED, OR NOT LATER THAN 30 DAYS OF SUCH SERVICES. IN THE EVENT OF DEFAULT, I/WE AGREE TO PAY ALL COSTS OF THE COLLECTIONS, INCLUDING ATTORNEY FEES.

Date

Patient or Responsible Party Signature

PRACTICE POLICIES

DISCLOSURE NOTICE: Any legal claims or civil actions, including, but not limited to, a claim for medical malpractice in any way related to your office visit /procedure, and medical services provided Fox Chase Pain Management dba Delaware Valley Pain and Spine Institute and its employees, shall be brought solely in the Courts of Bucks County, in the Commonwealth of Pennsylvania.

AT DVPSI, OUR MISSION IS TO DELIVER HIGH-QUALITY MEDICAL CARE. TO HELP US ACHIEVE OUR GOAL AND SERVE YOU BETTER, WE REQUEST THAT ALL PATIENTS ADHERE TO THE FOLLOWING ADMINISTRATIVE POLICIES. YOUR COOPERATION IS GREATLY APPRICIATED AND HELPS ENSURE A SMOOTH EXPERIENCE FOR EVERYONE. PLEASE BE AWARE THAT NON-COMPLIANCE WITH THESE POLICIES MAY RESULT IN ADDITIONAL FEES AND DELAYS IN YOUR APPOINTMENT. THANK YOU FOR YOUR UNDERSTANDING AND COOPERATION.

To ensure the highest quality and continuity of care, our practice utilizes a collaborative care model. This means that, in addition to seeing your physician, you may also be scheduled with one of our advanced practice providers (nurse practitioners or physician assistants) as part of your treatment plan.

Our midlevel providers work closely with the physicians and are highly trained to evaluate, manage, and treat your condition. This team-based approach allows us to provide timely appointments, thorough follow-up care, and comprehensive treatment.

By receiving care within our practice, you acknowledge and agree to participate in this collaborative model, which may include visits with both your physician and our advanced practice providers.

HIPAA

THIS IS A MEDICAL CONSENT REQUIRED BY LAW TO ENSURE THAT YOU ARE AWARE OF THE WAYS IN WHICH DELAWARE VALLEY PAIN AND SPINE MAY USE YOUR HEALTH INFORMATION FOR TREATMENT.

YOUR MEDICAL HEALTH INFORMATION IS CONFIDENTIAL. ALL INFORMATION PERTAINING TO YOUR HEALTH AND THE CARE THAT YOU RECEIVE, OR PAYMENT FOR THAT CARE, IS CONSIDERED CONFIDENTIAL AND PROTECTED BY DELAWARE VALLEY PAIN AND SPINE INSTITUTE. THE USE AND DISCLOSURE OF MEDICAL INFORMATION IS DESCRIBED IN DETAIL IN OUR PRIVACY NOTICE. THIS IS POSTED FOR REVIEW IN OUR OFFICES.

USING AND DISCLOSING INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. DELAWARE VALLEY PAIN AND SPINE BY LAW IS AUTHORIZED TO USE AND DISCLOSE YOUR MEDICAL INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. DELAWARE VALLEY PAIN AND SPINE IS A PARTICIPANT IN VARIOUS HEALTH INFORMATION EXCHANGES WHERE WE DISCLOSE YOUR HEALTH INFORMATION, AS PERMITTED BY LAW, TO OTHER HEALTHCARE PROVIDERS FOR YOUR TREATMENT, OR FOR PAYMENT OR OTHER HEALTHCARE OPERATIONS PURPOSES. FOR EXAMPLE, WE CAN SHARE THE NECESSARY INFORMATION IN ORDER TO BILL YOUR INSURER. PLEASE REFER TO THE PRIVACY NOTICE FOR ADDITIONAL INFORMATION.

