

# WELCOME

## PATIENT INFORMATION

DATE: \_\_\_\_\_  
SS/ID# \_\_\_\_\_  
PATIENT NAME \_\_\_\_\_  
LAST NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMAIL \_\_\_\_\_@\_\_\_\_\_

SEX  M  F AGE \_\_\_\_\_

BIRTHDAY \_\_\_\_\_

MARRIED  WIDOWED  SINGLE  MINOR  
 SEPARATED  DIVORCED  PARTNERED FOR \_\_\_ YEARS

OCCUPATION \_\_\_\_\_

PATIENT EMPLOYER/SCHOOL \_\_\_\_\_

EMPLOYER/SCHOOL ADDRESS \_\_\_\_\_

EMPLOYER/SCHOOL PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_

BIRTHDAY \_\_\_\_\_

SS# \_\_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_

WHOM MAY WE THANK REFERRING YOU? \_\_\_\_\_

## INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT? \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_

GROUP # \_\_\_\_\_

IS PATIENT COVERED BY ADDITIONAL INSURANCE?  Y  N

SUBSCRIBER'S NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_

GROUP # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

AND ASSIGN DIRECTLY TO **DR. ERIC GOLDBERG** ALL INSURANCE BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE FOR ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTS FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE \_\_\_\_\_

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE \_\_\_\_\_

DATE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

## PHONE NUMBERS

HOME PHONE (\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_) \_\_\_\_\_

BEST TIME AND PLACE TO REACH YOU \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT \_\_\_\_\_

NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

HOME # (\_\_\_\_) \_\_\_\_\_

WORK # (\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

IS CONDITION DUE TO AN ACCIDENT?  YES  NO

DATE \_\_\_\_\_

TYPE OF ACCIDENT  AUTO  WORK  HOME  OTHER

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT?

AUTO INSURANCE  EMPLOYER  WORKERS COMPENSATION

OTHER

ATTORNEY NAME (IF APPLICABLE) \_\_\_\_\_

## PATIENT CONDITION

REASON FOR VISIT \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

WHEN DID YOUR SYMPTOMS APPEAR? \_\_\_\_\_

IS CONDITION GETTING PROGRESSIVELY WORSE?  YES  NO  UNKNOWN

MARK AN X ON THE PICTURE WHERE YOU CONTINUE TO HAVE PAIN, NUMBNESS, OR TINGLING.

RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1 (LEAST PAIN) TO 10 (SEVERE PAIN). \_\_\_\_\_

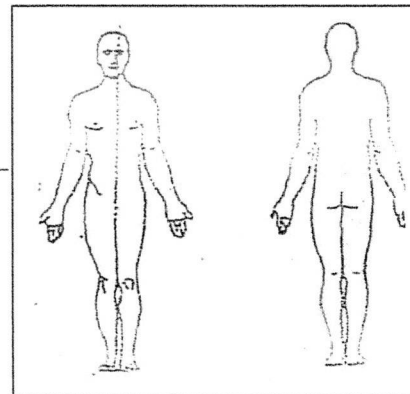
TYPE OF PAIN:  SHARP  DULL  THROBBING  NUMBNESS  ACHING  SHOOTING  
 BURNING  TINGLING  CRAMPS  STIFFNESS  SWELLING  OTHER

HOW OFTEN DO YOU HAVE THIS PAIN? \_\_\_\_\_

IS IT CONSTANT OR DOES IT COME AND GO? \_\_\_\_\_

DOES IT INTERFERE WITH YOUR  WORK  SLEEP  DAILY ROUTINE  RECREATION

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM  SITTING  STANDING  WALKING  BENDING  LYING DOWN



## HEALTH HISTORY

**WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOUR CONDITION?**

MEDICATIONS \_\_\_\_\_ SURGERY \_\_\_\_\_ PHYSICAL THERAPY \_\_\_\_\_ CHIROPRACTIC SERVICES \_\_\_\_\_ NONE \_\_\_\_\_  
 OTHER \_\_\_\_\_

