Ohio Institute for Orthopedics \ Institute for Orthopedic Surgery Lima, Ohio

Dr Michael F Stretanski PM&R, Interventional Pain Management.

Initial Informed Consent to Diagnose and Treat

This will serve as informed consent to diagnose and treat. You will be seen today by Dr. Stretanski (Dr Mike) who does many procedures both therapeutic and diagnostic in the office, in addition to physical exam, medical history, review medical record, and work-up if necessary.

Dr Mike does not write for any medications at all, including no pain meds. He does not discuss, have any opinions, recommend or get involved in any medication management whatsoever. You are here to be evaluated for procedures and other treatments.

In the interest of time and simplification. This will serve as informed consent to many of the things Dr. Mike can and usually does here in the office. This will be consent for office -based interventions such as, but not limited to, trigger point injections, ultrasound-guided injections of joints like sacroiliac joint, spinal structures like facet joints, or nerves. Also, this serves as consent for Nerve Conduction Study and EMG.

Dr Mike is a DO, an Osteopathic Physician, and routinely does manual medicine – like spinal and joint manipulation and often does it very smoothly in conjunction with his examination.

In general: The fact is that anything bad can happen anytime a doctor does anything for a patient- either related to known or unknown factors, such as if you are not diagnosed with a medical condition. There is never any guarantee with any medical treatment and many treatments may need to be repeated periodically.

Specifically: Steroids can cause water retention, swelling, flushing, and rise in blood sugars if you are a diabetic. Any injection can cause bleeding, bruising and carries a risk of infection or medication reaction. Injections also have the potential to get into areas we do not want them to go. Manual medicine is generally very safe, but people can get sore and sometimes feel worse before they feel better, this is also true of any injection. EMG/NCS gives you electric shocks but the machine is not capable of hurting you. The EMG needle carries the same risk as any skin entry.

Dr Mike will explain everything to you before doing anything and you will be informed of the plan or care and have the option to accept or decline. Any specific questions you have will be answered. You have the right to say stop at any time during your care and Dr Mike will stop.

My signature below indicated I have reviewed and understand the above and this Initial Consent will be in effect for subsequent visits.

Patient Signature:_____ DOS:_____/_____/2021

Witness:_____

OIO | Orthopaedic Institute of Ohio
Get well. Get moving again.

Michael F. Stretanski, D.O.

801 Medical Dr Ste A, Lima, OH 45804 ● 419-222-6622 ● Fax: 419-222-4069 ● www.orthoohio.com

Welcome to the Orthopaedic Institute of Ohio

To facilitate your surgical consultation, we request the following information to be brought to your appointment:

- Copy of your imaging disc if you had any done (MRI, CT scan, X-rays etc.)
  If this is not provided, we may have to reschedule your appointment.
  No disc needed if your imaging was done at Wilson Memorial Hospital, Lima Memorial Hospital, St. Rita's Medical Center or Van Wert County Hospital.
- Test Reports (EMG, Radiology)
- Driver's license
- Insurance Card(s)
- Current list of medications
- Co-pay, if applicable
- Please complete enclosed paperwork

Your appointment is on: _____A.M./P.M. at the following office:

_____ Lima Office – 801 Medical Drive, Ste. A, Lima, OH

_____ Sidney Office – 915 W. Michigan Street, Sidney, OH

_____ St. Marys Office – 1275 East Greenville Road, St. Marys, OH

_____ Findlay Office – 1501 Bright Road, Findlay, OH

* You may also log onto www.orthoohio.com to pre-register through our patient portal.

Sincerely,

Michael F. Stretanski, D.O.

