WEST COAST CENTER FOR ORTHOPEDIC SURGERY AND SPORTS MEDICINE
MANHATTAN BEACH CA

PATIENT INFORMATION

(PLEASE PRINT CLEARLY)

PATIENT'S NAME_____ **DATE**_____

DATE OF BIRTH_____**SOC. SEC.#**_____ **DRIVERS LIC#**_____

ADDRESS_____
Number & street **city** **state** **zip**

E-MAIL ADDRESS_____

HOME PHONE #_____ **CELL PHONE #** _____

PATIENTS/GUARANTOR'S EMPLOYER_____**PHONE #**_____

EMPLOYER ADDRESS_____
Number & street **city** **state** **zip**

EMERGENCY CONTACT:_____**PHONE #**_____

HOW WERE YOU REFERRED TO OUR OFFICE_____

INSURANCE INFORMATION (PLEASE LET US COPY YOUR INS. CARDS)

PRIMARY INSURANCE:

INS. CO. NAME_____

INSURED ID#_____

GROUP#_____

INSURED NAME_____

INS. CO. PHONE#_____

PATIENT'S RELATIONSHIP TO INSURED

SELF ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** ☐

SECONDARY INSURANCE:

INS. CO. NAME_____

INSURED ID#_____

GROUP#_____

INSURED NAME_____

INS. CO. PHONE#_____

PATIENTS RELATIONSHIP TO INSURED

SELF ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** ☐

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other plan to *KEITH S. FEDER, MD.* I hereby authorize/consent to treatment, by Keith S. Feder, MD and Associates. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I also understand that should legal action be necessary to collect any unpaid balance due for medical services rendered I will be held responsible for all attorneys' fees and other costs of collection to the full extent permitted by law. I hereby authorize said assignee to release information necessary to secure payment. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Signature of responsible party **Date**

WEST COAST CENTER FOR ORTHOPEDIC SURGERY AND SPORTS MEDICINE

FINANCIAL POLICY

We appreciate the opportunity of participating in your medical care. Your health is our concern. Our financial policy as set forth below is designed to allow us to offer the best medical care to all of our patients. With this in mind, we thank you in advance for adhering to the following terms.

The usual charge for an initial comprehensive examination is $250.00. Thereafter, a copayment and/or a percentage payable, as stated by your insurance policy, will be expected at the time of each visit. If you have not met your deductible however, then payment in full will be expected until your deductible is met. Thereafter your copayment/percentage will apply. If your insurance company refuses to divulge your deductible status, we will assume your deductible is not met unless you provide us with written proof that it is met, such as a copy of an explanation of benefits.

As a courtesy to you, we will bill your insurance company at no charge. However, we do ask that you provide complete and accurate insurance information as requested on the Patient Information sheet, which you complete at your first visit. It is your responsibility to update us regarding any change in that information and we may periodically ask you to complete a new form.

Once payment is received from your insurance company, we will bill you for any remaining balance due. If the insurance payment results in a credit balance and you are still receiving treatment, it will be applied to your account. If you have completed treatment, a refund check will be mailed to you.

If we experience undue delay in payment by your insurance company (beyond 45 days from the date of submission) we may ask you for full or partial payment and/or ask that you promptly follow-up with your insurance company to obtain expedited payment. If you have secondary insurance coverage, we will also bill them for you for the balance due after your primary insurance has paid.

If you are involved in an automobile accident and have “med pay” coverage, we will bill them directly until benefits have been exhausted. We can then bill your private health insurance for any dates not exceeding one year from time of submission or you can continue on a cash basis.

Please understand that your insurance coverage involves a contract between you/your employer and the insurance company and we are not a party to that agreement. West Coast renders service directly to you. Therefore, regardless of any insurance coverage (except Workers Compensation & Training to Win), you are personally responsible for all charges.

For your convenience we accept payment by cash, check or credit card.

If you are unable to meet these terms, or if you have any questions, please contact me at (310) 416-9700 to make other arrangements or have your questions answered. You will be asked to sign a financial agreement reflecting any special terms we agree upon.

Please sign and date below to indicate that you understand and agree to the foregoing terms.

Sincerely,

WEST COAST CENTER/KEITH S. FEDER, MD INC.

