

Welcome!

Jaclyn Bonder, MD

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

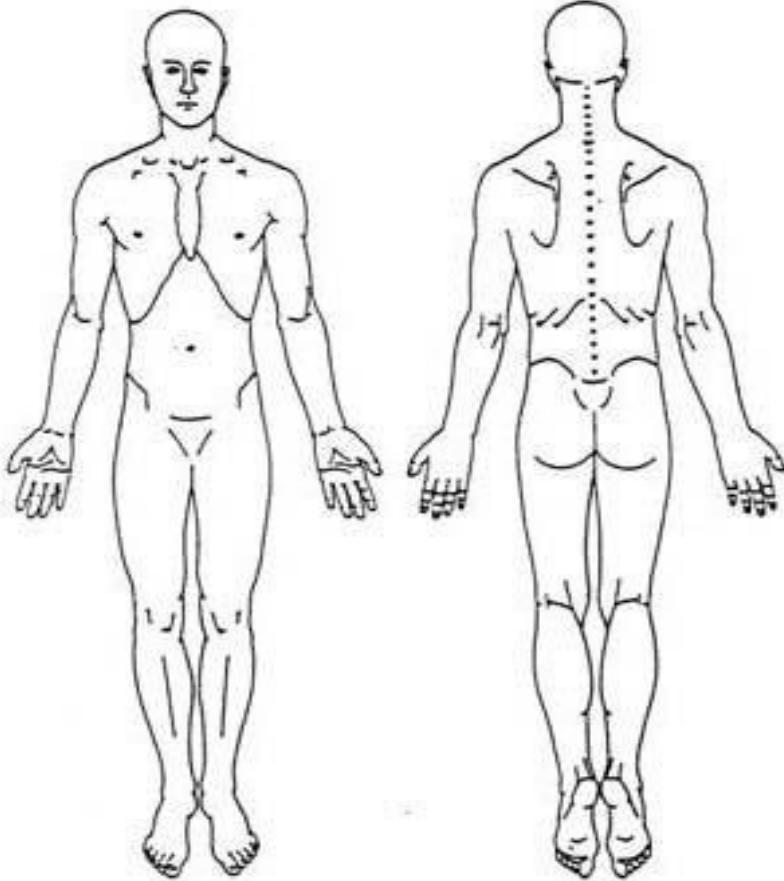


SCQ

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)

- Right Now: 0 1 2 3 4 5 6 7 8 9 10
- At Best: 0 1 2 3 4 5 6 7 8 9 10
- 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>

Urinary Symptoms

Do you experience any of the following?

- Urinary incontinence (leakage of urine or urinary accidents) NO YES
 If YES: (check all that apply)
- With: coughing/sneezing/laughing/exercise Occurs suddenly without warning
 Started during pregnancy Started after delivery of my baby
 Occurs because I cannot walk well enough to get to the bathroom on time
- Feeling like you suddenly need to urinate NO YES
- Feeling you urinate too frequently NO YES: How many times per day? ____
- Feeling like you cannot empty your bladder fully NO YES
- Cannot start your urine stream NO YES
- Wake up to urinate more than 2x per night NO YES: How many times per night? ____
- Pain with urination NO YES



Gastrointestinal

Do you experience any of the following?

- Fecal incontinence (leakage of feces or bowel accidents) NO YES
- Difficulty holding bowel movements or gas NO YES
- Constipation NO YES: How many bowel movements per week? ____
- Do you have increased pain with bowel movements? NO YES
- Does your pain improve after completing a bowel movement? NO YES

Sexual History

- Are you currently sexually active? NO YES
- Do you experience pain with sexual intercourse? NO YES

If YES: (check all that apply)

- With initial penetration Deep pain during sex
- With orgasms Because of body/leg positioning
- History of sexually transmitted disease? NO YES
- History of sexual problems? (i.e. erectile dysfunction, inability to have an orgasm) NO YES

Additional Medical History

- Do you have a history of?
- Depression NO YES
- Anxiety NO YES
- If YES: Are you treated with medications?
- Currently In the past Never
- Are you treated with counseling?
- Currently In the past Never
- Do you have trouble sleeping? NO YES
- If YES: (check all that apply)
- Difficulty falling asleep Difficulty staying asleep
- Because of pain Because of racing thoughts, worry, or other
- Have you ever:
- Been abused? NO YES
- Had an eating disorder? NO YES
- Felt unsafe at home or scared of your spouse/partner others? NO YES

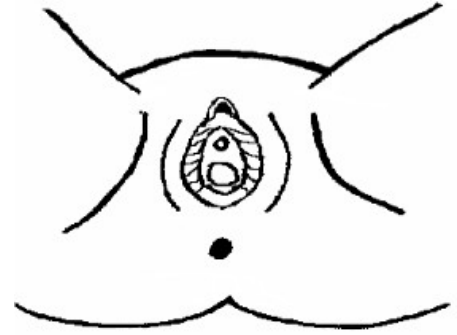


FOR WOMEN ONLY (MEN PLEASE SKIP THE REMAINING QUESTIONS)

Vulvar / Perineal Pain

(Pain outside and around the vagina and anus)

If you have vulvar pain, shade in the painful areas on the diagram:



Information about Your Pain

What typed of treatments / providers have you tried in the past for your pain? (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Family Practitioner | <input type="checkbox"/> Nutrition/Diet |
| <input type="checkbox"/> Anesthesiologist | <input type="checkbox"/> Herbal Medicine | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Anti-seizure medications | <input type="checkbox"/> Homeopathic Medicine | <input type="checkbox"/> Psychotherapy |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Lupron, Synarel, Zoladex | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Massage | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Botox injection | <input type="checkbox"/> Meditation | <input type="checkbox"/> Skin Magnets |
| <input type="checkbox"/> Contraceptive | <input type="checkbox"/> Narcotics | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Danazol (Danocrine) | <input type="checkbox"/> Naturopathic Medication | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> Depo-Provera | <input type="checkbox"/> Nerve blocks | <input type="checkbox"/> Trigger point |
| <input type="checkbox"/> Gastroenterologist | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Urologist |
| <input type="checkbox"/> Gynecologist | <input type="checkbox"/> Nonprescription medicine | |
- Other: _____

Obstetrical History

When was your last menstrual period? ____ / ____ / ____

Are you pregnant? NO YES; # of weeks ____

Number of pregnancies? _____

Number of children? _____

Ages of your children? _____

Are you currently breastfeeding? NO YES

Did you have back pain during your pregnancy? NO YES

How long was your last labor? _____

How long was your pushing phase? _____

What type of delivery/deliveries? (Check all that apply)

- Vaginal C-section Vacuum Forceps

Have you had an episiotomy or tearing of vagina or rectum? NO YES

Any complications during pregnancy? (Check all that apply)

- Hypertension Bleeding Contractions Diabetes
 Back Pain Pelvic Pain Bed Rest Other _____