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Demographic Information

Date:_____

Patient Name	**Home Phone**	**Cell Phone**	**Employer Phone**

Mailing Address (include PO Box and Apt. #)	**Family Doctor Name and Phone Number**
City, State, Zip	**Referring Doctor Name and Phone Number**

Age	**Date of Birth**	**Sex**	**Marital Status**	**Social Security Number**

Employer's Name	**Employer's Address**

SPOUSE/PARENT/GUARDIAN INFORMATION (Please circle which one)

Name	**Social Security #**	**Date of Birth**	**Relationship to patient**	**Marital Status**

Mailing Address

EMERGENCY CONTACT (phone number cannot be the same as patient's home or cell number)

Name	**Relationship**	**Phone**

INSURANCE INFORMATION (please present your insurance cards so that we may obtain a copy for our records)

Primary Insurance Company			**Secondary Insurance Company**		
Policy Holder's Name	**SS#**		**Policy Holder's Name**	**SS#**	
Date of Birth / **Co-Pay**	**Relationship to patient**		**Date of Birth** / **Co-Pay**	**Relationship to patient**	
Policy Holder's Address			**Policy Holder's Address**		
Policy Holder's Employer			**Policy Holder's Employer**		

If BWC: Date of Injury	**Pharmacy Card (company name)**	**ID Number**	**Phone**

E-mail Address	**I authorize OIO to leave a message at (please initial all that apply)**
	☐ Home ☐ Work ☐ Cell

Race:
- ☐ White/Caucasian
- ☐ Black or African-American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ Hispanic or Latino

Ethnicity:
- ☐ Latino or Hispanic
- ☐ Not Latino or Hispanic

Language:
- ☐ English
- ☐ Spanish
- ☐ Indian
- ☐ Other

Pharmacy Name	**Location**	**Pharmacy Phone Number**

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PATIENT AUTHORIZATION

I hereby authorize Orthopaedic Institute of Ohio, to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I also authorize the release of any necessary information, including medical information if requested by the above named insurance company. I permit a copy of this authorization to be used in such instances.

By signing below, I agree to pay all charges for services rendered by OIO which are not covered by the above referenced insurance coverage. If it becomes necessary for OIO to seek judicial action to enforce the above agreement, I agree to pay all collection fees and all attorneys' fees of OIO for such action. I also authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided or associated with my account.

REFERRALS

I understand that I am responsible for obtaining a valid referral from my primary care physician if required by my insurance company.

PRE-CERTIFICATION

I understand that OIO will attempt to obtain a pre-certification as a courtesy for me. I understand that OIO is not obligated to obtain pre-certification for me and it is my responsibility to obtain or to make sure any required pre-certification has been obtained for me prior to my procedure. I agree to advise and confirm with OIO that a pre-certification has been obtained for me. I understand in the event pre-certification is not obtained by me, I will be responsible for any amounts not paid, reduced or denied by my insurance company.

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

I agree to promptly pay all charges when billed for medical services rendered. As a parent or guardian, I agree legal responsibility for all charges incurred by the patient named on the previous page.

POLICY CONCERNING MEDICAL RECORDS

I hereby authorize OIO to release my medical information as I have directed. I understand that OIO does not copy records and that such record copying services are performed by the independent records copying company. Therefore, such record copying may be subject to a copying charge. I also understand that since OIO does not copy records that records must be requested at least two weeks in advance of desired receipt date. If there is a charge for copying my records, I understand that I will be billed by the independent records copying company based upon allowable charges under current Ohio law for copying medical records. Patients or other parties authorized by the patient to request medical records for legal issues, insurance, disability (not workman's compensation), physician change, or relocation from the area are subject to a copying charge. There will be no charge for copying records for a referral to another physician made by an OIO physician, or workman's compensation issues or any other situations covered by Ohio law.

PHOTOGRAPHY CONSENT

I give OIO permission to photograph my child for security purposes. I understand the picture will be retained in their medical record and used for identification purposes only.

PATIENT RIGHT TO PRIVACY/CONFIDENTIALITY

Orthopaedic Institute of Ohio is committed to patient privacy and confidentiality. In our Patient Bill of Rights, we state that our patients have a right to privacy and confidentiality. Therefore, you will be asked for your permission prior to the release of your records. Your medical information will be kept confidential to the degree required under existing law and regulation. However, from time to time we may need to contact you at home or work. If we need to contact you, may we have your permission to leave a message with regards to your care, any lab results, and appointment information, if you are unavailable or do not answer the phone? I understand that I may receive a copy of the Privacy Practices upon request.