_____ _____

SIGNATURE **DATE**

West Coast Center for Orthopedic Surgery & Sports Medicine
Release-Authorization-Assignment of Benefits

Consent to Treatment

I, the undersigned patient, agent for the patient, or legal guardian, consent to the procedures which may be performed on me during my visits to this office. I authorize **West Coast Center for Orthopedic Surgery and Sports Medicine** and its physicians, fellows, visiting residents, and/or technicians to perform on me any and all required and all required treatments and/or procedures, including but not limited to emergency treatment and services, laboratory procedures, minor surgeries, physical examinations, x-rays, injections, ultrasound guided injections, EMG/NCV studies, Ultrasound studies, or physical therapy sessions. I agree that if I discontinue medical care at this office contrary to the opinion or decision of this physician, I will hereby relieve this office, physicians, and associates of all responsibilities for my health.

Release of information

I, the undersigned patient, agent for the patient, or legal guardian, agree that the **West Coast Center for Orthopedic Surgery and Sports Medicine** and associates may disclose and/or release a portion or all of the patients record including his/her medical record, to any person or entity which is or may be responsible for all or any portion of the office and/or physician's charges.

In considering the amount of medical expenses to be incurred, I, the undersigned patient, agent for the patient, or legal guardian, have insurance, health insurance, and/or employee health care benefits coverage with the above captioned and/or has healthcare benefits/insurance/health insurance per the information provided, and hereby assign and convey directly to The West Coast Center for Orthopedic Surgery/Keith S. Feder MD Inc., Carol Frey, MD, Inc., associates, and healthcare provider(s), **as my designated Authorized Representatives.** ALL medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. **I hereby authorize the above-named provider(s) to release all medical information necessary to process my claims under HIPAA.**

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law including but not limited to, ERISA §502(a)(l)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the·medical services I received from the named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies including, but not limited to, (]) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my providers/in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

APPENDUM TO PATIENT FINANCIAL RESPONIBILITY

I acknowledge the possibility that a check and or checks may be sent directly to me instead of you, my provider. I understand this money is not mine even though the check may be written to me. I understand you are billing my insurance company as a courtesy to me, but the money paid by the insurance company belongs entirely to you. I therefore, agree to immediately, but certainly no later than 48 hours upon receipt of any such monies, forward this money directly to you. I will make no attempt to negotiate what portion I send to you. In any event, I acknowledge and

agree that I am legally responsible for any charges for service rendered to me and I will pay all fees including any co-pays or deductibles, if applicable.

NOTE: Please read the above agreements carefully and make sure that you understand all the items and conditions before signing below. If you do not understand, please review contents with the staff prior to signing. Your signature confirms that you have read and fully understand all the agreements, terms, and conditions above.

Authorization for the Release of Medical Records

I, the undersigned patient, agent for the patient, or legal guardian, hereby grant permissions to and authorize any physicians, medical practitioner, hospital, pharmacy, clinic, or other medical or medically-related facility or provider of medical or dental services or supplies, any employer, insurance or reinsurance companies, benefits plan administrator, educational institutions, or any federal, state or local government agencies, including social security administration, veteran administration, and/or entities release my complete medical records in their possession to **West Coast Center for Orthopedic Surgery and Sports Medicine** and/or its physicians. A photocopy or facsimile of this authorization shall be valid and effective as the original.

Medicare Patients Release of Information

I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made directly to this physician and/or medical group and I understand that I am responsible for the remaining balance not covered by other insurance.

Notice of Privacy Practice- HIPAA Compliance

This facility is HIPAA compliant. The patient's privacy is protected including medical and personal information. As required by law, we will use and disclose our patient's health information in a limited way according to the requirements by all applicable laws, I, the undersigned patient, agent for the patient, or legal guardian, have been informed of my privacy rights.

Patient's Name_____ **Signature**_____

Relationship to patient_____ **Date**_____

West Coast Center for Orthopedic Surgery and Sports Medicine

WEST COAST CENTER FOR ORTHOPEDIC SURGERY AND SPORTS MEDICINE
MANHATTAN BEACH CA

ORTHOPÆDIC FOOT AND ANKLE SPECIALIST

RE: Cancellation of PPO/EPO Contracts

Dear Patient:

Effective immediately our office does **not** participate with any Insurance plans. This became necessary due to the unreasonably low contract payments forced upon us by these plans.

Blue Shield and Blue Cross will send payments directly to you. Please deposit checks and either pay the doctor with a check or credit card and include the Explanation of Benefits (EOB'S) with payment.

We will bill your insurance companies as an out-of-network provider on your behalf.

Any questions regarding your insurance company should be directed to our billing staff at time of service.

Thank you for your cooperation and understanding.

Sincerely,

Dr. Feder & Dr. Frey

I have read and understand the above information.