RESTRICTIONS ON HOW DELAWARE VALLEY PAIN AND SPINE USES AND DISCLOSES YOUR PERSONAL HEALTH INFORMATION. YOU CAN ASK DELAWARE VALLEY PAIN AND SPINE TO RESTRICT THE MEDICAL INFORMATION USED OR SHARED ABOUT YOU FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. WE MAY NOT BE ABLE TO AGREE WITH YOUR REQUEST, AND WILL TELL YOU SO. IF WE DO NOT AGREE WITH YOUR REQUEST, WE ARE BOUND TO FOLLOW IT.

YOUR RIGHT TO REVOKE YOUR CONSENT. YOU CAN REMOVE YOUR CONSENT AT ANYTIME, AS LONG AS YOU DO SO IN WRITING.YOUR REMOVAL OF THE CONSENT WILL NOT APPLY TO ANY USE OR DISCLOSE BY DELAWARE VALLEY PAIN AND SPINE PRIOR TO THE REQUEST TO REMOVE THE CONSENT. THIS WILL NOT APPLY TO THE ORIGINAL CONSENT DATE UPTO THE REQUESTED REMOVAL DATE.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE PREPARATION OF INSURANCE CLAIMS ON MYSELF AND AUTHORIZE THE INSURANCE TO MAKE PAYMENT DIRECT TO THE PHYSICIAN ON ANY UNPAID CLAIM. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURACNE CLAIMS, INCLUDING ELECTRONIC SUBMISSIONS.

Date

Patient Signature

Optional: RELEASE OF YOUR PERSONAL HEALTH INFORMATION. PLEASE INDICATE IF YOU ARE GIVING PERMISSION TO DISCUSS YOUR HEALTH INFORMATION WITH A MEMBERS OF YOUR FAMILY OR A FRIEND. Please print.

Name: _____ Relationship _____ Phone # _____

Name: _____ Relationship _____ Phone # _____

_____ Date

_____ Patient Signature

PRACTICE POLICIES

APPOINTMENT TIME

ALL NEW PATIENTS ARE REQUIRED TO ARRIVE 30 MINUTES PRIOR TO THEIR SCHEDULED APPOINTMENT TIME. RETURNING PATIENTS ARE REQUIRED TO ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

FINANCIAL POLICY

- IT IS YOUR RESPONSIBILITY TO CANCEL OR RESCHEDULE YOUR OFFICE VISIT WITH A MINIMUM OF 24-HOURS ADVANCED NOTICE. FAILURE TO DO SO MAY RESULT IN A \$25 FEE FOR OFFICE VISITS AND \$50 FEE FOR PROCEDURES.
- IF YOU FAIL TO KEEP YOUR SCHEDULED APPOINTMENT, DVPSI RESERVES THE RIGHT TO CHARGE A \$25.00 FEE FOR OFFICE VISITS AND \$50 FEE FOR PROCEDURES.
- WE ACCEPT CASH, CREDIT CARD, DEBIT CARD, AND CHECKS. THERE IS A \$50.00 FEE FOR RETURNED CHECKS

MEDICATION REFILLS

- DVPSI REQUIRES ALL PATIENTS TO SIGN AN OPIOID AGREEMENT PRIOR TO RECEIVING PRESCRIPTIONS FOR CONTROLLED SUBSTANCES. MANDATORY URINE SCREENING AND COMPREHENSIVE URINE TESTING IS REQUIRED.
- ALL REFILLS FOR CONTROLLED SUBSTANCES SHOULD OCCUR AT THE TIME OF YOUR OFFICE VISIT.
- IT IS YOUR RESPONSIBILITY TO SCHEDULE A FOLLOW-UP APPOINTMENT PRIOR TO YOUR NEXT REFILL.
- PLEASE ALLOW 1 BUSINESS DAY TO PROCESS ALL REFILL REQUESTS MADE BY PHONE OR THROUGH THE PORTAL.
- PLEASE ALLOW ONE WEEK FOR YOUR INSURANCE TO AUTHORIZE YOUR MEDICATION. PLEASE CHECK WITH YOUR PHARMACY FOR UPDATES.
- MEDICATIONS PRESCRIBED DURING YOUR OFFICE VISIT WILL BE ELECTRONICALLY SENT TO YOUR PHARMACY BY THE END OF THE VISIT DAY.

