LOUDOUN SPINE & REHABILITATION

PATIENT INFORMATION

Personal Information*

Prefix: Mr./Mrs./Other:_____ Patient Name*:_____ (Last / First / Middle Initial) Suffix: Jr./Sr./Other: _____

Previous Name: _____ Preferred Name: _____ Email: _____

Mailing Address*: _____ (Street Address / Apt. # / City / State / Zip)

Home #:_____ Cell #:_____ Work #:_____ Ext: _____

Method of Contact for Appointment Reminders: ☐ Text Message ☐ Home Phone ☐ Cell Phone

Primary Care Provider (PCP):_____ (First / Last) Address:_____ Phone #: _____

Referring Provider:_____ (First / Last) Address:_____ Phone #: _____

Date of Birth*:_____ (mm/dd/yyyy) Birth Sex*:_____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #:_____-_____-_____ Employer Name:_____ Occupation:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A

Additional Information*

Race*: ☐ Caucasian/White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Other:_____

Ethnicity*: ☐ Hispanic/Latino ☐ Non-Hispanic or Latino

Gender Identity: ☐ Male ☐ Female ☐ Female-To-Male (FTM)/Transgender Male/Trans Man ☐ Male-To-Female (MTF)/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female ☐ Choose not to disclose ☐ Other, please specify: _____

Language*: ☐ English ☐ Spanish ☐ Other: _____

Sexual Orientation: ☐ Lesbian, gay/homosexual ☐ Straight/heterosexual ☐ Bisexual ☐ Don't know ☐ Choose not to disclose ☐ Something else: _____

Pharmacy Name*:_____ Address:_____ Phone #:

Emergency Contact*

Name:_____ (Last / First) Relationship: _____

Address: _____ (Street Address / Apt # / City / State / Zip)

Home #:_____ Work #:_____ Cell #: _____

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name:_____ (Last / First) Date of Birth:_____ (mm/dd/yyyy) Birth Sex:___ Social Security #:_____-_____- _____

Address: _____ (Street Address / Apt # / City / State / Zip)

Home #:_____ Cell #:_____ Work #:_____ Ext: _____

Primary Insurance Information*

Insurance Name:_____ Member ID #:_____ Relationship to Insured:_____

Employer:_____ Group #:_____ Effective Date: _____ (mm/dd/yyyy)

Insured's Information* - (if not self)

Name:_____ (Last / First) Date of Birth:_____ (mm/dd/yyyy) Birth Sex:___ Social Security #:____-_____- _____

Relationship to Insured:_____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: _____ (Street Address / Apt # / City / State / Zip)

Home #:_____ Work #:_____ Cell #: _____

Secondary Insurance Information

Insurance Name:_____ Member ID #:_____ Relationship to Insured:_____

Group#:_____ Effective Date: _____

Secondary Insured's Information - (if not self)

Name:_____ (Last / First) Date of Birth:_____ (mm/dd/yyyy) Birth Sex: ____ Social Security #:____-____- _____

Relationship to Insured:_____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: _____ (Street Address / Apt # / City / State / Zip)

Home #:_____ Work #:_____ Cell #: _____

CONSENT INFORMATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. **X_____ (Please initial)**

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If any LMG health professional, worker or employee should be directly exposed to your blood or your body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed. **X_____ (Please initial)**

If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test. **X_____(Please initial)**

CONSENT FOR HEALTH INFORMATION EXCHANGE

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Please initial beside the option of your choice:

Opt In: Send and Receive Documents
X_____ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

Opt Out
X_____ Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on
- all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. **X_____(Please initial)**

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis Date

_____
Relationship (if any)

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

_____
Patient's Name

I have a received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

_____
Signature

Date:_____

_____
Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) **Other:**

LOUDOUN MEDICAL GROUP PC
NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions or comments about this Notice please contact:

Loudoun Medical Group, PC
224-D Cornwall St. N.W., Suite 403
Leesburg, VA 20176

Our Privacy Officer is: Clara McAuley Nussbaum, Director of Compliance, 703-737-6010

Who Does this Notice Apply to?

Loudoun Medical Group, PC ("LMG"), has published this Notice. It applies to everyone who works for Loudoun Medical Group, PC, including our employees, contractors, and volunteers.