Signature Date

Print Patient Name

Keith S. Feder, M.D. & Carol Frey, M.D.
1200 Rosecrans Ave #208, Manhattan Beach, CA. 90266
310-416-9700 www.westcoastorthopedics.com

Keith S. Feder, M.D.
West Coast Center for Orthopedic Surgery and Sports Medicine

WEST COAST CENTER FOR ORTHOPEDIC SURGERY AND SPORTS MEDICINE
MANHATTAN BEACH CA

Carol Frey, M.D.
Orthopedic Foot & Ankle Center

POLICY FOR SUPPLIES

Because there is no guarantee that your insurance company will pay for the supplies that the doctor has ordered for you, we have made the following two options available to you, our patient.

1) The doctor requests that all supplies are paid for at the time the patient receives the item. You have the option of paying for the supplies at the time of your visit. **(or)**
2) You can wait until we submit a claim to your insurance carrier to request payment for the supplies needed. This may take up to 60 days or more to get a response from your insurance company. If you decide on this option, you will not receive any supplies until your insurance company pays us in full for the supplies, unless the doctor has made prior arrangements with you, the patient.

With either option, you will be responsible for any remaining balance that your insurance company does not pay. If your insurance company pays 100% then your deposit will be applied to any unpaid balance due on your account. If you do not have any unpaid balance on your account, your account will be credited, the balance will be used toward any further services rendered. If you do not have any unpaid balances a refund check will be issued, if requested by the patient.

PLEASE NOTE:

1) You will be responsible for any attempts or inquiries to your insurance company, regarding processing of this claim for payment. Professional services are rendered to you, our patient, not to your insurance company. Which means the insurance company is responsible to you directly.
2) All supplies are non-returnable once they leave our office for health and safety reasons.

Thank you for your understanding and cooperation.

PRINT NAME:_____

SIGNATURE:_____ **DATE:**_____

WITNESS:_____

1200 Rosecrans Ave. Suite 208, Manhattan Beach, CA 90266
(310) 416-9700 (310) 416-1144- fax

Member Authorization Form for a Designated Representative to Appeal a Determination

Date: _____

Member Name: _____

Member Number: _____

I hereby authorize Keith Feder M.D., Carol Frey M.D., West Coast Center for Orthopedic Surgery and Sports Medicine and Associates to appeal determination concerning:

_____
_____
_____
_____

on my behalf, as my Designated Representative, and as part of the appeal I hereby authorize in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

All medical and financial information contained in my insurance file, including but not limited to treatment for vernal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in the authorization, or as required or permitted by law. This authorization is valid for a period of one year.

×_____
Signature of Member or Legal Guardian/Representative

×_____
__Signature of Witness **__Designated Representative** (check one)

×_____
Name of Witness/ Designated Representative (Please Print)

×_____
Title (if on provider's staff of relationship of Member)

West Coast Center for Orthopaedic Surgery & Sports Medicine
1200 Rosecrans Avenue, Suite 208, Manhattan Beach, CA 90266
Phone: (310) 416-9700 Fax: (310) 416-1144

WEST COAST CENTER FOR ORTHOPEDIC SURGERY AND SPORTS MEDICINE MANHATTAN BEACH CA

MEDICAL HISTORY SCREENING FORM

Patient Name: _____ Date of Birth: _____Age: _____Today's Date: _____

Referred by:_____ Primary care physician/Internist: _____

Height: _____Weight: _____ Orthopedic surgeon: _____

MARITAL STATUS:

❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widow/Widower

LIVES WITH: (SOCIAL HISTORY):

❑ Alone ❑ Spouse ❑ Family ❑ Friends ❑ Nursing Home ❑ Retirement Home ❑ Other: _____

WORK STATUS (SOCIAL HISTORY):

Occupation: _____ Last date worked? _____ or ❑ N/A

❑ Not currently working ❑ Currently working ❑ Disabled If yes, how? _____❑ Retired ❑ Unemployed

❑ Work w/ restrictions ❑ yes ❑ no If yes, details please._____

❑ Left-handed ❑ Right-handed ❑ Ambidextrous

PERSONAL HABITS:

Cigarettes: ❑No ❑Yes pks/day_____ or cig/day _____Alcohol: ❑No ❑Yes If yes, how much? ❑Often ❑socially ❑Occasionally ❑Rarely
Chew tobacco : ❑ No ❑Yes, How many times a day? _____ Pipe: ❑ No ❑ Yes # cigars/day_____

