Chart #:______________________

PLEASE PRINT

Patient Information

PATIENT'S LAST NAME	FIRST NAME	MIDDLE/MAIDEN	SEX ☐ Male ☐ Female
BIRTH DATE / AGE	SOCIAL SECURITY #	CELL PHONE	PRIMARY PHONE #
PHYSICAL ADDRESS IF PO BOX	CITY	STATE	ZIP CODE
MAILING ADDRESS	CITY	STATE	ZIP CODE
MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated		E-MAIL ADDRESS	
EMPLOYED BY	OCCUPATION	WORK PHONE #	EXT
SPOUSE'S NAME / BIRTH DATE	SPOUSE'S SOCIAL SECURITY #	SPOUSE EMPLOYED BY	SPOUSE'S WORK PHONE #
REFERRING DOCTOR	ADDRESS	FAMILY DOCTOR	ADDRESS
LOCAL EMERGENCY CONTACT: NAME **(NOT LIVING WITH YOU)**		RELATIONSHIP	PHONE #

RACE: ☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian ☐ American Indian ☐ Alaska Native
☐ Native Hawaiian or other Pacific Islander ☐ Other ____

STUDENT: ☐ YES ☐ NO

Insurance Information

PRIMARY INSURANCE CO.			SECONDARY INSURANCE CO.		
POLICY HOLDER	POLICY NO.	GROUP NO.	POLICY HOLDER	POLICY NO.	GROUP NO.
POLICY HOLDER BIRTH DATE	POLICY HOLDER SOCIAL SECURITY #		POLICY HOLDER BIRTH DATE	POLICY HOLDER SOCIAL SECURITY #	

WILL YOU BE FILING WORKER'S COMP? ☐ YES ☐ NO

BODY PART BEING SEEN FOR: ____________________

DID YOU HAVE AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY OR ONSET: ____________________

IF PATIENT IS A MINOR, PLEASE COMPLETE CONSENT AND PARENT INFORMATION:

I, being the parent / guardian do hereby request and authorize Carolina Orthopaedic Specialists, P.A. or persons designated by them to perform necessary services for my child, including, but not limited to: x-rays, and administration of anesthetics which are deemed advisable by the physician, whether or not I am present at the actual appointment when the treatment is rendered.

Parent / Guardian Signature ____

FATHER'S NAME	FATHER'S SOCIAL SECURITY NUMBER	BIRTH DATE	HOME PHONE #	
FATHER'S ADDRESS	FATHER EMPLOYED BY		WORK PHONE #	EXT
MOTHER'S NAME	MOTHER'S SOCIAL SECURITY NUMBER	BIRTH DATE	HOME PHONE #	
MOTHER'S ADDRESS	MOTHER EMPLOYED BY		WORK PHONE #	EXT

AUTHORIZATION TO RELEASE INFORMATION AND BENEFITS TO PHYSICIAN:

I hereby authorize Carolina Orthopaedic Specialists, P.A. to release any medical information to the Insurance company(s), Medicare, Medicaid, Third Party Liability, or Workers Compensation. I designate and authorize payment directly to Carolina Orthopaedic Specialists, P.A. of any benefits payable to me for services rendered.
I understand that regardless of any insurance coverage applicable, I am responsible for any charges incurred in treatment.
I also understand that I will be responsible for all charges incurred in any collection efforts by Carolina Orthopaedic Specialists, P.A. All Self-Pay charges, co-pays and deductibles are due in full at the time service is rendered. I further agree that this assignment will not be withdrawn or voided at any time until this account is paid in full.

____ ____________________
SIGNATURE OF PATIENT / PARENT OR GUARDIAN DATE

Chart # ________________

Patient Name ________________________________

Due to Federal Regulations concerning patient privacy, we are unable to discuss your medical condition with anyone, including your family, without your permission.

Please read the following statements and mark the ones you wish our office to observe.

☐ Only discuss my health or financial information with me.

☐ Yes, Carolina Orthopaedic Specialists employees are allowed to discuss my medical condition and/or financial matters with my family.

Please list family members that this statement represents and their relationship to you:

____

____

____

☐ Yes, Carolina Orthopaedic Specialists employees are allowed to discuss my medical condition and/or financial matters with my clergy and/or close friends.

Please list names and relationship of these individuals:

____

____

____

☐ May leave any medical or financial information, test results, etc., on my answering machine or voice mail.

