Palmetto Clinics
Joints-Skin-Life

DATE: _____/_____/_____

NAME: _____

AGE: _____ BIRTH DATE: _____/_____/_____ □ MALE □ FEMALE

ADDRESS: _____

CITY / STATE / ZIP: _____

HOME PHONE #: _____ WORK PHONE#: _____

CELL#: _____ BEST TIME TO CONTACT: _____

E-MAIL ADDRESS: _____

CITY / STATE / ZIP: _____

□ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

EMERGENCY CONTACT: _____ PHONE NUMBER _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHAT IS YOUR MAIN AREA OF CONCERN? _____

HOW LONG HAVE YOU HAD THE PAIN? _____

HOW OFTEN DO YOU EXPERIENCE THE PAIN? _____

WHAT HAVE YOU DONE TO HANDLE THE PAIN? _____

_____

LIST ANY ACCIDENTS OR INJURIES YOU HAVE HAD IN YOUR LIFE (CAR ACCIDENTS, WORK ACCIDENTS, SLIP, FALLS, ETC.)

1. _____ DATE: _____
2. _____ DATE: _____
3. _____ DATE: _____
4. _____ DATE: _____
5. _____ DATE: _____

HOW HAS YOUR PAIN AFFECTED YOUR LIFE? _____

_____

HOW HAS YOUR PAIN AFFECTED YOUR WORK LIFE? _____

_____

HOW HAS YOUR PAIN AFFECTED YOUR HOBBIES, SOCIAL LIFE, ETC? _____

_____

WHAT ARE SOME OF THE THINGS THAT YOU USED TO DO BEFORE YOU HAD PAIN THAT YOU WOULD LIKE TO DO AGAIN? _____

_____

IF YOU WERE TO **NOT** ADDRESS YOUR PAIN, HOW WOULD THAT AFFECT YOUR LIFE? _____

_____

SINCE THIS PROBLEM STARTED, HAS IT GOTTEN WORSE? YES _____ NO _____

ON A SCALE OF 0-10 (10 BEING THE HIGHEST), WHAT IS YOUR PAIN LEVEL? _____

WHAT WOULD YOU LIKE YOUR PAIN LEVEL TO BE? _____

IF THERE WAS A WAY TO ALLEVIATE YOUR PAIN, WOULD YOU LIKE TO DO THAT? YES _____ NO _____

WHAT WOULD PREVENT YOU FROM ALLEVIATING YOUR PAIN LEVEL? _____

_____

LIST YOUR MEDICATIONS: _____

_____

SURGERIES: _____

_____

ADDITIONAL INFORMATION: _____

_____

_____ _____

PATIENT SIGNATURE DATE

HIPAA Notice of Privacy & Patient Consent Form

This Notice of Privacy Practices provides information about how we may use or disclose protected health information, and how you can get access to this information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
-The practice reserves the right to change the privacy policy as allowed by law.
-The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
-The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
-The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with anyone other than yourself?
YES NO

If YES, please name the person / people with whom we may discuss your medical condition:

_____

May we phone, email, or send a text to you to confirm appointment?
YES NO

May we leave a message on your answering machine at home or on your cell phone?
YES NO

Patient name: _____

Patient Signature or Guardian (if under 18):

_____ Date: _____

PATIENT HEALTH QUESTIONNAIRE

DATE: _____ PATIENT NAME: _____ PATIENT DOB: _____

Primary Region of Complaint: _____

Which symptom are you most concerned about? _____

When did your symptom start (specific day/ date)? _____ OR has your symptom been going on for a long time? **Y or N**

What caused you to seek care or how did your symptoms begin? _____

_____

_____

_____

What is the intensity of your primary symptom when it's at its worst? **(0 = No Pain and 10 = Worst Pain Possible)**

How often do you experience your symptoms? **(Constant/ Frequent/ Intermittent/ Occasional)**

Is your pain worse when you get up in the morning or does it get worse throughout the day?

Describe the nature of your primary symptom:

Aching/ Stiffness/ Radiating/ Numbness/ Tingling/ Dull/ Burning/ Pulling/ Sharp/ Throbbing/ Shooting/ Stabbing/ Stinging/ Cramping/ Tightness/ Weakness/ Pinprick/ Pinching/ Soreness/ Pressure/ Swelling/ Deep

What aggravates your primary symptom?

Sitting/ Standing/ Walking/ Bending/ Lifting/ Sleeping/ Sneezing/ Coughing/ Reaching/ Twisting/ Looking Up/ Looking Down/ General Movement/ Lying Supine/ Driving/ Typing/ Sitting at a computer/ Household Chores/ Exercise/ Stair Stepping

Does it radiate? **Y or N**
If yes, to where? (Include a brief history, pain intensity and nature of the symptom)?

What diagnostic tests have already been performed (include time frame and specific area tested)?

What Doctors have you seen in the past and what types of professional treatments have you tried (include time from and if they helped)?

What types of self-treating is done at home to help relieve your pain?

Rest/ Lying Down/ Sitting/ Standing/ Movement/ Applying Heat/ Applying Ice/ Analgesic topical pain relief gel/ Ibuprofen or other medication/ Stretching/ Exercise

How has your pain affected your life? Home life? Hobbies? Work?

What are some things you used to do before you had pain that you would like to do again if it was not a problem?

Can you remember a time, a specific time, before your pain started and affected you in the ways listed above? **Y or N**

Tell me about it, what was it like, how did you feel, what did you do, etc.:

What happens if you do nothing?

If there were a way to fix this problem so you would not have to suffer with it any longer, would you want to? **Y or N**

Trigger Points Finding:

Secondary Region(s) of Complaint (include a brief history, pain intensity, nature of the symptom and prior treatments):

Patient asked to bring a WRITTEN list of MEDICATIONS? **Y or N**