Illegal Drug use: ❑No ❑Yes, If yes, drug name_____

Over the counter medications _____

Vitamins _____

HISTORY OF PRESENT ILLNESS/INJURY:

Reason for visit/ Injured Body Part/Injury? _____

How and when did the problem start? _____
_____

EVALUATION OF PAIN/DISCOMFORT:

What activities are you unable to do because of the pain? _____
_____

Does the pain keep you awake at night? ❑ No ❑ Yes If yes, please give details. _____
_____

What makes it feel better? _____

What makes it feel worse? _____

Pain scale (circle one number) No Pain 1 2 (mild) 3 4 5 6 7 8(moderate) 9 10 Severe pain (severe)

PATIENT NAME: _____ Today's Date: _____

PREVIOUS TREATMENT FOR THIS PROBLEM:

What other physicians have you seen for this problem: _____

_____

What prescriptions are you using presently? _____

_____

Any physical therapy? ❑ No ❑ Yes If yes, name and date: _____

Any chiropractic care? ❑ No ❑ Yes If yes, name and date: _____

Other treatments? _____ _____

Use of assistive devices for this problem? ❑ Cane ❑ Splints ❑ Braces ❑ Walker ❑ Other:_____

Is this being covered by Workmen's Compensation? ❑ No ❑ Yes Date of Injury: _____

Is this being covered by Auto Insurance (MedPay)? ❑ No❑ Yes Date of Injury: _____

Is there a lawsuit or litigation pending in regard to your injury? ❑ No❑Yes

Attorney Name: _____

Address: _____

PAST MEDICAL HISTORY: (Please check all that apply. If you do not have anything to mark or add please select NONE)

❑ AIDS/HIV	❑ Gastrointestinal Disease	❑ Hypothyroidism	❑ Pneumonia
❑ Asthma	❑ Glaucoma	❑ Irregular Heartbeat	❑Prostate Disease
❑ Bladder Disease	❑ Gout	❑ Kidney Disease	❑ Rheumatoid Arthritis
❑ Bleeding Disorder	❑ Leukemia	❑ Seizure Disorder	❑ Blood Clots (DVT)
❑ Heart Attack	❑ Liver Disease	❑ Stomach Ulcers	❑ Bronchitis
❑ Heart Disease	❑ Lung Disease	❑ Stroke	❑ Heart Murmur
❑ Cancer If so, where? _____	❑ Multiple Sclerosis (MS)	❑ Tuberculosis	❑ Currently Pregnant
❑ Parkinson's Disease	❑ Hepatitis	❑ Osteoarthritis	❑ Vascular Disease
❑ Diabetes	❑ Hodgkin's Disease	❑ Osteoporosis	(circulation)
❑ Fibromyalgia	❑ Hypertension (High BP)	❑ Parathyroidism	❑ Other (describe):
❑ Gastroesophageal Reflux Disease (GERD)	❑ Hyperthyroidism		_____

❑ **NONE**

ANY current infections, open sores or open wounds? ❑No ❑Yes, If so, where? _____

PRIOR SURGERIES: (Please mark all that apply. If there are no prior surgeries, please select NONE)

❑ Appendectomy	❑ D&C (Dilation & Curettage)	❑ Pacemaker Insertion
❑ Arthroscopy: If so, where? _____	❑ Endoscopy	❑ Rotator Cuff Repair
❑ Ankle Repair	❑ Gastric Bypass	❑ ACL Repair
❑ Carpal Tunnel Release	❑ Bicep Tendon Repair	❑Shoulder Repair
❑ Menisectomy	❑ Hernia Repair	❑Stent Placement
❑ Labrum Repair	❑ Knee Replacement	❑ Achilles Tendon Repair
❑ Cholecystectomy (gallbladder)	❑ Hip Replacement	❑ Scope Subtalar
❑ Colonoscopy	❑ Wrist Repair	❑ Peroneal Tendon Repair
❑ Coronary Artery Bypass Graft (CABG)	❑ Laminectomy	❑ Other: _____

❑ **NONE**

If any of the above have been marked please provide the date of surgery (s):_____

_____

PRIOR FRACTURES: (Please write down what fractures you have had in the past. If there are NOT any fractures, please select NONE)

_____

_____

❑ **NONE**

PATIENT NAME: _____ **Today's Date:** _____

FAMILY HISTORY: (Please mark all that apply. If you have nothing to select or add, please select NONE)