Why Do We Publish this Notice?

LMG understands that information about you and your health is sensitive and personal. We are required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information. We are also required to notify affected individuals of any breach of unsecured protected health information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and obtain a copy of our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you. Requests for amendments and requests for accountings must be made in writing and directed to the Privacy Officer.

When Is This Notice Effective?

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from _____ until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

- *Treatment*. We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.
  These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- *Payment*. We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

  For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in

connection with payment for your care.

- *Health care operations*. We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

We may also use and disclose information about you in the following situations, without your prior authorization:

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- Unless you object, to friends or family members who are involved in your medical care.
- Unless you object, to notify, or to assist in notifying, a family member or friend of your location or condition.
- To health oversight authorities, for regulatory, licensing and other legal purposes.
- In litigation and legal proceedings, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
- To Funeral Directors/Medical Examiners/Coroners in the event of your death.
- When required by Federal, State or Local law.
- For medical research purposes, subject to your authorization or approval by an institutional review board or privacy board.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise the Privacy Officer in writing at the address given above.

Most uses and disclosures of psychotherapy notes and most uses and disclosures of your information for marketing purposes will require your written authorization. Further, LMG would typically be required to obtain your written authorization in order to sell your information. Except for uses and disclosures described in this notice, we may not use or disclose information about you for any other purpose without your written authorization.

What Legal Rights Do You Have In Connection With Your Information?

- Right to Inspect and Copy. You have the right to inspect or obtain copies of your medical information. To inspect and copy medical information, you must submit your request in writing to the Privacy Officer at the address set forth above. If you request a copy of the information, there will be a charge based on our costs.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.

  To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address set forth above. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support

the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for LMG;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You will be informed of the decision regarding any request for amendment of your medical information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your medical information. The accounting of disclosures typically would not list disclosures we made of medical information about you that were made for purposes of treatment, payment, or health care operations and that were made in response to a specific authorization from you.

  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address set forth above. Your request must state a time period for which you want the accounting (which may not be longer than six years prior to the request).

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to a requested restriction, unless (i) you are requesting that we not disclose information to a health plan for payment or health care operations of the health plan, and (ii) the information pertains solely to an item or service for which you or someone other than the health plan has already paid in full. If we do agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment. Additionally, even when we do not agree to a requested restriction, health information about you may only be disclosed to family or friends if, in the exercise of professional judgment, we believe it is in your best interest to have such information disclosed. However, under such circumstances, where practical, you will be given the opportunity to object to any such disclosure.

  To request restrictions, you must make your request in writing to the Privacy Officer at the address set forth above.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the Privacy Officer at the address set forth above. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- Complaints. If you believe your privacy rights have been violated, you may file a complaint with LMG or with the Secretary of the Department of Health and Human Services. To file a complaint with LMG, contact the Privacy Officer at the phone number or address set forth above. All complaints to the Department of Health and Human Services must be submitted in writing. We will not retaliate against you for filing a complaint.

LOUDOUN SPINE & REHABILITATION

Michael Kuo, MD | Fernando F. Mendez, PA-C
224-D Cornwall Street, NW, Suite 202
Leesburg, VA 20176
Office: 703-443-8110 | Fax: 703-443-2714

GENERAL WAIVER & POLICIES

If our staff becomes exposed to your bodily fluids, we have implied consent to test your bodily fluids in the necessary way to limit the staff's health risk.

If your insurance company issues payment to you in form of a check, you will either endorse the check to our office or immediately make payment in full of the amount issued to you by the insurance company for services rendered by our office to you.

Payment is due at the time of service. We accept cash, check, Mastercard, Visa, American Express and Discover.

Regarding insurance in which we participate:

If we are a participating provider, we expect payment in full of any co-pays, deductibles or co-insurance at the time of your visit. We will file the claim to your insurance company on your behalf, as a courtesy to you.

If a referral or pre-authorization is needed, it is your responsibility to be aware of that and obtain it before your visit. Failure to obtain a referral or pre-authorization, will become your responsibility and you must pay the fees in full for that visit.

We must verify all insurance benefits prior to any medical treatment. Some services require pre-authorization. If you request such service before pre-authorization is obtained, payment in full of our fees is expected at the time the service is rendered.

