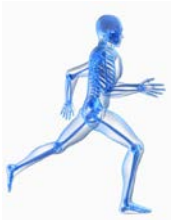


MICHIGAN ORTHOPAEDIC INSTITUTE, PC
OFFICE POLICIES

26025 Lahser Road
2ND Floor
Southfield, MI 48033
(248) 663-1900

33200 W. 14 Mile Rd
Suite 220
West Bloomfield, MI 48322
(248) 855-7400

Dear Valued Patient:

We would appreciate you taking a moment to review our office policies listed below.

APPOINTMENTS

- Patients are seen on an appointment basis only. We try to maintain our daily schedule, however, being an Orthopaedic practice emergencies frequently arise. We appreciate your patience and understanding.
- Due to many changes in insurance coverage and federal regulations of identity verification, it will be necessary to present your **insurance card** and **picture id** at each appointment.
- At times there will be more than one health care provider in the office treating patients. Please do not become distressed if you notice a patient in the reception room being taken before you. This person is probably seeing a different health care provider than you.
- If you are unable to keep your appointment, we need at least a 24 hour notice.
- If you do not show for an appointment and do not call you may be charged a **$25.00 no show fee**.
- If you are more than **20 minutes** late for your appointment, you may be asked to reschedule your appointment.

PRESCRIPTIONS

- If you need a new prescription or a refill of your current medication, please allow the office two (2) days to process your request. All prescription requests need to be verified by your physician before they are filled.

MEDICAL RECORDS

- We will complete one medical disability form per month at no charge to you. There will be a $10.00 fee for each additional form.
- The fee to obtain a copy of your medical record is based on the guidelines set forth in a new state law and varies in price depending on the size of your medical record.
- Please allow ten (10) to fifteen (15) business days to process any form or records requests.
- Due to new laws mandated by the U.S. Government pertaining to the privacy of your health information we must have a signed authorization by you, along with the name, address and phone number of all parties you wish your medical records be released to.

I acknowledge that I read and/or received a copy of the **Michigan Orthopaedic Institute, P.C**. Office Policies. I agree to the terms listed within.

PRINTED NAME:_____ **DATE**:_____

SIGNATURE:_____

Michigan Orthopaedic Institute, P.C.
Office Billing Policy

(This form requires a signature)

Insurance copayments will be collected on the date of service. If you are unable to pay your copayment today, please reschedule your appointment. For your convenience, our office accepts personal checks, Visa, MasterCard, American Express and cash.

Self pay (no insurance) patients must pay on the date of service. Our returned check fee is $30.00.

All previous balances are due prior to your next appointment. After 3 statements are sent there will be a $5.00 monthly statement fee for each additional statement sent.

Our Finance charges will be charged at a rate of .5% monthly and 6% annually for unpaid bills over 90 days past due.

If after 90 days, we have not received payment from your insurance company; our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill.

Due to many changes to insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay on top of these changes, it is not always possible. **It is your responsibility to know the special terms, deductibles, and/or copayments of your insurance coverage. Failure to notify us will result in non-covered expenses which will be your responsibility.**

If your insurance requires you to have a written referral or authorization such as an HMO, Workers Compensation or Auto Insurance it is the responsibility of the patient to obtain it PRIOR to the appointment. If you do not have the referral, you may need to reschedule your appointment or you will be responsible for the charges.

It is your responsibility to pay any deductible, co-insurance, or any other balance not paid by your insurance carrier.

Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

The intention of this notice is to clarify our policies and procedures and promote good communication between our patients and our office.

I understand the billing procedures associated with this office and completely understand additional charges will be incurred if I fail to comply. I also, acknowledge that if I do not pay in full for services rendered, on the date of service, I herby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Private Insurance and any other health plan to Michigan Orthopaedic Institute, P.C. A photocopy of this policy is to be considered as valid as the original. I further authorize Michigan Orthopaedic Institute, P.C. be allowed to release information regarding my treatment in order to receive payment.

Print Patient Name

Signature of patient and/or guardian if under 18 years

Date

Relationship to patient

*This form expires 1 year from the date it is signed

MICHIGAN ORTHOPAEDIC INSTITUTE, P.C.