Release of Medical Information Agreement

Federal and state law direct when the Practice may disclose a patient's Protected Health Information to persons involved in a patient's care. This form allows a patient to designate family members, friends or other individuals to whom the Practice may release Protected Health Information.

I, _____ (print patient name) hereby agree that the following person(s) involved in my care may receive medical information about me (friends or family members, not physicians).

External Prescription History

I give OIO permission to review external prescription history.

Name	Relationship to patient	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

This form is not intended as a full authorization to release all of your Protected Health Information. The individuals listed above will only receive Protected Health Information directly relevant to such individual's involvement in your care or payment related to your care. You may cancel or alter this designation at any time by informing OIO in writing of such change/alteration. Any cancellation or alteration can only apply to future disclosures or actions regarding your Protected Health Information and cannot cancel actions taken or disclosures made while the designation was in effect.

Date	Patient/ Parent or Guardian Signature	Date of Birth
_____	_____	_____

Rev:10/2014

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Patient Information

Please print all information. All blanks must be filled to allow us to serve you quickly and efficiently.

Patient Name:				**Appointment Date:**	
DOB:		**OFFICE USE ONLY:** Height:	Weight:	BP:	Pulse:
Referring Doctor:			**Family Doctor:**		

Are there any other physicians to whom you would like your medical records sent?
(Please include name, address and phone): _____

_____

_____

How were you referred to Orthopaedic Institute of Ohio (OIO):

◯ Physician ◯ Patient / Friend ◯ Health Connection ◯ Workers Comp

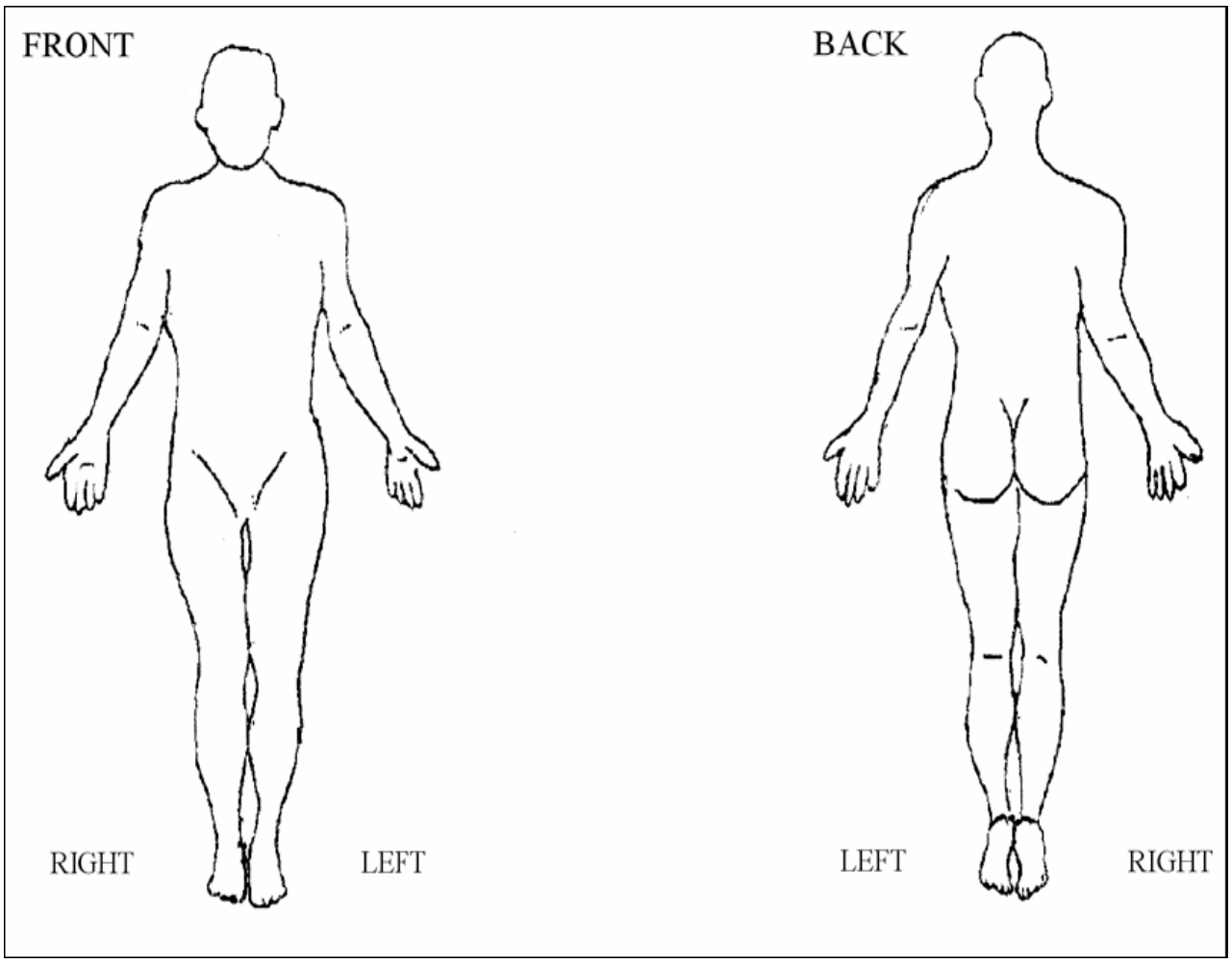
◯ OIO Reputation ◯ Insurance ◯ Radio / TV Advertisement ◯ Other: _____