INSURANCE REFERRALS

- IT IS YOUR RESPONSIBILITY TO OBTAIN REFERRALS, IF NECESSARY, FROM YOUR PRIMARY PHYSICIAN BEFORE YOUR OFFICE VISIT. FAILURE TO DO SO MAY REQUIRE YOU TO RESCHEDULE YOUR APPOINTMENT. WE REQUIRE REFERRALS 48 HOURS IN ADVANCE.
- WHILE DVPSI WILL OBTAIN ALL AUTHORIZATIONS REQUIRED BY YOUR INSURANCE COMPANY FOR PROCEDURES, IT IS YOUR RESPONSIBILITY TO OBTAIN THE APPROPRIATE REFERRAL, WHEN NECESSARY, FOR THE PROCEDURE. REFERRALS ARE REQUIRED FOR ALL HMO INSURANCES.

IMAGING AND TEST RESULTS

- IMAGING ORDERED BY THE PRACTICE THAT REQUIRE AUTHORIZATIONS ARE OBTAINED BY DVPSI AUTHORIZATION SPECIALISTS, IF YOUR INSURANCE REQUIRES AN AUTHORIZATION, YOU MUST PROVIDE THE FOLLOWING OR WE WILL BE UNABLE TO PROCESS AN AUTHORIZATION.
 - NAME AND ADDRESS OF FACILITY
NPI NUMBER OF FACILITY
- ALL TEST RESULTS WILL BE REVIEWED AT YOUR FOLLOW-UP VISIT. IT IS YOUR RESPONSIBILITY TO SCHEDULE A FOLLOW- UP VISIT IN ORDER TO REVIEW YOUR RESULTS.
- PLEASE BRING TO YOUR OFFICE VISIT ALL IMAGES AND REPORTS THAT APPLY TO YOUR COMPLAINT. THE DISCS ARE USUALLY PROVIDED BY THE IMAGING FACILITY, BUT IN CERTAIN CIRCUMSTANCES, YOU MAY NEED TO REQUEST A COPY YOURSELF.

PLEASE SIGN BELOW INDICATING YOU HAVE READ DELAWARE VALLEY PAIN AND SPINE INSTITUTE’S PRACTICE POLICIES IN FULL.

Date

* _____
Patient Signature

Date of Birth

Patient Name Printed

Revised April 2026



Questionnaire for Patients

We apologize for any inconvenience; however, this questionnaire is necessary and required for patients on Medicare or over the age of 60.

Patient Name: _____ DOB: _____ Todays Date: _____
Please Print

- 1) Do you currently have a diagnosed history of depression or bi-polar disorder?
Yes _____ No _____
- 2) Do you currently smoke? Yes _____ No _____
- 3) If you answered yes, do you wish to receive smoking cessation information?
Yes _____ No _____
- 4) Do you have an Advanced Care Plan, or do you have someone designated decision maker fulfilling your medical wishes?
Yes _____ No _____ Who is your decision maker ? _____
- 5) Have you ever had a DEXA Scan? Yes _____ No _____ (Women Only)
(If you have had a dEXA scan please have a copy faxed to our office)
- 6) Have you ever been diagnosed with Osteoporosis? Yes _____ No _____
- 7) Have you had a recent vertebrae fracture ? Yes _____ No _____
- 8) Do you take medication for osteoporosis ? Yes _____ No _____
- 9) Do you have high blood pressure? _____ Do you currently take blood pressure medication? _____
- 10) Are you diabetic? Yes _____ No _____ If yes, do you take medication? _____
- 11) If you answered yes, was you A1C greater than 9%? _____
- 12) Do you feel safe in your home or living environment? Yes _____ No _____
- 13) Do feel you are at risk of falling? Yes _____ No _____
- 14) If you answered yes, do you feel this is due to lack of any of the following?
Strength _____ Gait _____ Balance _____
- 15) Your current Height _____ Weight _____

Thank you

Name _____ DATE _____
 (PLEASE PRINT)