Patient Disclosure: Consulting Agreements with Orthopaedic Companies

Dear Patient:

We would like to inform you that many of our physicians have consulting agreements with various orthopaedic companies.

Your doctor has been active in his career with research and development of new implants and improved surgical instruments and techniques. As part of this work, they have worked under contract with orthopaedic companies, providing consulting services on new products and input on research and development. In addition your doctor may have given instructional lectures on implants and surgical techniques for other doctors and medical personnel. In return for this time and expertise, your doctor may have been paid a consulting fee.

Our offices may use products from a company one of our doctor's is a paid consultant for in the care of our patients, but also may use similar products from other implant manufacturers. We want to assure you that the selection of which product to use in your care-and the care of all our patients-is based only on what is best for the patient, not on which company makes the product.

All of our Orthopaedic surgeons are members of the American Academy of Orthopaedic Surgeons, (AAOS) which holds its members to extremely high ethical standards to ensure that even the appearance of a conflict of interest does not jeopardize the trust that patients place in our doctors.

AAOS has adopted Standards of Professionalism that require orthopaedic surgeon members to identify and disclose potential conflicts of interest to their patients, the public and colleagues. These standards also clearly articulate how and under what circumstances AAOS members may work with and be compensated by industry, as well as the penalties for failure to comply.

You can learn more about these Standards of Professionalism at the AAOS website: http://www.aaos.org/industryrelationships

It is important to our office that you are aware of these relationships with implant manufacturers, that our office puts the interests of patients first, and that we are available to answer any questions that you may have.

_____	_____	_____
Patient Printed Name	**Patient Signature**	**Date**

MICHIGAN ORTHOPAEDIC INSTITUTE, P.C.

NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 - (HIPAA)

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice your IIHI. By Federal and State Law, we must follow the terms of the notice of privacy practices that we have effect at the time.

We realize that these laws are complicated, but we must provide you with the following information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a hard copy of electronic copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Michigan Orthopaedic Institute, P.C.
26025 Lahser Road, 2nd Floor
Southfield, MI 48033
(248) 663-1907

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment**. Our practice may use your IIHI to treat you For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work. for our

practice-including, but not limited to, our doctors, nurses, medical assistants, office staff, medical students, and residents-may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment**. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from parties that may be responsible for such costs such as family members. Also, we may use your IIHI to bill you directly for and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations**. Practice may use and disclose your IIHI to operate business. As examples of the ways in which we may use and disclose your information for operations, practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders**. Practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options**. Practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services**. Practice may use and disclose your IIHI to inform you of health-related benefits or that may be of interest to you.

7. **Release of Information to Family/Friends**. Practice may release your IIHI to a family member, friend or other person that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatricians' office for treatment of a cold. In this example, the babysitter, the person who accompanied the child, may have access to this child's medical information.

8. **Disclosures Required By Law**. Practice will use and disclose your IIHI when we are required to do so by Federal, State or Local Law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks**. Practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

    - Maintaining vital records, such as births and deaths
    - Reporting child abuse or neglect

- Preventing or controlling disease, injury disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading contracting a disease or condition
- Reporting reactions to or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities**. Practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings**. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit similar proceeding. We also may disclose your IIHI response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to you of the request to obtain an order protecting the information the party has requested.

4. **Law Enforcement**. We may release IIHI if asked to do so by a law enforcement official:

   a. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   b. Concerning a death we believe has resulted from criminal conduct
   c. Regarding criminal conduct at our offices
   d. In response to a warrant, summons, court order, subpoena, or similar legal process
   e. To identify/locate a suspect, material witness, fugitive or person
   f. In an emergency, to report a crime (including the location or of the crime, or the description, identity or location of the perpetrator)

5. **Deceased Patients**. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release order for funeral directors to perform jobs.

   Discussions with Descendants. Practice may provide medical information after a patient's death to descendants and others who were involved in the patient's care prior to the death.

6. **Organ and Tissue Donation**. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation you are an organ donor.

