

Welcome!

Please indicate the physician you are seeing today:

- | | |
|--|---|
| <input type="checkbox"/> Jaclyn Bonder, MD | <input type="checkbox"/> Michael O'Dell, MD |
| <input type="checkbox"/> Nasim Chowdhury, MD | <input type="checkbox"/> Michael Saulle, DO |
| <input type="checkbox"/> Alfred Gellhorn, MD | <input type="checkbox"/> Michael Sein, MD |
| <input type="checkbox"/> Victoria Harrison, MD | <input type="checkbox"/> Jaspal Ricky Singh, MD |
| <input type="checkbox"/> Chi Chang David Lin, MD | <input type="checkbox"/> Vandana Sood, MD |
| <input type="checkbox"/> Leroy Lindsay, MD | <input type="checkbox"/> Jennifer Soo Hoo, MD |
| <input type="checkbox"/> Vincent Miccio, MD | <input type="checkbox"/> Katherine Yao, MD |
| <input type="checkbox"/> Mike Mizrahi, DO | |

Please Note: All information is confidential and will become a part of your medical record. Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. PLEASE PRINT CLEARLY

Patient Name:		Date of Visit:	
Date of Birth:		Social Security Number:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner		
Home Address:		Home Phone Number:	
		Other Phone Number:	
Preferred Email Address:		Emergency Contact Name and Number:	
		Relationship to Patient:	
Primary Insurance Carrier:		Insurance ID Number:	
Insurance Phone Number:		Are you the Primary Insurance Policy Holder? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If No, Please list the Name and Date of Birth of the Policy Holder:			
Does Your insurance plan require referrals for specialty visits? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, do you have a referral for today's visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	



Physician and Pharmacy Information

Referring Physician

Name:

Phone:

Fax :

Were you referred for a Consultation?

Yes No

Primary Care Provider

Name:

Phone:

Fax:

Preferred Pharmacy

Name:

Phone:

Fax:

Did you sustain your injury on the job or during a motor vehicle accident?

Yes No

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize the holder of medical information about me to release to my insurance and, if I am a Medicare patient, to the Centers for Medicare and Medicaid Services and its agents, any information necessary to determine these benefits or the benefits payable for related services. I request that payment of any benefits be made on my behalf to the provider of services. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for payment in full for these services including any amounts not paid by my insurance carrier such as Copayments, Deductibles, and other Non-covered services.

I understand that services deemed non-medically necessary are not covered by my insurance carrier and that I will be financially responsible for any such non-covered services.