❑ Bleeding Disorder
❑ Cancer: If so, where? __
❑ Diabetes
❑ Heart Disease
❑ Kidney Disease
❑ Musculoskeletal Disease
❑ Osteoarthritis
❑ Osteoporosis
❑ Prostate Disease
❑ Thyroid Disease
❑ Hypertension
❑ Stroke
❑ Other: _____

❑ NONE

REVIEW OF SYSTEMS: (Please mark all that apply. Mark NONE under EACH section if no symptoms are selected):

Constitutional:
❑ Anorexia
❑ Anxiety
❑ Body aches
❑ Fainting
❑ Fever
❑ Fatigue
❑ Fever
❑ Loss of appetite
❑ Seizures
❑ Sweats
❑ **NONE**
Comments: _____

Cardiovascular (CV):
❑ Angina
❑ Breathing, painful
❑ Coronary Artery Disease (CAD)
❑ Congestive Heart Failure (CHF)
❑ Chest pain
❑ Chest discomfort
❑ Chest tightness
❑ Dizziness
❑ Dyspnea (difficulty breathing)
❑ High blood pressure
❑ Irregular heartbeat
❑ Palpitations
❑ Shortness of breath (SOB)
❑**NONE**
Comments: _____

Genitourinary (GU):_____
❑ Bladder infection
❑ Burning with urination
❑ Frequency
❑ Kidney disease
❑ Kidney stones
❑ Retention
❑ Urgency
❑ UTI (urinary tract infection) frequency: _____
❑ **NONE**
Comments: _____

Ears, Nose, Mouth & Throat (ENMT):
❑ Allergies
❑ Obstructed Breathing
❑ Bloody Nose
❑ Polyps
❑ Congestion
❑ Sinus Pain
❑ Frequent Colds
❑ Frequent Colds
❑ Stuffy Nose
❑ Mouth Breathing
❑ Ulcers
❑ **NONE**
Comments: _____

Respiratory:
❑ Bronchitis
❑ Respiratory Disease
❑ Emphysema
❑ Tuberculosis
❑ Pneumonia
❑ Wheezing
❑ Sleep apnea
❑ **NONE**
Comments: _____

Gastrointestinal (GI):
❑ Abdominal pain
❑ Abdominal swelling
❑ Bloody stools
❑ Bloody stools
❑ Bowel movement, painful
❑Colon cancer, family history
❑ Constipation
❑ Diarrhea
❑ Gas/bloating
❑ GERD (gastroesophageal reflux disease)
❑ Heartburn
❑ Hemorrhoids
❑ IBS (irritable bowel syndrome)
❑ Indigestion
❑ Nausea
❑ Ulcer disease
❑ Urinary incontinence
❑ Vomiting
❑ **NONE**
Comments: _____

PATIENT NAME: _____ Today's Date: _____

REVIEW OF SYSTEMS continued: (Please mark all that apply. Mark **NONE** under EACH section if no symptoms are selected)

Musculoskeletal:
- ❑ Ambulatory dysfunction
- ❑ Arthritis
- ❑ Back pain
- ❑ Back stiffness
- ❑ Balance, (poor)
- ❑ Deformities
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Herniated disc
- ❑ Joint pain
- ❑ Joint, red and hot
- ❑ Joint stiffness
- ❑ Leg swelling
- ❑ Numbness
- ❑ Paresthesia
- ❑ Rheumatoid arthritis
- ❑ Varicose veins
- ❑ Tremors
- ❑ **NONE**

Comments:_____

Hematologic/Lymphatic:
- ❑Bleeding/clotting disorder
- ❑Blood disease
- ❑Sickle cell anemia
- ❑Easy bleeding
- ❑Easy bruising
- ❑Radiation treatment of any kind
- ❑**NONE**

Comments: _____

Skin:
- ❑Basal cell carcinoma
- ❑Birthmarks
- ❑Bruising
- ❑Eczema
- ❑Latex allergy
- ❑Sneezing
- ❑Rash/Rashes
- ❑Raynaud's
- ❑Shingles
- ❑Sores
- ❑Squamous cell carcinoma
- ❑Tattoo
- ❑**NONE**

Comments: _____

Nails:
- ❑Cracking
- ❑Peeling
- ❑**NONE**

Comments: _____

Neurological:
- ❑ Amnesia
- ❑ CVA (cerebrovascular accident)
- ❑ Blackout
- ❑CVA (cerebrovascular accident)
- ❑Depression
- ❑Disorientation
- ❑Dizziness
- ❑Epilepsy
- ❑Multiple Sclerosis
- ❑Paralysis
- ❑Stroke
- ❑TIA (transient ischemic attack)
- ❑**NONE** Comments:_____