7. **Research**. Our practice may use and disclose your IIHI for research purposes certain limited circumstances. We will obtain your written authorization to use your IIHI for research except when an Internal Review Board or Privacy Board has that the waiver of your authorization satisfies the following: the use or disclosure involves no more than a minimal risk to your privacy based on the (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the at the earliest consistent the research (unless there is a health or research justification for the or such retention is otherwise required by law); and (C) adequate written assurances that the PHI not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI. A single authorization may be used for a range of research activities.

8. **Serious Threats to Health or Safety**. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another or the public. Under these circumstances, we only make disclosures to a person or organization able to help prevent the threat.

9. **Military**. Our practice may disclose your IIHI you are a member of U.S. or foreign military forces (including veterans) and required by the appropriate authorities.

10. **National Security**. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials order to protect the President, other officials or foreign heads of state, or to conduct

11. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation**. Our practice may release your IIHI for workers' compensation and similar programs.

13. **Immunization Records.** Practice may, to facilitate communication of immunization records to schools, disclose proof of immunizations directly to schools without written authorization. This applies when a school is required by law to collect immunization information, providing the parent or guardian agrees to the disclosure

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications**. You have the right to request that our practice communicate you about your health and related issues a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the **Michigan Orthopaedic Institute, P.C.**

office that is providing you services, specifying the requested method of contact, or the location where you to be contacted. Our practice accommodates reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your HHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you. In order to request a restriction our use or disclosure of your IIHI, you must make your request in writing to the **Michigan Orthopaedic Institute, P.C.** office that is providing you services. Your request must describe in a clear and concise fashion:

   (a) The information you wish restricted;
   (b) Whether you are requesting to limit practice's use, disclosure or both; and
   (c) To whom you want the limits to apply

3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the UHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Michigan Orthopaedic Institute, P.C. office that is providing you services in order to inspect and/or obtain a copy of your IIHI! Practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of denial another licensed health care professional chosen by us will conduct reviews.

4. **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for practice. To request an amendment, your request must be made in writing and submitted to Orthopaedic Institute, P.C. You must provide us with a reason that supports your request for amendment. Practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures**. All of patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures practice has made of your IIHI for non-treatment, nonpayment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the Michigan Orthopaedic Institute, P.C. office you are receiving services from All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but practice may charge you for additional lists within the same 12-month period. Practice will notify you of the costs involved with additional

requests and you may withdraw your request before you incur any costs.

Restrictions of Disclosures. The Practice must agree to an individual's requested restriction on disclosure of PHI if the disclosure pertains solely to a health care item or service for which the individual has paid the covered entity in full (i.e., paid out of pocket).

6. **Right to an Paper Copy of This Notice**. You are entitled to receive an or paper copy of notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain an electronic or paper copy of this notice, contact the Michigan Orthopaedic Institute, P.C. office that you are receiving services.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with practice or with the Secretary of the Department of Health and Human Services. To file a complaint with practice, contact the **Michigan Orthopaedic Institute, P.C.** office you are receiving services from or **Compliance Officer Ms. Sue Simmons at 26025 Lahser Road, 2nd Floor, Southfield, Michigan, 48033**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures**. Practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing.

9. **Additional Disclosures.** The Practice is required to notify you and obtain the individuals authorization and written consent for the following disclosures:
   a. Disclosure of psychotherapy notes
   b. PHI for marketing purposes
   c. The sale of PHI

10. **Fund Raising.** Practice does not solicit for fund raising. Should at any time the Practice initiate a fund raising activity, individuals may elect to opt out of receiving communications from the covered entity related to fund raising .

11. **Breach Notification of PHI.** The Practice is required to notify affected individuals following a breach of unsecured PHI. The Practice makes every effort to secure PHI and comply with all State and Federal laws protecting the individual rights.

Again, if you have any questions regarding this notice or health information privacy policies, please contact the **Michigan Orthopaedic Institute, P.C.** office you are receiving services.

Notice effective 11/23/2010

Amended effective: September 23, 2013

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the **Michigan Orthopaedic Institute, P.C**. Notice of Privacy Practices.