Signature

Date



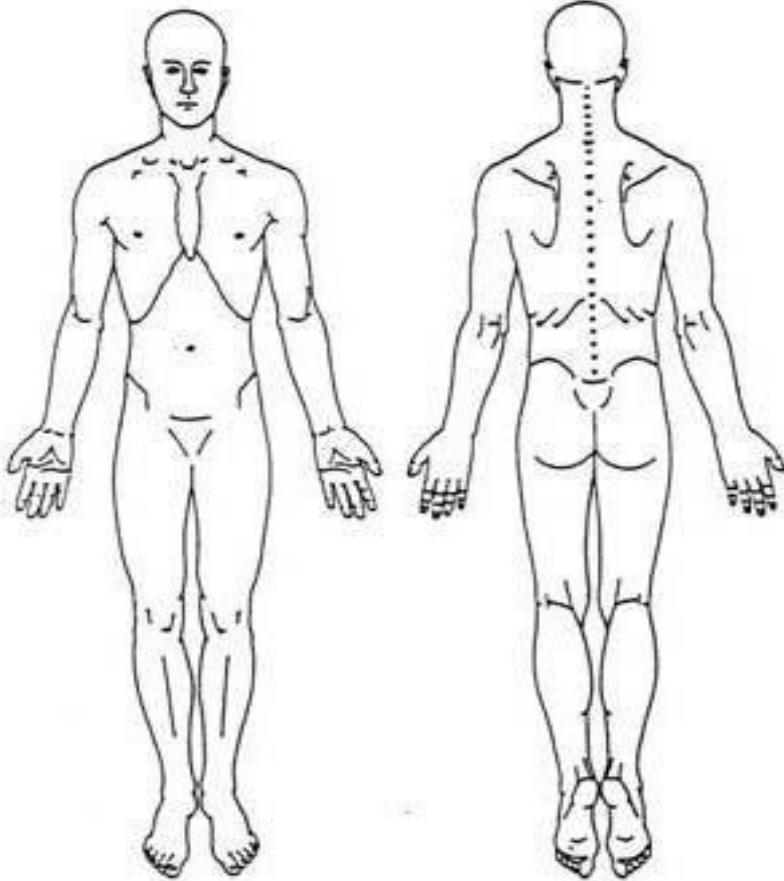
SCQ

BP _____ Pulse _____
HT _____ WT _____

Patient Name:	Patient Date of Birth:
Why are you here today?	Referring Provider:
Duration of symptoms?	
How did it begin?	

Please complete the pain drawing below by marking where you feel pain right now on the figures below.
(If you do not feel pain, please skip to page 2)

RATE YOUR PAIN ON A SCALE OF 0 TO 10
(0 = no pain 10 = extreme pain)



1. Right Now: 0 1 2 3 4 5 6 7 8 9 10

2. At Best: 0 1 2 3 4 5 6 7 8 9 10

3. At Worst: 0 1 2 3 4 5 6 7 8 9 10

4. What does the pain feel like (check all that apply)?

- | | | |
|------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sore | <input type="checkbox"/> Aching | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Tender | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Pulling | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Unsure | |

5. What makes it better (check all that applies)?

- | | | |
|---|-----------------------------------|--|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Bending Forward |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Bending Back |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Twisting | <input type="checkbox"/> Lying Down |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Weather Change |
| <input type="checkbox"/> Sexual Intercourse | <input type="checkbox"/> Nothing | |

6. What makes it worse (check all that applies)?

- | | | |
|---|-----------------------------------|--|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Bending Forward |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Bending Back |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Twisting | <input type="checkbox"/> Lying Down |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Weather Change |
| <input type="checkbox"/> Sexual Intercourse | <input type="checkbox"/> Nothing | |

7. Since the pain began, is it (check one): getting better getting worse staying the same

8. Have you ever had pain in this area prior to this episode? NO YES If yes, when? _____

9. Have you had any recent falls? NO YES

10. How far can you walk?

11. Do you require an assistive device (e.g. cane, brace)? NO YES

12. Do you need help with household activities? NO YES

Do you have any of the following symptoms (check all that apply)?

- | | | | | |
|---|---|---|---------------------------------------|---|
| <input type="checkbox"/> Easy Bleeding/Bruising | <input type="checkbox"/> Weight Change | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Joint pain/ Swelling | <input type="checkbox"/> Morning Stiffness | <input type="checkbox"/> Weakness | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Bowel/Bladder Changes | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Vision Change | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Other _____ | | | |

Have you had any of the following tests or treatments for your current problem?

	NO	YES	Date(s)		NO	YES	Date(s)
X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	_____	EMG (Nerve Test)	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	Injection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____				

If yes, list names of medications for current problem _____

Medical History		
Past Medical Problems:	Past Surgeries	Dates
Name All Current Medications:	List Any Medication Allergies	

Do you have allergies to any of the following?

- Shellfish Iodine Contrast/ IV Dye Latex

Does anyone in your family have any of the following medical problems?

Family Member	Alive	Arthritis	Cancer	Heart Disease	Diabetes	Other
	<input type="checkbox"/> Y					
	<input type="checkbox"/> N					
	<input type="checkbox"/> Y					
	<input type="checkbox"/> N					
	<input type="checkbox"/> Y					
	<input type="checkbox"/> N					

Have you received the Pneumonia Vaccination?

- No Yes

Date: _____ / _____ / _____

Have you received the Influenza Immunization?

- No Yes

Date: _____ / _____ / _____



Social History

<p>Do you smoke?</p> <p><input type="checkbox"/> Yes How many packs per day? ____</p> <p><input type="checkbox"/> Not currently, but I used to. Quit date: ____ / ____ / ____</p> <p><input type="checkbox"/> No</p>	<p>Do you consume alcohol</p> <p><input type="checkbox"/> Yes How many drinks in one week? ____</p> <p><input type="checkbox"/> No</p>
<p>Current Residence:</p> <p><input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Other</p> <p>Stairs? Elevator? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Employment Status:</p> <p><input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Disability <input type="checkbox"/> Worker's Compensation</p> <p>If applicable, what is your occupation? _____</p>