Psychiatric:
- ❑Anxiety
- ❑Crying frequently
- ❑Insomnia
- ❑Memory loss
- ❑Mood changes
- ❑OCD
- ❑Psychiatric treatment
- ❑**NONE**

Comments: _____

Allergy/Immunologic:
- ❑ Allergies If yes, What: _____
- ❑Food allergy
- ❑Nasal
- ❑Asthma
- ❑Chills
- ❑Coughing
- ❑Diarrhea
- ❑Difficulty breathing
- ❑Difficulty swallowing
- ❑Fever
- ❑Hives
- ❑Itchy skin
- ❑**NONE**

Comments: _____

Hair:
- ❑Alopecia(loss of hair)
- ❑Increased hair growth
- ❑**NONE**

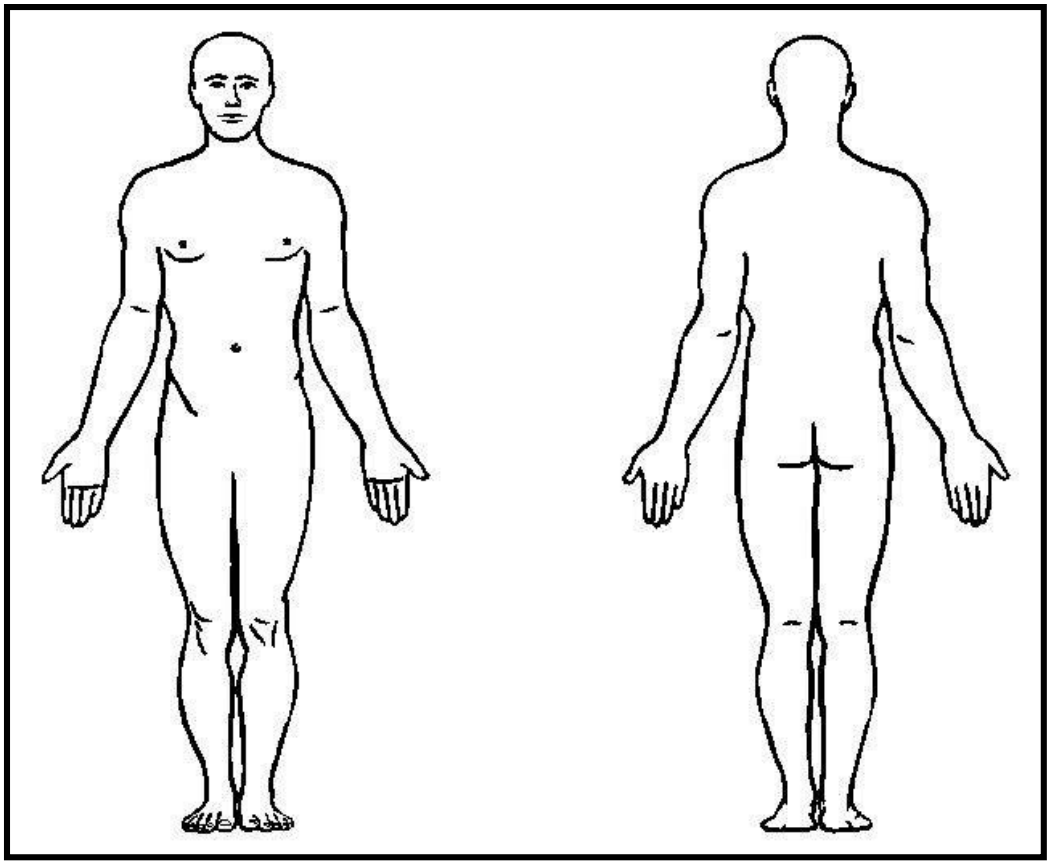
Comments: _____

LOCATION OF PAIN

Draw location of your pain in body outlines below and indicate how bad it is by putting the number from 1 to 10 in the area of the pain. (1 being mild and 10 being extreme)

INDICATE CONDITION IN THE APPROPRIATE AREAS ON THE DIAGRAM

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
*****	^^^^^	+++++	#####	/////	xxxxx



FRONT **BACK**

Has your condition been aggravated or is there a new condition? ❑**Yes** ❑**No**

Please explain _____

_____

What feels better today? _____

_____

_____ _____ _____

Signature of Patient or Responsible Party **Printed Name** **Date**