Date: _____ Signature: _____

Michigan Orthopaedic Institute

WWW.MOIMD.COM

*****If this visit is related to Worker's Comp, an Auto Injury, or a Public Liability claim, please alert the front desk staff immediately! *****

Patient Demographic Information

(Please Print)

TODAY'S DATE: _____

NAME: _____ DOB: ____ /____ /_____ S.S. # _____
LAST FIRST MI

ADDRESS: _____ CITY_____ STATE_____ ZIP _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

WORK PHONE: _____ EMAIL: _____

Sex:	**Marital Status:**	**Race:**	**Ethnicity:**
Male	Single Married	American Indian Asian African American	Hispanic Non-Hispanic
Female	Widowed Divorced	Native Hawaiian White Type-Unknown	Type-Unknown

Preferred Language: English Spanish French Creole Other: _____

MAY WE LEAVE ROUTINE MESSAGES ON YOUR PERSONAL ANSWERING MACHINE/VOICEMAIL? YES NO

WHICH PHONE NUMBER? _____

MAY WE SHARE YOUR PROTECTED HEALTH INFORMATION WITH A FAMILY MEMBER? YES NO

PLEASE LIST NAMES: _____

NAME OF EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: _____ ALTERNATE PHONE: _____

ARE YOU COMING FROM A SKILLED NURSING FACILITY? YES NO

NAME OF FACILITY: _____ ADDRESS: _____

DATE OF INJURY:

*****FOR OFFICE USE ONLY*****

INITIALS

PRIMARY INSURANCE: _____

POLICY HOLDERS NAME: _____ D.O.B: _____

SECOND INSURANCE: _____

POLICY HOLDERS NAME: _____D.O.B: _____

THIRD INSURANCE: _____

POLICY HOLDERS NAME: _____D.O.B: _____

SPORTS MEDICINE OF MICHIGAN
KYLE ANDERSON, MD

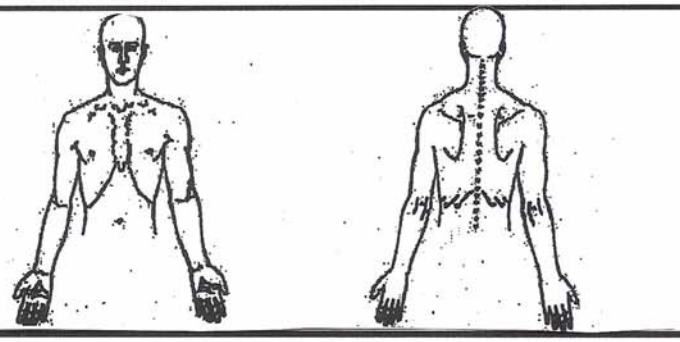
SHOULDER QUESTIONNAIRE

Last Name:	First Name:	Today's Date:
DOB:	Hand Dominance: R L Ambi	Sex: M F

Occupation:	Initial Assessment? Yes No
Sports / Activities / Hobbies:	Follow up? Yes No

Are you having pain in your shoulder? (circle correct answer) YES NO

Mark where your pain is:



Do you have pain in your shoulder at night?	Yes No
Do you take pain medication? (Aspirin, Advil, Motrin, Tylenol, Aleve, etc.)	Yes No
Do you take narcotic pain medication? (Codeine or stronger)	Yes No
How many pills do you take each day? (average)	*PILLS*
How bad is your pain today? (mark line)	0 I___I___I___I___I___I___I___I___I___I___I 10 No pain at all — Pain as bad as it can be
Does your shoulder feel unstable? (as if it is going to dislocate)	Yes No
How unstable is your shoulder? (mark line)	0 I___I___I___I___I___I___I___I___I___I___I 10 Very stable — Very unstable

Circle the number in the box that indicates your ability to do the following activities:
0 = Unable to do; 1 = Very difficult to do; 2 = Somewhat difficult; 3 = No difficulty

ACTIVITY	RIGHT ARM	LEFT ARM
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side	0 1 2 3	0 1 2 3
3. Wash back / fasten bra in back	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lbs. above shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhead	0 1 2 3	0 1 2 3
9. Do usual work – List:	0 1 2 3	0 1 2 3
10. Perform sports – List:	0 1 2 3	0 1 2 3

GENERAL HEALTH QUESTIONNAIRE

Patient Name: _____

Date
□□/□□/□□

OP Date
□□/□□/□□

The following questions are about your general health. Please answer these questions taking into account all medical conditions you may have.

In general, would you say your health is: O Excellent O Very Good O Good O Fair O Poor
(Please fill in ONLY ONE BUBBLE)

Compared to one year ago, how would you rate your health in general now?
(Please fill in ONLY ONE BUBBLE)

- O Much better than 1 year ago
- O Somewhat better now than 1 year ago
- O About the same as 1 year ago
- O Somewhat worse no than 1 year ago
- O Much worse now than 1 year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? **(Please fill in only one bubble per row)**

	Yes, Limited a lot	**Yes, limited a little**	**No, not limited at all**
a. Vigorous activities, such as running, lifting, heavy objects, or participation in strenuous activities.	O	O	O
b. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	O	O	O
c. Lifting or carrying groceries	O	O	O
d. Climbing **several** flights of stairs	O	O	O
e. Climbing **one** flight of stairs	O	O	O
f. Bending, kneeling, or stooping	O	O	O
g. Walking **more than a mile**	O	O	O
h. Walking **several blocks**	O	O	O
i. Walking **one block**	O	O	O
j. Bathing or dressing yourself	O	O	O

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of physical health?

	Yes	No
a. Cut down the amount of time you spent on work OR other activities.	O	O
b. Accomplished less than you would like.	O	O
c. Were limited in the kind of work OR other activities.	O	O
d. Had difficulty performing the work OR other activities. (for example: it took extra effort)	O	O

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
a. Cut down the amount of time you spent on work OR other activities.	O	O
b. Accomplished less than you would like.	O	O
c. Didn't do work OR other activities as carefully as usual.	O	O

During the past 4 weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(Please fill in ONLY ONE BUBBLE)

- O Not at all
- O Slightly
- O Moderately
- O Quite a bit
- O Extremely

How much pain have you had during the past 4 weeks?

(Please fill in ONLY ONE BUBBLE)

- O None
- O Very Mild
- O Mild
- O Moderate
- O Severe
- O Very Severe

During the past 4-weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(Please fill in ONLY ONE BUBBLE)

- O Not at all
- O Slightly
- O Moderately
- O Quite a bit
- O Extremely

How have you been feeling during the past 4 weeks? For each question, please give the one answer that comes closest to the way you having been feeling. **(Please fill in ONLY ONE BUBBLE PER ROW)**

	All of The Time	Most of The Time	A Good Bit of The Time	Some of The Time	A Little of The Time	None of The Time
a. Do you feel full of pep?	O	O	O	O	O	O
b. Have you been a very nervous person?	O	O	O	O	O	O
c. Have you felt so down in the dumps nothing could cheer you up?	O	O	O	O	O	O
d. Have you felt calm and peaceful?	O	O	O	O	O	O
e. Did you have a lot of energy?	O	O	O	O	O	O
f. Have you felt downhearted and blue?	O	O	O	O	O	O
g. Did you feel worn out?	O	O	O	O	O	O
h. Have you been a happy person?	O	O	O	O	O	O
i. Did you feel tired?	O	O	O	O	O	O

During the past 4 weeks, how much of the time have your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? **(Please fill in ONLY ONE BUBBLE)**

- O All of the time
- O Most of the time
- O Some of the time
- O A little of the time
- O None of the time

Please choose the answer that best describes how true or false each of the following statements is for you. **(Please fill in ONLY ONE BUBBLE PER ROW)**

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
a. I seem to get sick a little easier than other people.	O	O	O	O	O
b. I am as healthy as anybody I know.	O	O	O	O	O
c. I expect my health to get worse.	O	O	O	O	O
d. My health is excellent.	O	O	O	O	O

HEALTH HISTORY *(Confidential)*

Patient Name: _____ Today's Date: _____

Symptom or problem for which you are seeing the doctor today: _____

Birth date: _____Pharmacy name and phone number: _____

Referring Doctor: _____Cardiologist: _____

SYMPTOMS: CHECK (√) SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

GENERAL
- □ Anxiety
- □ Balance problems
- □ Chills
- □ Depression
- □ Difficulty walking
- □ Dizziness
- □ Fainting
- □ Fever
- □ Headache
- □ Hot flashes
- □ Loss of sleep
- □ Loss of weight
- □ Numbness