ORTHO PAIN CHART

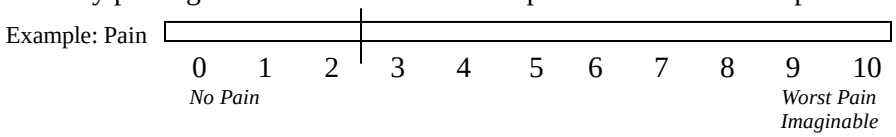
Mark the areas of your body where you feel the pain and/or sensations below, using the appropriate SYMBOL.

Mark the areas where your pain radiates, include all affected areas.

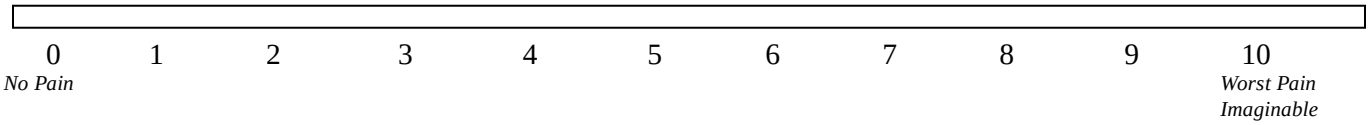
Numbness	Pin & Needles	Burning/Aching	Stabbing
======	00000	XXXXX	//////



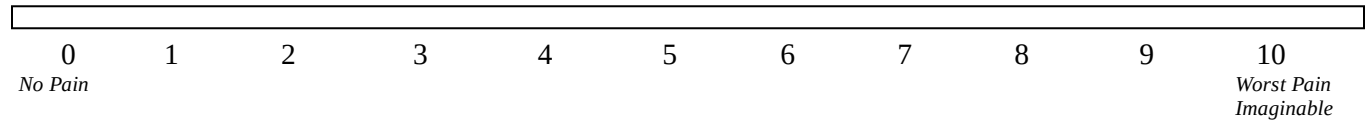
Please indicate your current pain level by placing a line below with "0" = no pain and "10" = worst pain imaginable.