If any service submitted to your insurance company is rejected due to "non-covered service" or "not medically necessary", the bill then becomes your responsibility.

Regarding insurance in which we do not participate:

Payment of our fees is due in full at the time of service. It is your responsibility to submit the bill to your insurance company so that they may reimburse you.

General Information:

Your insurance policy is a contract between you and your insurance company. We are not privy to that contract.

Accounts that are over 90 days past due, which are not paid in full, will be turned over to collections. You will then be responsible for any collection/attorney fees and/or interest expenses that are incurred in an attempt to collect this debt.

Medicare and/or your private insurance carrier will only pay for services that determine to be "reasonable and customary" under Section 1862 (a) (1) of the Medicare law.

It will be the patient's responsibility to verify that your insurance will cover any procedure that you are requesting to be done or that we provide.

Private and Commercial insurances will deny coverage for the following reasons:

A. Patient is not listed as a covered dependent on said plan
B. Patient policy has terminated at time of service and/or patient did not present the front desk with a current insurance card
C. Acupuncture
D. Botox medication/injection procedure
E. Non-covered Medicare procedures (see ABN form)

You may receive a statement/invoice if you do not present the following at the time of your visit:

A. A referral/referring script from your primary care physician
B. An insurance company issued referral or authorization
    - If you have exceeded the number of visits allowed by your pre-authorization or insurance referral
    - If you have reached the cap on the allowed amount of any certain approved benefit
C. If we have not been given a current insurance card anytime you receive a new card (regardless of whether it appears any information has changed)
D. Are a self-pay patient
E. If the insurance determines that the procedure we perform is not medical necessary despite our indications or the judgement call by our provider deeming it medically necessary

If Medicare and/or my commercial insurance should deny any or all charges and/or I do not present any of the items above, I agree to be personally and fully responsible for any and all balances due.

Name: _____

Signature:_____Date: _____

LOUDOUN SPINE & REHABILITATION

Michael Kuo, MD | Fernando F. Mendez, PA-C
224-D Cornwall Street, NW, Suite 202
Leesburg, VA 20176
Office: 703-443-8110 | Fax: 703-443-2714

POLICY

Patient Name: _____

Loudoun Spine and Rehabilitation seeks to provide excellent medical care for all of our patients. That is our exclusive focus. Except as required by law, Loudoun Spine and Rehabilitation will not participate in any legal proceedings or complete attorney related paperwork.

I have read and understand the above.

Signature:_____Date: _____

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NEW PATIENT QUESTIONNAIRE

Name: _____ Date: _____ Injury Date: _____

Height: _____ Weight: _____ Age: _____ Date of Birth: _____

Who referred you to Loudoun Spine and Rehabilitation? _____

Who is your primary care physician? _____

Please list the physicians, therapists, chiropractors and other health care providers you have seen for your pain, along with the approximate dates:

_____

_____

List any **drug allergies or contrast/dye allergies:**

_____

_____

Current medications: **(please complete or bring your medication list)**

Name of Medication	Dosage	Frequency	Reason

Please list any previous pain medications you have taken in the past and note if they helped or not:

_____

_____

Please list any serious/chronic illnesses you may have or have had (i.e., high blood pressure, diabetes, thyroid):

_____

_____

Please list any surgeries you have had:

_____

_____

Please check if you have any of these: ☐ PACEMAKER ☐ NEUROSTIMULATOR ☐ ANEURSYM CLIPS
Do you have any metal in your body from a medical procedure? ☐ YES ☐ NO
Have you ever been a welder, grinder, or done any metalworking? ☐ YES ☐ NO

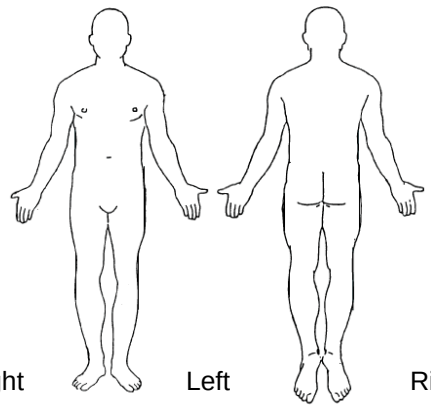
LOUDOUN SPINE & REHABILITATION

Name: _____ Date of Birth: _____

Please answer the following questions about your symptoms:

1. When did they begin? _____
2. Was there an injury or accident that initiated the symptoms? _____
   _____
3. What have you tried to relieve your symptoms? _____
   _____
4. How would you describe your pain?
   ☐ DULL ☐ PRESSURE ☐ ACHING ☐ STABBING ☐ THROBBING ☐ STIFFNESS
   ☐ SHOOTING ☐ BURNING ☐ CUTTING ☐ PINS/NEEDLES ☐ TINGLING
   ☐ ELECTRIC SHOCKS
5. How often do you experience these symptoms?
   ☐ CONTINUOUSLY ☐ DAILY ☐ WEEKLY ☐ MONTHLY
   ☐ OTHER:_____
6. Which positions **INCREASE** your pain?
   ☐ STANDING ☐ SITTING ☐ LYING ☐ WALKING ☐ TWISTING ☐ REACHING
   ☐ LIFTING ☐ BENDING ☐ OTHER:_____
7. Which positions **REDUCE** your pain?
   ☐ STANDING ☐ SITTING ☐ LYING ☐ WALKING ☐ TWISTING ☐ REACHING
   ☐ LIFTING ☐ BENDING ☐ OTHER:_____

Please mark on the figure the location of your symptoms:
Pain = XXX Numbness/tingling = OOO



PAIN SCALE: (**check** your pain intensity)

- ☐ 0 = No pain
- ☐ 1
- ☐ 2 = Tolerable (no activities prevented)
- ☐ 3
- ☐ 4 = Tolerable (some activities prevented)
- ☐ 5
- ☐ 6 = Intolerable (but can watch TV, read)
- ☐ 7
- ☐ 8 = Intolerable (can't watch TV, read, etc.)
- ☐ 9
- ☐ 10 = Intolerable (can't even talk)

LOUDOUN SPINE & REHABILITATION

Name: _____ Date of Birth: _____

Family History: Any illnesses in your family (mother, father, brother, sister)? _____
_____

Social History: Occupation: _____ Are you currently working? ☐ YES ☐ NO

Marital status: ☐ DIVORCED ☐ MARRIED ☐ SEPARATED ☐ SINGLE ☐ WIDOWED
Cigarette use: ☐ NEVER ☐ FORMER SMOKER ☐ CURRENT SMOKER (_____packs per day)
Alcohol consumption: ☐ NEVER ☐ RARE ☐ OCCASIONALLY ☐ FREQUENTLY (___drinks per day)
Recreational Drug use: ☐ NEVER ☐ RARE ☐ OCCASIONALLY ☐ FREQUENTLY
What type of exercise/sports do you perform and how often? _____
D o you have any hobbies? _____

Review of Symptoms: Have you recently had any of the following?

☐ Change in appetite or weight
☐ Fevers
☐ Chills
☐ Night sweats
☐ Headaches
☐ Visual changes
☐ Double vision
☐ Ringing in your ears (tinnitus)
☐ Hearing deficit
☐ Gum bleeding
☐ Hoarseness
☐ Difficulty swallowing
☐ Difficulty sleeping
☐ Frequent urination
☐ Blood in urine
☐ Burning urination
☐ Need to urinate urgently
☐ Mental problems
☐ Anxiety
☐ Depression
☐ Gout
☐ Diabetes
☐ Rashes
☐ Difficulty with breathing
☐ Cough
☐ Blood in your sputum
☐ Wheezing
☐ Lung disease
☐ Palpitations
☐ Chest pain
☐ Passing out
☐ Abdominal pain
☐ Bloating
☐ Constipation
☐ Diarrhea
☐ Dark or blood stools
☐ Convulsions or seizures
☐ Heart murmur
☐ High cholesterol
☐ Ulcer
☐ Liver problems or hepatitis
☐ Pregnancy
☐ AIDS or HIV positive
☐ Skin breakdown
☐ Excessive sweating
☐ Other symptoms not asked above:_____

If you have any of the following **diagnostic tests,** please indicate the date of the test and the results:

Regular x-ray: _____
Myelogram: _____
Discogram: _____
EMG/NCS: _____
CT Scan:_____
MRI:_____
Bone Scan:_____
Other:_____