WOMEN ONLY

Menopause:
□ Yes □ No

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- □ Arms □ Hips
- □ Back □ Legs
- □ Feet □ Neck
- □ Hands □ Shoulders
- □ Groin

GENITO-URINARY
- □ Lack of bladder control
- □ Difficulty/pain urinating

GASTROINTESTINAL
- □ Bowel changes
- □ Lack of bowel control
- □ Heartburn/Indigestion
- □ Hemorrhoids
- □ Nausea
- □ Stomach pain

CARDIOVASCULAR
- □ Chest pain
- □ Irregular heart beat
- □ Rapid heart beat
- □ Swelling of ankles

EYE, EAR, NOSE, THROAT
- □ Difficulty swallowing
- □ Loss of hearing
- □ Sinus problems

SKIN
- □ Bruise Easily
- □ Itching
- □ Rash

CURRENT HEIGHT _____

CURRENT WEIGHT _____

PHYSICIAN NOTES:

CONDITIONS: CHECK (√) CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

- □ AIDS/HIV
- □ Alcoholism
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Bi-polar Disorder
- □ Bleeding Disorders
- □ Blood Pressure, High
- □ Bronchitis
- □ Cancer_____
- □ Cerebral Palsy
- □ Chemical Dependency
- □ Cirrhosis of Liver
- □ COPD
- □ Diabetes
- □ Emphysema
- □ Epilepsy or Seizures
- □ Fractures _____
- □ GERD
- □ Glaucoma
- □ Gout
- □ Heart Disease
- □ Hepatitis Type A, B, C
- □ High Cholesterol
- □ Kidney Disease
- □ Legally Blind
- □ Liver Disease
- □ Lupus
- □ Meningitis
- □ Migraine Headaches
- □ Multiple Sclerosis
- □ Neuropathy
- □ Osteoporosis
- □ Pacemaker
- □ Pneumonia
- □ Polio
- □ Prostate Problem
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis
- □ Ulcers in Stomach
- □ Ulcers of Skin
- □ Other _____

_____

_____

FAMILY HISTORY: CHECK (√) ALL THAT APPLIES AND INDICATE THEIR RELATIONSHIP TO YOU:

- □ Heart Disease _____
- □ Arthritis _____
- □ Cancer_____
- □ Diabetes _____
- □ Osteoporosis _____
- □ Scoliosis _____

SOCIAL HISTORY:

Do you exercise? □ Yes □ No Type of exercise: _____ Times per week: _____

Tobacco Use: Current every day smoker Current some day smoker Never smoker Former Smoker

Alcohol Use: None Social Moderate Heavy

Employer/Occupation: _____ Are you able to work now? _____

Is your current problem related to work or an accident? _____ Is there an attorney working with you? _____

List all medications (PRESCRIPTIONS and NON-PRESCRIPTION) you are presently taking, include frequency and dose.

MEDICATION NAME	DOSE	HOW OFTEN PER DAY
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
• **Are you taking any blood thinners** (Coumadin, Heparin, Plavix, Aspirin)		
•		
•		
•		

Do you have any allergies to medicines and foods? □ Yes □ No

If yes, please list:_____

_____

Do you have skin sensitivity or allergy to metals: □ Yes □ No

_____

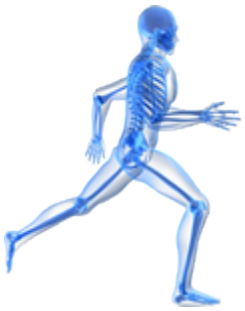
List all surgical procedures you have had and the approximate date.

SURGICAL PROCEDURE	DATE

I certify that the above information is correct to be the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Legal Guardian Signature: _____

Reviewed by: _____Date:_____



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Transcription Form

Patient Name:_____

DOB: _____Date:_____

Referring Physician_____

Where are they located? _____

Would you like reports sent to this doctor? Yes or No

Primary Care Physician_____

Where are they located? _____

Would you like reports sent to this doctor? Yes or No