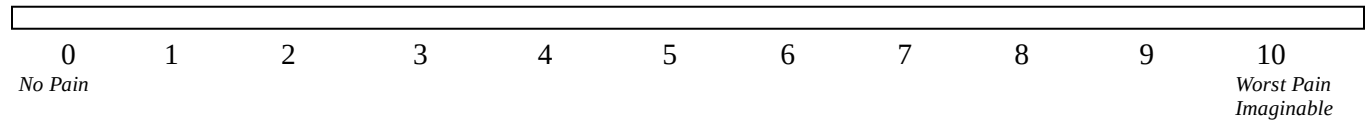
Pain at its worst:



Pain at its best (lying down, resting):



Pain on average:



HISTORY OF PRESENT COMPLAINT

1. Age: ____ ◯Male ◯Female Pain is on which side? ◯Right ◯Left
2. Where is your problem located? ☐Neck ☐Upper Back ☐Arm ☐Lower Back ☐Hip ☐Leg
3. How long have you had this problem? _____ Since? _____/_____/_____ (Month/Day/Year)
4. Briefly, please give the details of how this problem originally started: _____

_____

_____

5. Was this from a work-related injury? ◯Yes ◯No Is it under workers compensation ◯Yes ◯No

   Have you missed any work because of this problem? ◯Yes ◯No How much? _____
6. Is this the result of a motor vehicle accident? ◯Yes ◯No
7. Is there a Third Party responsible for payment? ◯Yes ◯No
8. Please describe your present pain/problem now (what you feel, where, when, etc.): _____

_____

_____

9. Have you had spinal surgery in the past: (Check one) ◯Yes ◯No How many times? _____

   What type of surgery(s) was/were performed? ☐Discectomy ☐Laminectomy ☐Fusion ☐IDET ☐Unknown ☐Other _____

   What spinal level? _____

   What was the date of your most recent spine surgery? _____

   Did you improve from your spine surgery procedure(s)? ◯Yes ◯No

10. Which of the following best describes your ratio for neck & arm or back & leg discomfort (if appropriate):

A. 100% back pain and 0% leg pain	A. 100% neck pain and 0% arm pain
B.90% back pain and 10% leg pain	B. 90% neck pain and 10% arm pain
C. 75% back pain and 25% leg pain	C. 75% neck pain and 25% arm pain
D. 50% back pain and 50% leg pain	D. 50% neck pain and 50% arm pain
E.25% back pain and 75% leg pain	E. 25% neck pain and 75% arm pain
F. 10% back pain and 90% leg pain	F. 10% neck pain and 90% arm pain
G. 0% back pain and 100% leg pain	G. 0% neck pain and 100% arm pain

11. For any pain/numbness in your arm(s) or leg(s), which side is worse? (Choose one if appropriate):

Leg Symptoms	**Arm Symptoms**
A. 100% left leg and 0% right leg	A. 100% left arm and 0% right arm
B. 75% left leg and 25% right leg	B. 75% left arm and 25% right arm
C. 50% left leg and 50% right leg	C. 50% left arm and 50% right arm
D. 25% left leg and 75% right leg	D. 25% left arm and 75% right arm
E. 0% left leg and 100% right leg	E. 0% left arm and 100% right arm

CURRENT PAIN PROFILE

12. Please choose letters A – F (in first column) to answer the questions in column two.

A. Unable to tolerate B. About 15 minutes only	How long can you sit?
C. About 30 minutes only D. About 45 minutes	How long can you stand?
E. About 1 hour F. Indefinitely	How long can you walk?

13. Which of the following activities change the nature of your pain?

	Aggravates Pain	**Relieves Pain**	**Neither**
Sitting			
Standing			
Walking			
Leaning forward (brushing teeth)			
Bending forward			
Lying in your side			
Lying on your back			
Lying on your stomach			
Rising from sitting			
Changing positions			
Coughing / Sneezing			
Driving			

Now go back and CIRCLE the box to indicate **the most aggravating activity** and the **most relieving activity.**

