INITIAL INTAKE EXAMINATION

3/2023

NAME:_____ DOB:_____ Age:_____ Date of Exam:_____

Health History Vitals: Ht:_____ Wt:_____ BP:_____ P:_____ SP02:_____

What is the main reason for seeking treatment?_____ Pain Level: (0-10)_____

What, if anything has made the problem worse? ❑driving ❑walking ❑ working ❑bending ❑standing ❑sports ❑sitting ❑sleeping

What, if anything, has made the problem better? ❑rest ❑ice ❑ heat ❑elevation ❑NSAIDS/Tylenol ❑pain meds

History of Present Injury/Illness:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea/Vomiting
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression/Anxiety	❑ Shortness of Breath	❑ Cold Feet/Hands
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Night Pain	❑ Bowel/Bladder Change
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension/Stress	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell/Taste	❑ Cold Sweats	❑ Chest Pain	❑ Fainting
❑ Dizziness	❑ Loss of Memory	❑ Blurred Vision	❑ Stomach Problems	❑ Other_____

_____

_____

_____

Medical History:

❑ Hypertension	❑ Heart Disease	❑ Migraines	❑ Liver Disease	❑ Rheumatoid Arthritis
❑ Diabetes	❑ Pinched nerve	❑ Cancer	❑ Kidney Disease	❑ Fibromyalgia
❑ High cholesterol	❑ Herniated disc	❑ Ulcers	❑ Osteoporosis	❑ Thyroid problems
❑ Pacemaker	❑ Stroke	❑ Arthritis	❑ Bleeding Disorders	❑ CoVid Infection
❑ Asthma	❑ Seasonal Allergies	❑ Constipation	❑ Menopause	❑ Hemorrhoids

Details: _____

Are you currently under medication or medical care? ❑ Yes ❑ No Who is your primary care Dr? _____

Please list ALL medications **including** over-the counter and vitamins: (**Be sure to include dosage and frequency**)

_____

_____

Allergies: _____

Surgeries and/or hospitalizations (**type & date**): _____

_____

Is there a **family history** of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

❑ High Blood Pressure _____ ❑ Diabetes _____ ❑ Bleeding Disorders_____
❑ Cancer _____Type:_____ ❑ Arthritis _____ ❑ Other _____

Intake of following: Cigarettes___ cigs/day (include VAPE) Alcohol ____drinks/week Caffeine _____ cups/day Illicits_____

Exercise frequency: ❑Never ❑Daily ❑Few Days/Wk ❑ Weekly ❑Walks ❑Runs ❑Lifts ❑_____

Occupation:_____ Does work mostly involve : ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor ❑Computer
Diet: Regular_____ Other:_____ Meals per day _____

WOMEN ONLY: Date of LMP:_____ Hysterectomy: YES/ NO Birth Control YES/ NO ***Any possibility of pregnancy: YES / NO***
Number of pregnancies_____ Number of live births _____ Type of delivery: Vaginal____/Cesarean____

- Reviewed with patient by: _____

Name:_____ 3/2023

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do have frequent falls or find that you trip over your feet while walking? NO YES
    Comment: _____
12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES
    Comment: _____
13. Medicines previously tried, dosage, duration and outcome.

    ☐Advil ☐Aleve ☐Tylenol ☐Steroids ☐Prescriptions for a period of ☐0-3mos, ☐3-6mos, ☐6-12 mos ☐12+mos
14. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind?
    _____
15. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for?
    _____
16. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it?
    _____
17. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: _____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____**I have read and understand the above consent form.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Bluestone Medical.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____
Signature of Patient/Guardian Date

X_____ _____
Witness (Office Staff) Date

Name:_____ DOB:_____ Bluestone Medical

Informed Consent

We are an integrated office that offers a variety of injections to assist in relieving pain. Lidocaine/Marcaine/Bupivicaine (numbing agents) are medications that are potentially utilized in our injections. We will not utilize steroids unless we are not getting a response from our more natural alternatives. Should you not respond to treatment and you choose to use a steroid, the lowest dose will be utilized and **you will be informed prior to the use of any steroids.**

The incidence of serious complications listed above requiring treatment is very low (less than 1% in our experience). Your provider believes the benefits of the procedure outweigh its risks or it would not have been offered to you. It is your decision and right to accept or decline to have the procedure done.
Some risks for complications include but are not limited to: bleeding, infection, allergic reaction to injectable medication, and pain/swelling at injection site. There is a remote risk of pneumothorax (lung collapse) with some injections. Signs of this would include chest pain, shortness of breath, and cough. Should these symptoms develop, you should report immediately to the emergency department for evaluation.

□ _____ **Trigger Point Injections**
Trigger point injections are a specific type of local injection that your physician can use to treat local areas of muscle pain and spasm. Trigger point injections can help break the cycle of pain in your back and neck and help restore normal muscle function and motion.

□ _____ **SI Injections**
Sacroiliac Joint Injection injections are primarily therapeutic injections. These injections eliminate pain temporarily by filling the SI joint with an anesthetic medication that numbs the joint, the ligaments, and joint capsule around the SI joint.

□ _____ **Knee Injections**
Knee injections can be utilized to relieve pain and decrease inflammation to the knee joint.

□ _____ **Hyaluronic Acid (HA)** Joint Fluid Therapy, also called a viscosupplement, is a nonsurgical, nonpharmacological therapy for knee osteoarthritis. HA therapy can help relieve pain, improve mobility and get you back to your normal activities. HA therapy contains highly purified sodium hyaluronate, also known as hyaluronan or hyaluronic acid. Hyaluronan is a natural substance found in joint cartilage and in the fluid that fills the joints, synovial fluid. Hyaluronan acts like a lubricant and shock absorber in synovial fluid of a healthy joint. ***Please notify us if you have an allergy to eggs before receiving this injection.***

□ _____ **Shoulder Injections**
Injections in the shoulder joint are necessary for therapeutic reasons in the course of treatment for shoulder pain.

□ _____ **Hip/IT Band Joint Injections**
If this area experiences arthritis, injury or mechanical stress, one may experience hip, buttock, leg or low back pain. A hip joint/bursa injection should be considered for patients with these symptoms. The injection can help relieve the pain, and decreases inflammation and improves range of motion.

□ _____ **Other:**_____

I have read or have had read to me the above information, I understand there are risks involved with this procedure, to include rare complications, which may not have been specifically mentioned above. The risks have been explained to my satisfaction and I accept them and consent to this procedure. This consent shall be valid for the duration of 1 year or until specifically revoked.

_____ _____ _____ _____
Patient Signature Date Witness Signature/Printed Name Date

_____ _____
Parent/ Legal Guardian of Minor Signature Date

Revised 1/2023