Additional comments: ____

____

____

Patient/Guarantor Signature ________________________________

Date ____

Mark S. Brazinski, MD
Michael P. Bunch, MD
Donald A. Campbell, MD
Christopher T. Daley, MD
Alfred E. Geissele, MD
Matthew D. Hannibal, MD
James A. Hurt, III, MD
Jeffrey P. Keverline, MD
Timothy H. Kirkland, MD
Ralph J. Maxy, MD
Patrick O'Brien, MD
W. Luke Robinson, MD
J. Barry Sanderlin, MD
Stephen J. Sladicka, MD
James E. Stanislaw, MD
Mark A. Tiffany, MD
Earl W. Walker, Jr., MD
Jason D. Zook, MD

PAIN TREATMENT CENTER

PAIN HISTORY AND PHYSICAL

Name:____________________________ **Chart#:**______________ **Referring MD:**____________

Date of Birth:____________________________ Age:____________ **Primary Care MD:**____________

What pain is the reason for today's visit? ____

PLEASE FILL OUT THE PAIN DRAWING. MARK THE AREAS OF THE BODY CORRESPONDING WITH WHERE YOU FEEL THE PAIN.

USE THE FOLLOWING SYMBOLS TO DISTINGUISH BETWEEN THE DIFFERENT TYPES OF PAIN.

NUMBNESS: ____________

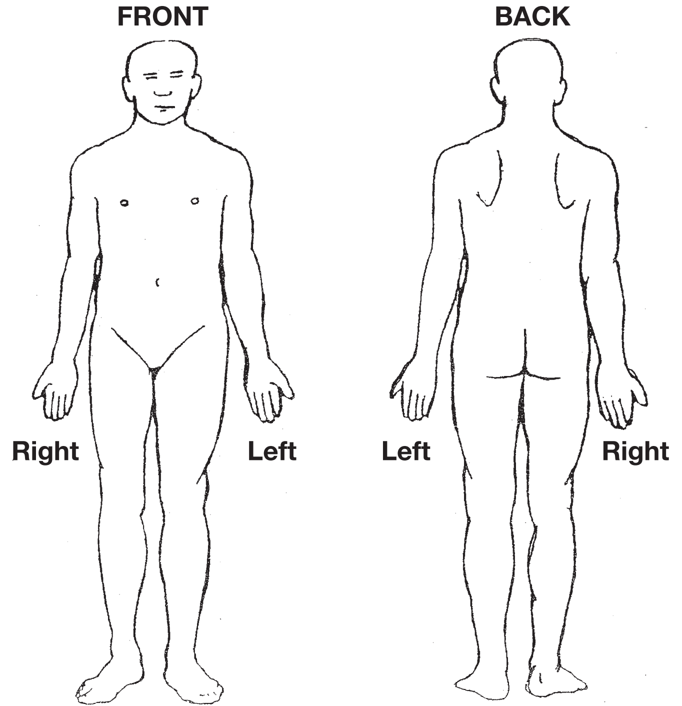
BURNING: X X X X X X X

ACHING: ┼┼┼┼┼┼┼┼┼┼┼┼

PINS AND NEEDLES: O O O O O O O

STABBING: / / / / / / / / / / / /

OTHER: * * * * * * * * *



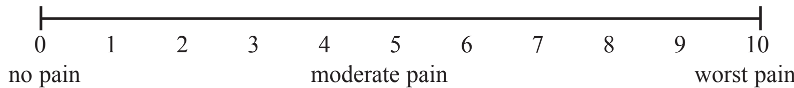
When did your pain begin (approximate date)?____

Describe what happened.____

____

____

Since the onset of symptoms, has the pain / soreness: ☐ improved ☐ worsened ☐ stayed the same



Which number describes your pain on a usual basis? ________ least? ________ worst? ________

Describe your pain (check all that apply): *McGill Questionnaire*

☐ sharp ☐ aching ☐ burning ☐ tingling ☐ throbbing ☐ shocking ☐ dull
☐ stabbing ☐ shooting ☐ other ____________________________

How often do you have this pain? ☐ rarely ☐ infrequently ☐ sometimes ☐ frequently ☐ constantly

What do you do to decrease your pain? ____

What activities increase your pain? ☐ walking ☐ standing ☐ lying ☐ bending / twisting
☐ lifting/carrying ☐ typing ☐ kneeling ☐ sitting ☐ pushing / pulling ☐ coughing / sneezing
☐ eating ☐ bathing ☐ using toilet ☐ getting up from chair/bed ☐ other: ____________________

Are you constipated?____

Describe your usual job:
☐ sedentary (lifts less than 10 lbs) ☐ light (lifts up to 20 lbs) ☐ medium (lift up to 50 Lbs)
☐ heavy (occasionally lifts up to 100 Lbs) ☐ very heavy (often lifts 100 or more)

Are you presently? ☐ working full time ☐ part time (hours / week ☐ unemployed
☐ homemaker ☐ retired ☐ on medical leave ☐ disabled

How many days have you been absent from work in the last year due to pain? ______________________________

Check any of the following that apply:
☐ worker's compensation claim filed ☐ receiving worker's comp. payments
☐ lawsuit pending ☐ lawyer retained - Attorney's name: ______________________________

How would you describe your current quality of life? ☐ very good ☐ good ☐ acceptable ☐ poor ☐ unbearable

How would you describe your sleep? ☐ restful ☐ usually good ☐ interrupted ☐ restless ☐ sleepless

Have you had any test related to your pain?______________________________

____

If yes, where? ______________________________

Check if you have used any of the following services.