14. If the symptoms of your present pain have changed, please indicate the most appropriate statement: (Circle one)

A. My symptoms have remained the same since the time of onset.

B. My symptoms are more severe since the time of onset

C. My symptoms are less severe since the time of onset.

15. How have the symptoms of your present pain changed: (Circle one)

A. No change in symptoms

B. Increased aggravation in one arm or leg

C. Increased aggravation in both arms or legs

D. Increased aggravation in the back or neck

E. Increased aggravation in both arms/legs and back/neck

PAST BACK HISTORY

16. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury: (Check one of each)

	Which type	Helpful	No Help	Not Used
Anti-inflammatory				
Muscle Relaxants				
Narcotic Pain Medications				
Hot Packs				
Ice				
Ultrasound				
TENS Unit / Muscle Stim (Circle)				
Physical Therapy Treatment				
Back/Neck Exercises				
Chiropractor				
Injections				
Acupuncture / Massage				
Traction / VAX-D (Circle)				
Other				

17. Please indicate whether you have had any of the following studies and write when/where the most recent was:

	YES	NO	When/Where		YES	NO	When/Where
Regular X-ray of Spine				Myelogram			
CT Scan of spine				Discogram			
EMG				MRI of spine			
Nuclear Bone Scan				Bone Density			

18.Have you had any past episodes of similar pain or injury? ◯Yes ◯No (please describe)

_____

_____

_____

19. List all other physicians with whom you have consulted in the past year for this problem.

_____

_____

_____

MEDICAL/SURGICAL HISTORY

Please choose all current and past medical conditions

High blood pressure	◯Yes ◯No	Cancer - Where?	◯Yes ◯No
Heart attack	◯Yes ◯No	Kidney Failure	◯Yes ◯No
Heart failure	◯Yes ◯No	Kidney Stones	◯Yes ◯No
Abnormal heart rhythm	◯Yes ◯No	Osteoporosis	◯Yes ◯No
Lung disease	◯Yes ◯No	Osteoarthritis	◯Yes ◯No
Tuberculosis	◯Yes ◯No	Rheumatoid arthritis	◯Yes ◯No
Asthma	◯Yes ◯No	Bleeding disorders	◯Yes ◯No
Bronchitis	◯Yes ◯No	Anemia	◯Yes ◯No
Emphysema	◯Yes ◯No	Blood clots in legs/lung	◯Yes ◯No
Liver disease	◯Yes ◯No	Endometriosis	◯Yes ◯No
Hepatitis	◯Yes ◯No	Ovarian cysts	◯Yes ◯No
Diabetes	◯Yes ◯No	Anxiety	◯Yes ◯No
Thyroid disease	◯Yes ◯No	Depression	◯Yes ◯No
Stomach ulcers	◯Yes ◯No	Schizophrenia	◯Yes ◯No
Gastric Reflux	◯Yes ◯No	Anorexia/bulimia	◯Yes ◯No
Irritable bowel	◯Yes ◯No	Alcoholism	◯Yes ◯No
Stroke	◯Yes ◯No	Seen a psychiatrist	◯Yes ◯No
Seizures	◯Yes ◯No	HIV	◯Yes ◯No
Malignant Hyperthermia	◯Yes ◯No	Pacemaker or AICD	◯Yes ◯No
Have you ever had or presently have MRSA?			◯Yes ◯No
Have you been in close contact with someone who has had MRSA within the last year?			◯Yes ◯No
Are you a Health Care Worker	◯Yes ◯No	Sleep Apnea	◯Yes ◯No
Do you have CPAP Machine	◯Yes ◯No	Do you use the CPAP Machine	◯Yes ◯No

20. Are you under a doctor's care for any other medical condition? ◯Yes ◯No If yes, please explain:

_____

_____

21. Have you been seen by a Dentist in the last year? ◯Yes ◯No

22. Do you have any dental problems (broken, chipped or loose teeth, abscess, gum disease) ◯Yes ◯No

If yes, please explain: _____

Surgeries/Hospitalizations: **Please PRINT CLEARLY**

Procedure	Date

Latex Allergy? ◯**Yes** ◯**No** **Drug Allergies:** ◯**Yes** ◯**No** **Metal Allergies:** ◯**Yes** ◯**No**
If yes, please list below:

ALLERGIES (medications, food, seasonal etc.)	REACTIONS/SYMPTOMS OF ALLERGIES

Please list the medications you are CURRENTLY taking:

SOCIAL HISTORY

23.Current work status: ◯Working full-time, regular duty ◯Working part-time, regular duty ◯Not working
◯Working restricted duty (Since_____) ◯Retired ◯Disabled (Since _____) ◯Student
◯Homemaker ◯Unemployed

Company: _____ Occupation:_____ Title:_____

How long have you worked for this company?_____

24. Marital status: ◯Single ◯Married ◯Divorced ◯Widowed

25. Number of Children:_____

26. I live: ◯Alone ◯With:_____

27. I live in a: ◯House ◯Apartment ◯Assisted living ◯Nursing home

28. Are you a ? ◯ Current smoker ◯ Former smoker ◯ Nonsmoker ◯ Current every day smoker

◯ Current some day smoker ◯ Current smoker, status unknown ◯ Unknown if every smoked

How long have you smoked? ◯ More than 5 years ◯ Less than 5 years

How much do you smoke? ◯ 5 or less ◯ 6 to 10 ◯ 11 to 20 ◯ 21-30 ◯ 31 or more

How soon after you wake do you smoke your first cigarette? ? ◯ within 5 minutes ◯ 6-30 min ◯ after 60 min

If you quit smoking, how long ago did you quit?_____

How old were you when you started smoking? _____

29. Do you drink any alcoholic beverages? (Check one) ◯ Yes ◯ No

How many drinks per day? ◯ 0-1 ◯ 2-3 ◯ 4-5 ◯ more than 5 How many? _____

For how many years? ◯ 1-2 years ◯ 3-5 years ◯ more than 5 years

30. Have you ever had a problem with drug dependence? ◯ Yes ◯ No Alcoholic in past? ◯ Yes ◯ No

31. Do you exercise? ◯ Yes ◯ No

How many times per week? ◯ 1 time ◯ 2 times ◯ 3 times ◯ daily

How long do you exercise? ◯ 10 minutes ◯ 15 minutes ◯ 30 minutes ◯ more than 30 minutes

32. Are there any lawsuits pending or contemplated related to your problem? ◯ Yes ◯ No

If yes, please give your attorney's name and phone number: _____

33. Please write any additional information that you feel is important for us to know.

_____

_____

FAMILY HISTORY

What illnesses run in your close family (other than yourself)?

Scoliosis	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Spine disease	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Arthritis	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Heart disease	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
High blood pressure	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Diabetes	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Cancer	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Bleeding disorder	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Mental Illness	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Alcoholism	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Kidney disease	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Malignant Hyperthermia	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents
Other:	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents

REVIEW OF SYSTEMS

General					
Unexplained weight loss	◯ Yes ◯ No	Appetite change	◯ Yes ◯ No	Fever/Chills	◯ Yes ◯ No
Night sweats	◯ Yes ◯ No	Marked fatigue	◯ Yes ◯ No	Difficulty sleeping	◯ Yes ◯ No
EAR/NOSE THROAT					
Difficulty swallowing	◯ Yes ◯ No	Hoarseness	◯ Yes ◯ No	Loss of hearing	◯ Yes ◯ No
Ear pain	◯ Yes ◯ No	Nosebleeds	◯ Yes ◯ No	Gum trouble	◯ Yes ◯ No
EYES					
Glasses	◯ Yes ◯ No	Change of vision	◯ Yes ◯ No		
CARDIOVASCULAR					
Heart or chest pain	◯ Yes ◯ No	Abnormal heartbeat	◯ Yes ◯ No	Leg swelling	◯ Yes ◯ No
Poor heart function	◯ Yes ◯ No				
LUNG					
Morning cough	◯ Yes ◯ No	Shortness of breath	◯ Yes ◯ No	Productive cough/sputum	◯ Yes ◯ No
DIGESTIVE					
Nausea/vomiting	◯ Yes ◯ No	Stomach pain/ulcers	◯ Yes ◯ No	Blood in stool	◯ Yes ◯ No
Frequent diarrhea	◯ Yes ◯ No	Frequent constipation	◯ Yes ◯ No	Hemorrhoids	◯ Yes ◯ No
Uncontrolled loss of stool	◯ Yes ◯ No	Heartburn/ Acid Stomach	◯ Yes ◯ No		
SKIN					
Frequent rashes	◯ Yes ◯ No	Frequent itchiness	◯ Yes ◯ No	Easy bruising	◯ Yes ◯ No
Swollen ankles	◯ Yes ◯ No				
NEUROLOGICAL					
Seizures	◯ Yes ◯ No	Blackouts/fainting	◯ Yes ◯ No	Tremor	◯ Yes ◯ No
Headaches/migraines	◯ Yes ◯ No				
MUSCULOSKELETAL					
Joint pain	◯ Yes ◯ No	Joint swelling	◯ Yes ◯ No	Back pain	◯ Yes ◯ No
Neck pain	◯ Yes ◯ No	Muscle pain	◯ Yes ◯ No		
GENITOURINARY					
Burning on urination	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Pelvic pain	◯ Yes ◯ No
Difficulty starting to urinate	◯ Yes ◯ No	Urinate at night more than once	◯ Yes ◯ No	Unable to completely empty bladder	◯ Yes ◯ No
PSYC IATRIC					
Depression	◯ Yes ◯ No	Nervous exhaustion	◯ Yes ◯ No	Anxiety	◯ Yes ◯ No
Paranoia	◯ Yes ◯ No	Obsessive/ Compulsive behavior	◯ Yes ◯ No		

OIO-WS-201

Print Patient Name: _____ DOB: _____
Patient/Guardian Signature:_____ Date: _____

Revised 10/27/2020

OIO | Orthopaedic Institute of Ohio

Get well. Get moving again.

Michael F. Stretanski, D.O.

PLEASE ANSWER ALL QUESTIONS

Patient Name: _____DOB: _____

Thank you for choosing the Orthopaedic Institute of Ohio for your spine care. Please complete the following questions regarding the care and treatment that you have received in the past for your neck and/or back on another sheet of paper and bring this with you to your next appointment. This information will be used to help get approval through insurance if further testing or surgery is recommended. When answering the questions, please be specific and give as much detail as possible.

1. List all the over the counter medications that you have taken for your back/neck - What brand, how often taken and for how long?_____
2. List all prescription NSAIDS or steroids taken (prednisone, naproxen, lodine) - What brand, how often taken and for how long?_____
3. List all prescription pain medication taken (Vicodin, Tylenol 3, oxycontin) - What brand, how often taken and for how long?_____
4. Physical therapy - Where completed, when and for how long?_____
5. Home exercise program - Prescribed by whom, how long?_____
6. Chiropractic treatment - List treatment provided, when you started treatment and how often you went.
7. Epidural injections - How many have you had, dates of those procedures and where did you have the injections._____
8. Pain management program – Where and when did you complete this program?_____
9. Weight loss- How much weight have you lost from your original weight? Are you involved in a weight loss program?_____
10. Acupuncture – How many visits have you had and when?_____
11. Psychological Therapy – Where and when did you have therapy, what was your diagnosis and what medication did they prescribe for you?_____
12. Have you had a functional capacity evaluation? If yes, when and where did you have this evaluation?
13. List any other medical treatment that you have had for your spine. Include activity modification, sleeping patterns and/or use of any supports while sleeping, ie pillow, etc. _____
14. Smoking - If you are a past smoker list the date you quit. If you presently smoke- how many cigarettes do you currently smoke per day and if you have tried or are currently trying to quit smoking what assistance have you used, if any? _____

If you have any questions, please don't hesitate to call our office. Thank you for your time and effort in completing these questions.

USE A SEPARATE SHEET IF NECESSARY TO ANSWER ALL QUESTIONS

Revised 10/27/2020