**NAME AND ADDRESS OF OTHER DOCTORS WHO HAVE TREATED YOUR CONDITION** \_\_\_\_\_

DATE OF LAST: PHYSICAL EXAM \_\_\_\_\_ SPINAL X-RAY \_\_\_\_\_ BLOOD TEST \_\_\_\_\_  
 SPINAL EXAM \_\_\_\_\_ CHEST X-RAY \_\_\_\_\_ URINE TEST \_\_\_\_\_  
 DENTAL X-RAY \_\_\_\_\_ MRI, CT-SCAN, BONE SCAN \_\_\_\_\_

**PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE ONE OF THE FOLLOWING:**

AIDS/HIV	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DIABETES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	MIGRAINE-HEADACHES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	STROKE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ALCOHOLISM	<input type="checkbox"/> YES	<input type="checkbox"/> NO	EMPHYSEMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	MISCARRIAGE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	SUICIDE ATTEMPT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ALLERGIES SHOT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	EPILEPSY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	MONONUCLEOSIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	THYROID PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ANEMIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	FRACTURES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	MULTIPLE SCLEROSIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TONSILLITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ANOREXIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	GLAUCOMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	MUMPS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TUBERCULOSIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
APPENDICITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	GOITER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	OSTEOPOROSIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TUMORS GROWTH	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ARTHRITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	GONORRHEA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PACEMAKER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	THYROID FEVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ASTHMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	GOUT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PARKINSON'S DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ULCERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
BLEEDING DISORDERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HEART DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PINCHED NERVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	VAGINAL INFECTION	<input type="checkbox"/> YES	<input type="checkbox"/> NO
BREAST LUMP	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HEPATITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PNEUMONIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	VENEREAL DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
BRONCHITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HERNIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	POLIO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	WHOOPIING COUGH	<input type="checkbox"/> YES	<input type="checkbox"/> NO
BULIMIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HERNIATED DISK	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PROSTATE PROBLEM	<input type="checkbox"/> YES	<input type="checkbox"/> NO	OTHER		
CANCER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HERPES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PROSTHESIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
CATARACTS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HIGH CHOLESTEROL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PSYCHIATRIC CARE	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
CHEMICAL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	KIDNEY DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	RHEUMATOID ARTHRITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
DEPENDENCY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	LIVER DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	RHEUMATIC FEVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
CHICKEN POX	<input type="checkbox"/> YES	<input type="checkbox"/> NO	MEASLES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	SCARLET FEVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

<b>EXERCISE</b> <input type="checkbox"/> NONE <input type="checkbox"/> MODERATE <input type="checkbox"/> DAILY <input type="checkbox"/> HEAVY	<b>WORK ACTIVITY</b> <input type="checkbox"/> SITTING <input type="checkbox"/> STANDING <input type="checkbox"/> LIGHT LABOR <input type="checkbox"/> HEAVY LABOR	<b>HABITS</b> <input type="checkbox"/> SMOKING                      PACKS A DAY _____ <input type="checkbox"/> ALCOHOL                         DRINKS/WEEK _____ <input type="checkbox"/> COFFEE/CAFFEINE DRINKS    CUPS/DAY _____ <input type="checkbox"/> HIGH STRESS LEVEL              REASON _____
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ARE YOU PREGNANT?  YES  NO    DUE DATE \_\_\_\_\_

<u>INJURIES/SURGERIES YOU HAVE HAD</u>	<u>DESCRIPTION</u>	<u>DATE</u>
FALLS	_____	_____
HEAD INJURIES	_____	_____
BROKEN BONES	_____	_____
DISLOCATIONS	_____	_____
SURGERIES	_____	_____

<b><u>MEDICATIONS</u></b> _____ PHARMACY NAME _____ PHARMACY TEL# _____	<b><u>ALLERGIES</u></b> _____ _____	<b><u>VITAMINS/HERBS/MINERALS</u></b> _____ _____
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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

*I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.*

NAME \_\_\_\_\_ BIRTHDAY \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

TOTAL MEDICAL N.Y. PC  
93-24 QUEENS BLVD. SUITE 1G  
REGO PARK, NY, 11374  
(T) 718-730-9040 (F) 718-730-9043

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/ OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH

\_\_\_\_\_  
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO DR. ERIC GOLDBERG ALL INSURANCE BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE FOR ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE- NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTS FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

# Your Information. Your Rights. Our Responsibilities.

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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.