Please respond to each question or statement by marking one box per row.

| <u>Physical Function</u> | | Without any difficulty | With a little difficulty | With some difficulty | With much difficulty | Unable to do |
|---------------------------|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| PFA11 | Are you able to do chores such as vacuuming or yard work?..... | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| PFA21 | Are you able to go up and down stairs at a normal pace?..... | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| PFA23 | Are you able to go for a walk of at least 15 minutes?..... | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| PFA33 | Are you able to run errands and shop? | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| <u>Anxiety</u> | | | | | | |
| In the past 7 days... | | Never | Rarely | Sometimes | Often | Always |
| EDAND01 | I felt fearful..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| EDAND02 | I found it hard to focus on anything other than my anxiety | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| EDAND03 | My worries overwhelmed me..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| EDAND03 | I felt uneasy | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| <u>Depression</u> | | | | | | |
| In the past 7 days... | | Never | Rarely | Sometimes | Often | Always |
| EDDEP04 | I felt worthless..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| EDDEP05 | I felt helpless..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| EDDEP29 | I felt depressed..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| EDDEP41 | I felt hopeless..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| <u>Fatigue</u> | | | | | | |
| During the past 7 days... | | Not at all | A little bit | Somewhat | Quite a bit | Very much |
| F07 | I feel fatigued | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| AN3 | I have trouble <u>starting</u> things because I am tired..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

Fatigue

In the past 7 days...

| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| FATE041 How run-down did you feel on average? ... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| FATE040 How fatigued were you on average? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

Sleep Disturbance

In the past 7 days...

| | Very poor | Poor | Fair | Good | Very good |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Sleep109 My sleep quality was | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |

In the past 7 days...

| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Sleep155 My sleep was refreshing | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |

| | | | | | |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Sleep20 I had a problem with my sleep | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

| | | | | | |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Sleep4 I had difficulty falling asleep | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

Ability to Participate in Social Roles and Activities

| | Never | Rarely | Sometimes | Usually | Always |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| SRPPER11 _CoPS I have trouble doing all of my regular leisure activities with others | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |

| | | | | | |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| SRPPER18 _CoPS I have trouble doing all of the family activities that I want to do | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

| | | | | | |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| SRPPER23 _CoPS I have trouble doing all of my usual work (include work at home) | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

| | | | | | |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| SRPPER45 _CoPS I have trouble doing all of the activities with friends that I want to do | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

Pain Interference

In the past 7 days...

| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| PAIN02 How much did pain interfere with your day to day activities? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

| | | | | | |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| PAIN22 How much did pain interfere with work around the home? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

| | | | | | |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| PAIN31 How much did pain interfere with your ability to participate in social activities? .. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

| | | | | | |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| PAIN34 How much did pain interfere with your household chores? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

Cognitive Function - Abilities

In the past 7 days...

| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| PC66 I have been able to concentrate | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

| | | | | | |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| PC27 I have been able to remember to do things, like take medicine or buy something I needed | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|

Pain Intensity

In the past 7 days...

| | | | | | | | | | | | |
|--|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|---|
| Global07 How would you rate your pain on average? | <input type="checkbox"/> 0 No pain | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 Worst pain imaginable |
|--|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|---|



Name: _____ Date of Birth: _____

Email: _____ Best Phone Number: _____

Height: _____ Weight: _____ Age: _____

Referring Physician: _____ Ph: _____

Primary Care Physicians: _____ Ph: _____

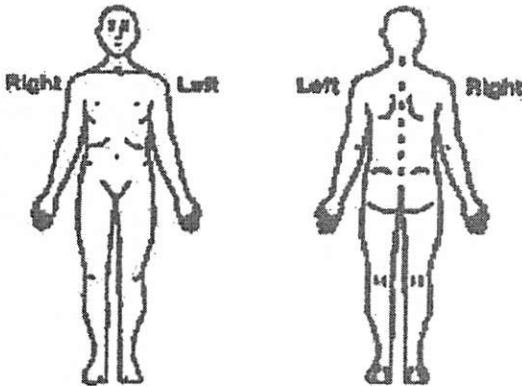
Who referred you to the practice: _____

Pain History

What is your primary complaint? _____

How long have you had your current pain symptoms? _____ weeks _____ months _____ years

Please shade areas where you are hurting:



Pain Symptom/Quality:

How would you describe your pain?
(Please check all that apply)

- | | | |
|---------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Sharp | <input type="checkbox"/> Cutting |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull/Aching |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Pressure | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |

Circle the Average Pain Intensity:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (mauled by bear)

What is the **lowest** pain score this week? _____

What is the **highest** pain score this week? _____

What makes the pain **better**? _____

What makes the pain **worse**? _____

www.dvpsi.com

DVPSI: Personalized Restorative Medicine, Multidisciplinary and State of Art Care



Numbness: Yes / No Where: _____

Weakness: Yes / No Where: _____

History of Prior Treatments:

OTC Medications (Tylenol Advil)

Prescription Medications (non-opioids) - please circle medications below

Gabapentin (Neurontin) Lyrica Cymbalta NSAIDS Other Antidepressants

Opioids/Narcotics

Please list previous opioids tried: _____

Physical Therapy

Chiropractic Therapy

Acupuncture

TENS unit

Topical Cream

Home Exercise Program

Back/Neck/Other Brace

Massage

Other: _____

Past Medical History:

Have you had any of the following health problems (Please check all that apply)?

Heart attack

Coronary Artery Disease

Chest Pain

Atrial Fibrillation

Heart Valve placement

Deep Vein Thrombosis

Diabetes

Stroke

Hypertension

Asthma or Wheezing

COPD (Emphysema /Bronchitis)

Kidney Disease

Liver Disease

Seizure or Epilepsy

Bleeding Problem

Depression

Anxiety

Thyroid Disease

Arthritis (specify location) _____

Cancer (what type) _____

Other conditions/diseases _____

Past Surgical History

Please list all surgeries and provide approximate dates:



Current Medications

| Name | Dose | Frequency | Name | Dose | Frequency |
|------|------|-----------|------|------|-----------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Please list any DRUG ALLERGIES:

SOCIAL HISTORY

FAMILY LIFE: Please specify living arrangements:

- Living alone
 Living with friends
 Living with spouse/ partner
 Living with spouse/ partner and children
 Living with children
 Living with other

CURRENT EMPLOYMENT STATUS: Please check one:

- Employed Full-time
 Employed Part-time
 Student
 Disability
 Retired
 Unemployed
 Full time Parent/Homemaker

SUBSTANCE ABUSE

- Do you currently use tobacco products? Yes No
 Did you previous use tobacco products? Yes No
 Do you currently or have you previously been treated for illicit drug or alcohol abuse? yes no

FAMILY HISTORY: Please specify any medical or psychiatric conditions common in your family and who suffers with these ailments:

Condition: _____ Specific family member(s): _____
 Condition: _____ Specific family member(s): _____
 Condition: _____ Specific family member(s): _____

COVID VACCINATED Yes No



REVIEW OF SYSTEMS: Please check all items you feel apply to you:

- Recent gain of weight: _____ pounds over _____ weeks/months/years
- Recent loss of weight: _____ pounds over _____ weeks/months/years
- Fever
- Dizziness
- Difficulty swallowing
- Double or blurry vision
- Nausea
- Diarrhea
- Easy or excessive bruising
- Rash
- Genital pain
- Hypothyroidism
- Chest pain
- Joint stiffness
- Pain in extremity (specify): _____
- Loss of Consciousness
- Seizures
- Vomiting
- Heart burn
- Easy or excessive bleeding
- Diabetes
- Difficulty urinating
- Hyperthyroidism
- Heart palpitations
- Decreased Range of Motion
- Swelling (specify): _____
- Difficulty walking
- Muscle weakness
- Constipation
- Adrenal Disease
- Shortness of Breath

PHARMACY INFORMATION _____ PHONE _____

ADDRESS _____