Delaware Valley Pain and Spine Institute
Welcome Letter

Dear Patient,

Thank you for choosing Delaware Valley Pain & Spine Institute. We look forward to providing you with exceptional care. To ensure your first visit goes smoothly, please review the information below carefully.

Before Your Appointment

Please visit our website and download the **New Patient Registration Forms.** All paperwork should be completed prior to your appointment whenever possible. Completing your forms in advance allows us to spend more time addressing your healthcare needs during your visit.

Arrival Time

All new patients are required to arrive **30 minutes prior to their scheduled appointment time.** This allows sufficient time for registration, insurance verification, and review of your medical information.

What to Bring

Please bring the following items with you to your appointment:

- Valid photo identification
- Current insurance card(s)
- Medication card (if applicable)
- Completed new patient paperwork (if not submitted in advance)

Prior Imaging Studies

If you have had any imaging studies related to your condition, including:

- MRI
- CT Scan
- X-rays
- Ultrasound
- Bone Scan

You are required to obtain a copy of the **imaging disc/CD and the corresponding radiology report** from the imaging facility where the study was performed and bring them to your appointment. Failure to provide imaging studies may delay evaluation and treatment recommendations.

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Previous Pain Management Treatment

If you have previously been treated for pain by another physician, pain management specialist, orthopedic provider, neurologist, neurosurgeon, chiropractor, or other healthcare provider, please contact that office and request that they fax the most recent office notes related to your treatment.

Medical records should include, at minimum:

- The last several office visit notes
- Procedure reports (if applicable)
- Relevant treatment records

Please have records faxed to our office prior to your appointment whenever possible.

Appointment Cancellation Policy

We understand that situations may arise requiring you to reschedule or cancel an appointment. We respectfully request a minimum of **24 hours' notice** for all appointment cancellations.

Appointments canceled with less than 24 hours' notice, as well as missed appointments ("no-shows"), may be subject to a cancellation fee.

Important Reminder

Incomplete paperwork, failure to arrive on time, or failure to provide requested records and imaging may result in your appointment being delayed or rescheduled.

If you have any questions prior to your appointment, please contact our office. We appreciate the opportunity to participate in your care and look forward to meeting you.

Sincerely,

Delaware Valley Pain & Spine Institute
Patient Services Department

DELAWARE VALLEY PAIN AND SPINE INSTITUTE
MEDICAL RECORDS REQUEST

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Date of Request: _____

Records Requested From:

Physician/Facility: _____

Fax Number: _____ Phone Number: _____

Please provide the following records for the above-named patient:

☐ Last two (2) office visit notes

☐ All imaging reports / results

☐ Physical therapy evaluations, treatment notes, progress notes, and discharge summaries

☐ Operative reports and surgical reports (if your office performed surgery on this patient)

☐ Any additional records relevant to the patient's diagnosis and treatment

☐ _____

Please send records to:

Delaware Valley Pain and Spine Institute

Fax: _____ Phone: _____

Address: _____

City: _____ State: PA. Zip Code _____

OR

☐ Patient (Provide copies directly to the patient listed above)

Patient Authorization: I hereby authorize the release of the medical records listed above to Delaware Valley Pain and Spine Institute or directly to me, the patient, as indicated above. This authorization is voluntary and may be revoked in writing at any time except to the extent action has already been taken in reliance upon it.

Patient Signature: _____ Date: _____

Adopted 6/2026

Preferred Office
Trevose _____
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 APPRIOVED 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 RESPONSIBILTY 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 ORIGNAL 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 SUSBSTANCES 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 FOLLW- 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 AIC greater than 9%? _____

12) Do you feel safe in your home or living environment? Yes _____ No _____

13) Have you fallen more than 2x in the past year? 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

June 2026

Name _____ DATE _____

(PLEASE PRINT)

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

	Physical Function	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
PFA21	Are you able to do chores such as vacuuming or yard work?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA20	Are you able to go up and down stairs at a normal pace?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA09	Are you able to go for a walk of at least 15 minutes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA53	Are you able to run errands and shop?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	Anxiety In the past 7 days...	Never	Rarely	Sometimes	Often	Always
EDANX01	I felt fearful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX08	I found it hard to focus on anything other than my anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX09	My worries overwhelmed me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX53	I felt uneasy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Depression In the past 7 days...	Never	Rarely	Sometimes	Often	Always
EDDEP01	I felt worthless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP08	I felt helpless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP09	I felt depressed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP53	I felt hopeless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Fatigue During the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
H57	I feel fatigued	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
AD	I have trouble starting things because I am tired	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Fatigue

In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
How run-down did you feel on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How fatigued were you on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Sleep Disturbance

In the past 7 days...	Very poor	Poor	Fair	Good	Very good
My sleep quality was	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was refreshing	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
I had a problem with my sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I had difficulty falling asleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Ability to Participate in Social Roles and Activities

	Never	Rarely	Sometimes	Usually	Always
I have trouble doing all of my regular leisure activities with others	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
I have trouble doing all of the family activities that I want to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
I have trouble doing all of my usual work (include work at home)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
I have trouble doing all of the activities with friends that I want to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Pain Interference

In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
How much did pain interfere with your day to day activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How much did pain interfere with work around the home?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How much did pain interfere with your ability to participate in social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How much did pain interfere with your household chores?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Cognitive Function – Abilities

In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
I have been able to concentrate	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I have been able to remember to do things, like take medicine or buy something I needed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Pain Intensity

In the past 7 days...											
How would you rate your pain on average?	☐ 0 No pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst pain imaginable

Name:_____ Date of Birth:_____

Email:_____ Best Phone Number:_____

Height:_____ Weight_____ Age:_____

Referring Physician: _____ Ph: _____

Primary Care Physicians:_____ Ph: _____

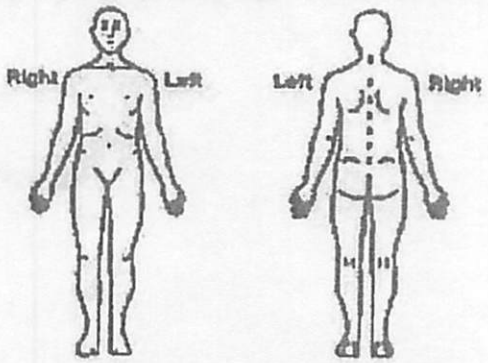
Who referred you to the practice:_____

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)

☐Burning	☐Sharp	☐Cutting
☐Throbbing	☐Cramping	☐Dull/Aching
☐Shooting	☐Pressure	☐Constant
☐Occasionally	☐Numbness	☐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?_____

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_____