		Helped relieve pain?	
Emergency room treatment	☐	☐ Yes	☐ No
Hospitalization	☐	☐ Yes	☐ No
Pain Medications	☐	☐ Yes	☐ No
Surgery	☐	☐ Yes	☐ No
Epidural injections	☐	☐ Yes	☐ No
Counseling	☐	☐ Yes	☐ No
Acupuncture	☐	☐ Yes	☐ No
Physical therapy	☐	☐ Yes	☐ No
Chiropractic care	☐	☐ Yes	☐ No
Massage therapy	☐	☐ Yes	☐ No
Doctors office visits	☐	☐ Yes	☐ No
Brace / corsets	☐	☐ Yes	☐ No

Constitutional: check any that apply:
_____ weight gain _____ weight loss _____ decreased energy _____ fainting _____ sweating

Cardiovascular:: _____ murmur _____ angina _____ swelling

Respiratory: _____ shortness of breath _____ wheezing _____ coughing

Hema / Lymph: _____ easy bruising/bleeding _____ phlebitis _____ blood disorders

Skin: _____ color changes _____ hair loss on arms or legs _____ temperature on arms or legs

Neuro: _____ headaches _____ visual changes _____ bothered by bright lights _____ weakness
_____ paralysis _____ dizziness _____ clumsiness _____ spasms/cramping _____ numbness

GI: _____ constipation _____ loss of bowel control _____ heartburn _____ diarrhea

GU: _____ urinary retention _____ loss of bladder control

Musculoskeletal: _____ muscle aches _____ joint pain _____ joint stiffness _____ swelling
_____ muscle wasting

Psychological: _____ anxiety _____ irritability _____ sleep disturbances _____ depressed mood _____ suicidal ideations

Endocrine: _____ changes in sex drive _____ hot/cold intolerence _____ sweating

MEDICAL HISTORY

YES	NO	Have you ever had . . .	Explain:	YES	NO	Have you ever had . . .	Explain:
_____	_____	heart disease?	__________________	____	____	epilepsy (seizures)?	___________________
_____	_____	heart attack?	__________________	____	____	drug addiction?	___________________
_____	_____	high blood pressure?	__________________	____	____	ulcers?	___________________
_____	_____	stroke?	__________________	____	____	cancer?	___________________
_____	_____	asthma?	__________________	____	____	psychiatric illness?	___________________
_____	_____	tuberculosis?	__________________	____	____	depression?	___________________
_____	_____	hepatitis or yellow jaundice?	__________________	____	____	migraines?	___________________
_____	_____	kidney disease?	__________________	____	____	fibromyalgia?	___________________
_____	_____	aids exposure?	__________________	____	____	arthritis?	___________________
_____	_____	acid reflux?	__________________	____	____	anxiety?	___________________
_____	_____	thyroid disease?	__________________	____	____	Other?:	___________________
_____	_____	diabetes mellitus?	__________________	____	____		___________________
_____	_____	glaucoma?	__________________	____	____		___________________

Please list any surgeries and the dates you had them:____

____

____

YES	NO	SOCIAL HISTORY
_____	_____	Are you allergic to any foods? If yes, what?______________________________
_____	_____	Are you allergic to any medications? If yes, what?__________________________
_____	_____	Are you allergic to Iodine? ____________________ adhesive tape? ____________________
_____	_____	Do you drink alcoholic beverages? ______________ How much? ______________________
_____	_____	Do you smoke? ________ How many packs per day?__________ How many years?__________
_____	_____	Are you pregnant? Last menstrual period? _______
_____	_____	History of drug use? ______________________________________

YES	NO	
_____	_____	Wear removable dentures?
_____	_____	Other prosthesis?
_____	_____	Have any major physical or congenital defects?
_____	_____	Pacemaker or internal defibrillator?
_____	_____	Metal pierced jewelry?

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

YES	NO	**Family History: Has anyone in your family:**
_____	_____	Had a tendency to bleed excessively?
_____	_____	Had unusual reactions to anesthesia?
_____	_____	Disease? Explain:____

List current medications:

Name	Dosage/mg	# of times taken per day
______________________	________________	____________
______________________	________________	____________
______________________	________________	____________
______________________	________________	____________
______________________	________________	____________
______________________	________________	____________

Is there anything else you would like the doctor to know? ________________________________

____

I have reviewed these three pages in its entirety: ______________________________

Physician Signature