Effective: February 12, 2014

## LAYERED SUMMARY TEXT –

### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

### Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

## Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

### Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

#### Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

#### Our Uses and Disclosures

##### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

#### How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### Do research

We can use or share your information for health research.

#### Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### Respond to organ and tissue donation requests



We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For certain government functions such as national security, or for confidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it. We will use or disclose your information for other purposes described here unless you tell us we can't in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Signature of Patient \_\_\_\_\_ Print Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient Summary Form

PSF-750 (Rev. 2/16/2009)

### Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

\*Fax number may vary by plan.

### Patient Information

Female  Male

Patient name: Last [ ] First [ ] MI [ ] Patient date of birth: [ ] [ ] [ ]

Patient address: [ ] [ ] [ ] City [ ] State [ ] Zip code [ ] [ ]

Patient insurance ID# [ ] Health plan [ ] Group number [ ]

Referring physician (if applicable) [ ] Date referral issued (if applicable) [ ] Referral number (if applicable) [ ]

### Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) [ ]

2. Federal tax ID (FEIN) of entity in box #1 [ ]

3. Name and credentials of the individual performing the service(s) [ ]

4. Alternate name (if any) of entity in box #1 [ ]

5. NPI of entity in box #1 [ ]

6. Phone number [ ] [ ] [ ]

7. Address of the billing provider or facility indicated in box #1 [ ]

8. City [ ]

9. State [ ]

10. Zip code [ ] [ ]

### Provider Completes This Section

Date you want THIS submission to begin:

[ ] [ ] [ ]

### Patient Type

- 1 New to your office
- 2 Est'd, new injury
- 3 Est'd, new episode
- 4 Est'd, continuing care

### Cause of Current Episode

- 1 Traumatic
- 2 Unspecified
- 3 Repetitive
- 4 Post-surgical
- 5 Work related
- 6 Motor vehicle

### Date of Surgery

[ ] [ ] [ ]

### Type of Surgery

- 1 ACL Reconstruction
- 2 Rotator Cuff/Labral Repair
- 3 Tendon Repair
- 4 Spinal Fusion
- 5 Joint Replacement
- 6 Other

### Diagnosis (ICD code)

Please ensure all digits are entered accurately

1° [ ] [ ] [ ] [ ]

2° [ ] [ ] [ ] [ ]

3° [ ] [ ] [ ] [ ]

4° [ ] [ ] [ ] [ ]

### Nature of Condition

- 1 Initial onset (within last 3 months)
- 2 Recurrent (multiple episodes of < 3 months)
- 3 Chronic (continuous duration > 3 months)

### DG ONLY

### Anticipated CMT Level

- 98940  98942
- 98941  98943

### Current Functional Measure Score

Neck Index [ ] DASH [ ] [ ] [ ]

Back Index [ ] LEFS [ ] [ ] (other)

### Patient Completes This Section

(Please fill in selections completely)

Symptoms began on:

[ ] [ ] [ ]

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?

- 1 Constantly (75%-100% of the time)
- 2 Frequently (51%-75% of the time)
- 3 Occasionally (26% -50% of the time)
- 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

6. How is your condition changing, since care began at this facility?

- 0 N/A -- This is the initial visit
- 1 Much worse
- 2 Worse
- 3 A little worse
- 4 No change
- 5 A little better
- 6 Better
- 7 Much better

7. In general, would you say your overall health right now is...

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

Patient Signature: X

Date:

Indicate where you have pain or other symptoms:

