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Patient Information:

Name (Last, First): _____ Date: _____

Address: _____
Street City State Zip Code

Phone (Home): _____ (Work): _____ (Cell): _____

Social Security Number: _____-_____-_____ Birth Date: _____/_____/_____ Sex: (M / F) Email:

_____ Alternate Email: _____

Employer (of insured party): _____ Employer Phone: _____

Physician Information:

Name of Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____

Name of Primary Care Physician: _____ Phone: _____
(If different than referring physician)

Address: _____City: _____ State: _____

Emergency Contact:

Name: _____

Phone (Home): _____ (Cell): _____

Relationship to Patient: _____

Robert Nocerini, M.D.
7704 San Jacinto Pl, Suite 200
Plano, TX 75024

Office: 469-945-7966 Fax: 972-695-3075

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Financial Policy

We are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibilities as our patient. It is your responsibility to contact our office to notify us of any changes to your information, such as a change in address, telephone number, or insurance information. We require you to sign this agreement before care is rendered.

All co-payments, co-insurance and deductibles must be paid at time of service as required by the terms of our contract with your health insurance provider. Please understand that failure on our part to collect these payments can be considered insurance fraud. For your convenience we accept MasterCard, Visa, Discover, and American Express, as well as cash and check payments.

Please keep in mind that your health insurance policy is a contract between you and your insurance company. As a courtesy to you, we will file your claim with your insurer if you agree to have payment made directly to our practice. If your insurance company does not provide payment within 90 days we may require payment from you. If we later receive a check from your insurer, we will refund any overpayment to you. Please be aware that some of the services you receive may not be covered or may be deemed not medically necessary by Medicare or other insurance companies. You will be responsible for payment of all charges for services not covered by your insurance company.

When you schedule an appointment, that time is reserved specifically for you. We kindly ask that you provide a minimum of 24 hours' notice when cancelling an appointment**. If you do not give adequate notice or fail to keep your scheduled appointment you may be charged a fee of $50.00.** Patients with three missed appointments may be terminated from the practice.

Payment is due prior to services being rendered unless a payment plan arrangement is made with Northstar Joint and Spine. If payments are not made according to an agreed upon payment plan, further non-emergent care will not be provided until the amount due is paid in full. If it becomes necessary to turn your account over to a collection agency due to delinquency, you agree to pay reasonable attorney fees or collection expenses incurred by Northstar Joint and Spine. **All returned checks will be assessed a $30.00 returned check fee.**

The self-pay amount covers only the professional services provided by your physician. You are financially responsible for all ancillary services, for example laboratory, x-ray, outside referrals, or other services not performed by Northstar Joint and Spine or its providers.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. Please initial next to each statement indicating your understanding:

____ I have read and understand the financial policy of Northstar Joint and Spine and agree to be bound by the terms.
____ I understand it is my responsibility to notify Northstar Joint and Spine of any changes in my pertinent information.
____ I understand that I will be responsible for all charges related to the services provided to me by Northstar Joint and Spine.
____ I understand that the charges presented to me are due in full on the day of service unless arrangements have been made with the Billing Manager in advance.

I have read, understand, and been allowed to ask questions about this policy. I agree to comply with the policy as described.

Patient Name: _____

Signature: _____

Date: _____

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PATIENT CONSENT FOR TREATMENT

Welcome to Northstar Joint and Spine. Please take a moment to review and sign this Consent for Treatment form. Northstar Joint and Spine reserves the right to make changes to this form. If changes are made, you will be presented with a new form for signature. Our clinic staff is available to answer any questions you may have.

I. Patient Rights and Responsibilities

Northstar Joint and Spine acknowledges that I have rights as a patient, and I acknowledge that I have responsibilities as a patient. These are discussed in the Patient Rights and Responsibilities and the Notice of Privacy Practices documents; copies are available to me upon request. I acknowledge being offered these documents.

II. Consent for Treatment

I voluntarily present to Northstar Joint and Spine for medical evaluation, diagnosis, and/or treatment. I consent and authorize Robert Nocerini, MD, or his designee(s) to provide diagnostic and therapeutic treatment, which may be necessary or advisable in his professional judgment. By signing this consent form, I do not waive my right to refuse recommended tests or treatment(s).

III. Payment for Services/Assignment of Benefits

I understand that, regardless of my assigned insurance benefits, I am financially responsible for payment of services rendered to me. If the providers involved in my care accept third-party reimbursement for all or part of the services I receive, I hereby agree to assign such benefits to Northstar Joint and Spine and authorize such third party to make payment directly to Northstar Joint and Spine. I understand that Northstar Joint and Spine may disclose a limited amount of health information to third parties to obtain payment for the health care services provided.

I authorize Northstar Joint and Spine to communicate with any pharmacy regarding my prescription medication information including prescription history and benefits. I consent to electronic transmission of prescription information and any necessary communication with my pharmacies.

If insurance or third-party payment is used, I agree to pay co-payments, co-insurance, deductibles, and outstanding balances. I understand that I will not be billed for amounts which Northstar Joint and Spine is contractually or legally obligated to discount. If my account becomes delinquent and is referred to an attorney or collection agency for collections, I agree to pay reasonable and necessary attorney's fees and collection expenses. I certify that the information given by me in applying for payment under any medical insurance program, including Medicare, is correct.

Patient's Printed Name: _____

Patient's Signature _____

Date _____

***Legal Representative's Printed Name**_____

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Legal Representative's Signature_____

Date _____

*If representative, specify relationship to the patient*_____

**Note: Proof of legal authority may be required for legal representatives.* *If signing as the legal representative, I represent to Northstar Joint and Spine that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to Northstar Joint and Spine.

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NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

This document is meant to inform our patients of their rights and responsibilities while they are undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to the patient's guardian, next of kin, or legally authorized responsible person if the patient (a) has been adjudicated incompetent in accordance with the law, (b) is found to be medically incapable of understanding the proposed treatment or procedure, (c) is unable to communicate his, her, or their wishes regarding treatment, or (d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights

1. **Access to Care.** You will be provided with impartial access to treatment and services within this practice's capacity and availability and in keeping with applicable laws and regulations. This is true regardless of race, creed, sex, national origin, religion, sexual orientation, gender identity, disability or handicap.

2. **Respect and Dignity.** You have the right to considerate, respectful care and services at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.

3. **Privacy and Confidentiality.** You have the right, within the law, to personal and informational privacy. This includes the right to:

    - Be interviewed and examined in surroundings that ensure reasonable privacy
    - Have a person of your own sex present during a physical examination or treatment
    - Not remain disrobed any longer than is required for accomplishing treatment or services
    - Request transfer to another treatment room if a visitor is unreasonably disturbing
    - Expect that any discussion or consultation regarding care will be conducted discreetly
    - Expect all written communications pertaining to care to be treated as confidential
    - Expect medical records to be read only by individuals directly involved in the delivery of care, quality-assurance activities, or the processing of insurance claims. No other persons will have access without your written authorization.

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4. **Personal Safety.** You have the right to expect reasonable safety regarding the practice's procedures and environment.

5. **Identity.** You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for your care.

6. **Information.** You have the right to obtain complete and current information concerning your diagnosis (to the degree known), your treatment, and any known prognosis. This information should be communicated in terms that you understand.

7. **Communication.** If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.

8. **Consent.** You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.

    - Consent discussions will include an explanation of the condition, the risks and benefits of treatment, and the consequences of no treatment.

    - Except in the case of incapacity or life-threatening emergency, you will not be subjected to any procedure unless you provide voluntary, written consent.

    - You will be informed if the practice proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.

9. **Consultation.** You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.

10. **Charges.** Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.

11. **Rules and Regulations**. You will be informed of the practice's rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints.

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Patient Responsibilities

1. **Keep Us Accurately Informed.** You have the responsibility to provide, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health, including unexpected changes in your condition.

2. **Follow Your Treatment Plan.** You are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care, implement the physician's orders, and enforce the applicable practice rules and regulations.

3. **Keep Your Appointments.** You are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice.

4. **Take Responsibility for Noncompliance.** You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.

5. **Be Responsible for Your Financial Obligations.** You are responsible for ensuring that the financial obligations of health care services are fulfilled as promptly as possible and for providing up-to-date insurance information.

6. **Be Considerate of Others.** You are responsible for being considerate of the rights of other patients and personnel and for assisting in the control of noise, smoking, and the number of visitors. You also are responsible for being respectful of practice property and property of other persons visiting the practice.

7. **Be Responsible for Lifestyle Choices.** Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.

I have read and understand the Notice of Patient Rights and Responsibilities

Print Name: _____

Signature: _____

Date: _____

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HIPAA/PRIVACY PRACTICES NOTICE

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.

WHAT IS THIS NOTICE? This notice tells you:

- How we use and release your health information.
- Your rights concerning your health information.
- Our responsibilities to protect your health information.

TO WHOM DOES THIS NOTICE APPLY?

This notice applies to: **Northstar Joint and Spine**

WHAT ARE OUR RESPONSIBILITIES TO YOU?

Your health information is personal. We are required by law to protect the privacy of your health information and will only release your health information as allowed by law or with special written permission (authorization) from you. We use the least amount of health information needed to do our work. Only those who need your health information to provide services are allowed to use it. Northstar Joint and Spine protects your information whether verbal, on paper or electronic.

WHEN IS THE NOTICE EFFECTIVE?

This notice is effective on February 1, 2022. Northstar Joint and Spine reserves the right to change this notice after the effective date. We reserve the right to make the revised notice apply for all health information that we already have about you, as well as any information we receive in the future.

HOW DO WE USE AND RELEASE YOUR HEALTH INFORMATION?

Northstar Joint and Spine must use and release some of your health information to conduct its business. The following section explains some of the ways we are permitted to use and release health information without authorization from you.

USE AND RELEASE OF YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION:

TREATMENT PURPOSES

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While we are providing you with healthcare services, we may need to share your health information with other healthcare providers or other individuals who are involved in your treatment. Examples include doctors, hospitals, pharmacists, therapists, nurses, and labs that are involved in your care.

PAYMENT PURPOSES

Northstar Joint and Spine may need to share a limited amount of health information to obtain or provide payment for the healthcare services provided to you. Examples include:

Eligibility - Northstar Joint and Spine may contact the company or government program that will be paying for your health care. This helps us determine if you are eligible for benefits, and if you are responsible for paying a copayment or deductible.

Claims - Northstar Joint and Spine and businesses we work with share health information for billing and payment purposes. For example, your doctor must submit a claim form to get paid, and the claim form must contain certain health information.

HEALTHCARE OPERATIONS PURPOSES

Northstar Joint and Spine may need to share your health information in the course of conducting healthcare business activities that are related to providing health care to you. Examples include:

- **Quality Improvement Activities** – Northstar Joint and Spine may use and release health information to improve the quality or the cost of care. This may include reviewing the treatment and services provided to you. This information may be shared with those who pay for your care, or with other agencies that review this data.
- **Health Promotion and Disease Prevention** - We may use your health information to tell you about disease prevention and healthcare options.
- **Case Management and Referral** - If you have a health problem or a healthcare need is identified by you or one of your providers, you may be referred to an organization such as a home health agency, medical equipment company or other community or government program. This may require the release of your health information to these agencies.
- **Appointment Reminders** – Northstar Joint and Spine may use your health records to remind you of recommended services, treatments, or scheduled appointments.
- **Business Associates** - There are some services provided at Northstar Joint and Spine through contracts with business associates such as medical transcription services, electronic medical record, practice management company and record storage. We require business associates to protect your health information.
- **Audits** - Northstar Joint and Spine may use or release your health information to make sure that its business practices comply with the law and Northstar Joint and Spine policies. Examples include audits involving quality of care, medical bills, or patient confidentiality.
- **Business Activities** - We may use or release your health information to perform internal business activities. Examples include business planning, computer systems maintenance, legal services and customer service.

OTHER PURPOSES

Robert Nocerini, M.D.
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- **Required By Law** - Sometimes we must report some of your health information to legal officials or authorities, such as law enforcement officials, court officials, governmental agencies, or attorneys. Examples include reporting suspected abuse or neglect, reporting domestic violence or certain physical injuries, or responding to a court order, subpoena, warrant or lawsuit request.
- **Public Health Activities** - We may be required to report your health information to authorities to help prevent or control disease, injury or disability. Examples include reporting certain diseases, injuries, birth, or death information; information of concern to the Food and Drug Administration; or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.
- **Health Oversight Agencies** - We may be required to release health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the healthcare system, or for governmental benefit programs.
- **Activities Related to Death** - We may be required to release health information to coroners, medical examiners, and funeral directors so they can carry out their duties related to your death. Examples include: identifying the body, determining the cause of death, or, in the case of funeral directors, carrying out funeral preparation activities.
- **Research Purposes** - At times, we may use or release health information about you for research purposes; however, all research projects require a special approval process before they begin. This process may include asking for your authorization. In some instances, your health information may be used but your identity is protected.
- **To Avoid a Serious Threat to Health or Safety** - As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to anyone's health or safety.
- **Military, National Security or Incarceration/Law Enforcement Custody** - We may be required to release your health information to the proper authorities so they may carry out their duties under the law. This may be the case if you are in the military or involved in national security or intelligence activities, or if you are in the custody of law-enforcement officials.
- **Worker's Compensation** - We may be required to release your health information to the appropriate persons to comply with the laws related to workers' compensation or other similar programs that provide benefits for work-related injuries or illness.

USE AND RELEASE OF YOUR HEALTH INFORMATION REQUIRING YOUR AUTHORIZATION

- **Persons Involved in Your Care** - In certain situations, we may share your health information about you to persons involved with your care, such as friends or family members. We may also give information to someone who helps pay for your care. You have the right to approve such releases, unless you are unable to function, or if there is an emergency.
- **Notification / Disaster Relief Purposes** - In certain situations, we may share your health information with the American Red Cross or another similar federal, state, or local disaster relief agency, to help the agency to locate persons affected by the disaster.

WHEN IS YOUR AUTHORIZATION REQUIRED?

Except for the types of situations listed above, we must obtain your authorization for any other types of releases of your health information. If you provide us authorization to use or release health information about you, you may cancel that authorization in writing at any time. Any authorization you sign may be cancelled by following the instructions described on the authorization form.

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WHAT ARE YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION?

Northstar Joint and Spine wants you to know your rights regarding your health information.

-

- **Right to Receive This Notice of Privacy Practices** - You have the right to receive a paper copy of this notice at any time. You may obtain a copy of the current notice by requesting us at (469) 945-7966.
- **Right to Request Confidential Communications** - You have the right to ask that Northstar Joint and Spine communicate your health information to you in different ways or places. For example, you can ask that we only contact you by telephone at work, or that we only contact you by mail at home. We will do this whenever it is reasonably possible. You can find out how to make such a request by contacting the practice manager.
- **Right to Request Restrictions** - You have the right to request restrictions or limitations on how your health information is used or released. We have the right to deny your request. You may obtain information on how to ask for a restriction on the use or release of your information by contacting the practice manager or the privacy officer.
- **Right to Access** - With a few exceptions, you have the right to review and receive a copy of your health information. Some of the exceptions include:
    - Psychotherapy notes.
    - Information gathered for court proceedings.
    - Any information your provider feels would cause you to commit serious harm to yourself or to others

You can get a copy of your health information by submitting a request in writing to the Medical Record Release of Information division of our practice. This division will provide you with the necessary forms and assistance. We may charge you a fee to copy and/or mail your health record to you. If you are denied access to your health record for any reason, Northstar Joint and Spine will tell you about the reasons in writing. We will also give you information about how you can file an appeal if you are not satisfied with our decision.

- **Right to Amend** - You have the right to ask that Northstar Joint and Spine amend information in your health record if it is not correct or complete. You must provide the reason why you are asking for a change. You may request a change by sending a request in writing to the Medical Record Release of Information division. This division will provide you with the necessary forms and assistance.
    - We may deny your request if:
    - We did not create the information.
    - We do not keep the information.
    - You are not allowed to see and copy the information; or
    - The information is already correct and complete.

  For release of information, please use the following phone numbers: (469) 945-7966

- **Right to a Record of Releases** - You have the right to ask for a list of releases of your health information by sending a request in writing. Your request may not include dates earlier than the six years prior to the date of your request. If you request a record of releases more than once per year, Northstar Joint and Spine may charge a fee for providing the list.

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The list will contain only information that is required by law. This list will not include releases for treatment, payment, healthcare operations or releases that you have authorized.

WHAT CAN YOU DO IF YOU HAVE A COMPLAINT ABOUT HOW YOUR HEALTH INFORMATION IS HANDLED?

If you believe that your privacy rights have been violated, you may file a complaint with Northstar Joint and Spine or with the Secretary of Health and Human Services. To receive help in filing a complaint with Northstar Joint and Spine, you may contact us at (469) 945-7966. You will not be denied treatment or penalized in any way if you file a complaint.

Patient's Printed Name: _____

Patient's Signature: _____

Date: _____

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HIPAA RELEASE FORM FOR RELATIVES AND NON-HEALTH CARE PROVIDERS AND MODES OF COMMUNICATION

Patient Name: _____ Date of Birth _____/_____/_____

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

[ ] Spouse: _____
[ ] Child(ren): _____
[ ] Other: _____

[ ] Information is not to be released to anyone.

How would you like us to communicate with you?

[ ] By checking this box, I consent to the following: The Northstar Joint and Spine may contact me to provide health care information such as appointment reminders and information about treatment, payment, or my account. Northstar Joint and Spine may:

	May include care/ treatment details	**OMIT care/ treatment details**
[ ] Phone/ Voicemail:	[ ]	[ ]
[ ] SMS:	[ ]	[ ]
[ ] E-Mail:	[ ]	[ ]
[ ] Mail:	[ ]	[ ]

I understand that this statement will remain in effect until I notify Northstar Joint and Spine in writing of any changes.

Patient Signature _____ Date _____

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I authorize the following PHI to be released from the medical record of:		
Name of Patient		Date of Birth
Phone Number	Alt. Phone	
Address		
City	State	Zip Code

Northstar Joint and Spine

7704 San Jacinto Pl
Suite 200
Plano, TX 75024
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Release Records from/ to:

Doctor/Facility

Address

City **State** **Zip**

Phone **Fax**

REASON FOR DISCLOSURE (Choose only one option below)

[ ]Treatment/Continuing Medical Care [ ]Personal Use [ ]Billing or Claims [ ]Insurance [ ]Legal Purposes
[ ]Disability Determination [ ]School [ ]Employment
[ ]Other: _____

Information to be released

Dates From_____ To_____

[ ]All health information [ ]History/Physical Exam [ ]Past/Present Medications
[ ] Lab Results [ ]Physician's Orders [ ]Patient Allergies
[ ]Operation Reports [ ]Consultation Reports [ ]Progress Notes
[ ]Discharge Summary [ ]Diagnostic Test Reports [ ]EKG/Cardiology Reports
[ ]Pathology Reports [ ]Billing Information [ ]Radiology Reports & Images
[ ]Other: _____

Your initials are required to release the following information:

____ Mental Health Records (Excluding psychotherapy notes) ____ Genetic Information (Including Genetic Test Results)
____ Drug, Alcohol, or Substance Abuse Records ____ HIV/AIDS Test Results/Treatment ____ Cancer Treatment Records

EFFECTIVE TIME PERIOD: I understand that this authorization will expire 90 days from my last date of service visit. A photocopy of this form will be considered as valid as the original. I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

RIGHT TO REVOKE: I understand I may revoke this authorization, in writing, at any time by notifying Northstar Joint and Spine at the address indicated below. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment, cancer treatment, HIV/AIDS related information, and psychiatric/mental health information.

By signing below, I acknowledge that I have read and understood the authorization.

_____ _____
Signature of patient or Legal Authorized Representative Date

_____ _____
Signature of Parent/ Legal Guardian Date

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Workers' Compensation Disclaimer

Please read the following disclaimer carefully and check the option that applies to you. Please print and sign your name, and provide the date, where requested below.

☐ NOT WORK-RELATED: The condition that I am seeking treatment for today is NOT work-related. I will NOT be filing a workers' compensation claim for this condition. I do not currently have an open Workers' Compensation claim connected to my condition. I understand that failure to disclose this information truthfully will result in all charges becoming my responsibility. I understand that in the event I inform my personal health benefit plan issuer this injury/condition is work-related, my personal insurance company may not accept responsibility for the charges incurred; therefore, I will be responsible for payment in full.

Print Patient Name: _____

Patient Signature: _____

Date: _____

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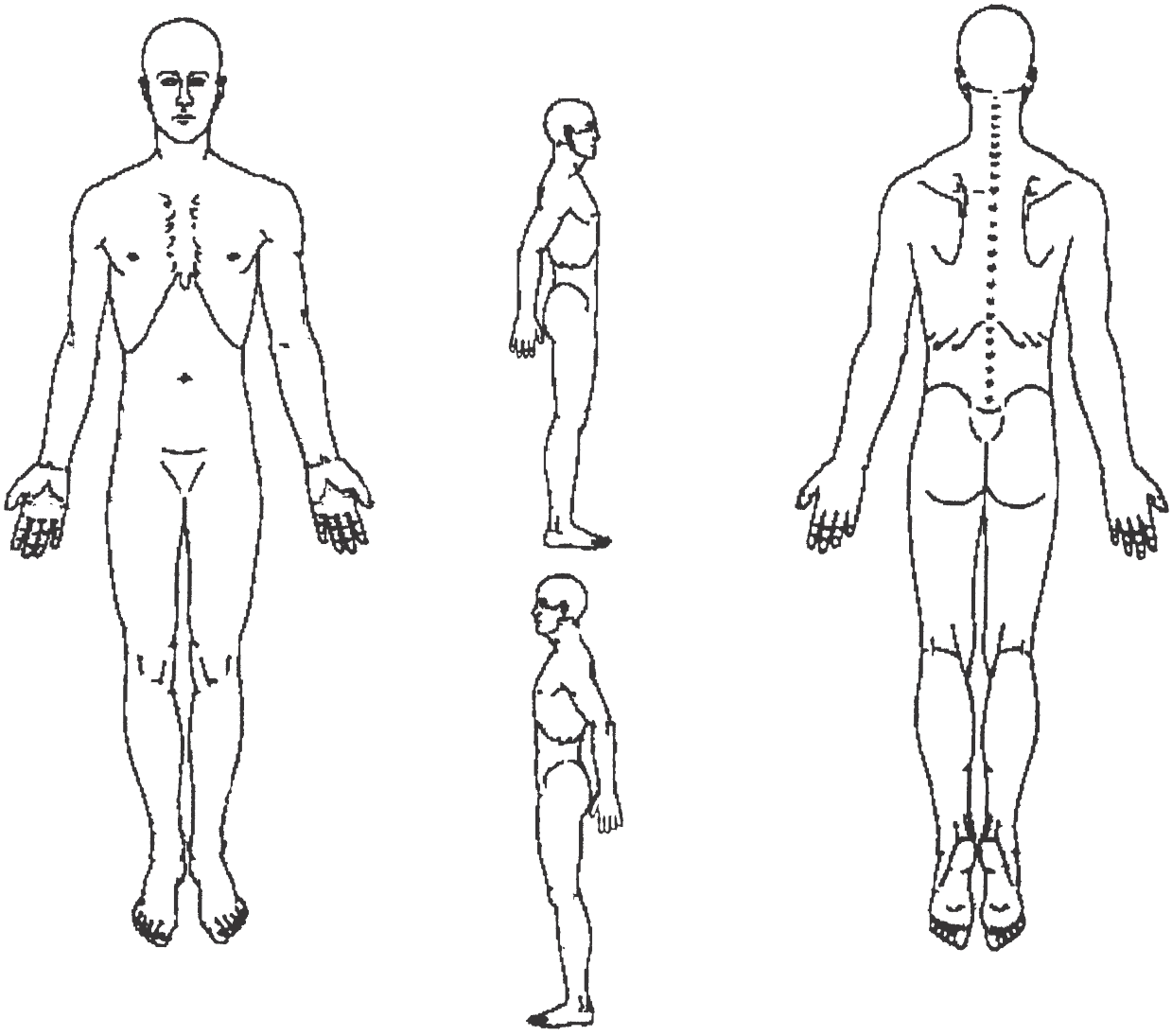
NEW PATIENT QUESTIONNAIRE

Name _____ DOB _____
How did you hear about us? _____
Primary Care Physician: _____
Referring Physician: _____
Preferred Pharmacy: _____

PAIN HISTORY

Please mark where your pain is located

_____Neck ____Mid Back ____Lower Back
_____Shoulder ____Arm ____Hand
_____Hip ____Buttocks ____Thighs ____Knee ____Calf ____Ankle ____Foot



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- **What Month/Year did your pain first begin?** _____

- **How did your pain begin?**
  - _____Without any precipitating event _____ After an accident
  - Is your pain work related? _____Yes _____ No
  - Do you have an open Workers Compensation claim related to your condition/pain? _____Yes _____No
  - Is there pending litigation related to your pain? _____Yes_____ No
  - Other_____

- **Please circle your level of pain with 0 being no pain, and 10 representing the worst possible pain:**

0 1 2 3 4 5 6 7 8 9 10

- **What does your pain feel like?**

☐Sharp ☐Shooting
☐Tingling ☐Cramping
☐Dull ☐Aching

- **How does your pain change with time?** _____Constant _____Intermittent _____Fluctuating
- **When is your pain the worst?** _____Morning _____ Afternoon _____Evening

- **What makes your pain BETTER?**
  - _____
- **Which makes your pain WORSE?**
  - _____
- **How does pain affect your lifestyle? (What can you no longer do because of your pain?)**
  - _____
  - _____
  - _____

PAST MEDICAL HISTORY – Please circle

High Blood Pressure
Previous Heart Attack
Acid Reflux/Stomach Ulcers/Hepatitis/Cirrhosis
Diabetes
Cancer
Heart Disease
COPD/Asthma/Other Lung Disease
Kidney Disease
Stroke/Seizures
Blood Clots/Clotting Disorders/DVT/Pulmonary Embolism
Other Medical conditions_____

SURGICAL HISTORY

Please list any surgeries you have had:

Type of surgery _____Year _____
Type of surgery _____Year _____

Type of surgery _____Year _____
Type of surgery _____Year _____

FAMILY HISTORY

Please list any medical conditions that run in your family

_____

_____

ALLERGIES:

Please list any allergies or intolerances you may have to medications, foods, or other substances:

Name of Medication	Adverse Reaction Experienced	When was the last time this happened?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to Iodine Contrast Dye (e.g. IVP Dye)? ____Yes ____No
If you answered yes, what type of reaction did you have and when?

_____

CURRENT MEDICATIONS:

Please list the medications you currently take:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please review and mark **ALL** items that have applied to you **within the last month** (including today)

GENERAL HEALTH:	Weight loss	Weight gain	Fatigue	Loss of appetite
EYES:	Eye pain	Double vision		
EARS/NOSE:	Ear pain	Hearing loss	Ringing in ears	
MOUTH/THROAT:	Sore throat	Problems	Swallowing	Hoarseness
CHEST/HEART:	Chest pain	Racing/pounding heart	Trouble breathing lying down	
RESPIRATORY:	Cough	Wheezing	Shortness of breath	
GASTROINTESTINAL:	Heartburn	Nausea/vomiting	Diarrhea/Constipation	Abdominal pain
URINARY TRACT:	Blood in urine.	Increased urination	Pain w/urination	
MUSCULOSKELETAL:	Back pain	Knee Pain	Hip Pain	Ankle Pain Stiff joints
SKIN:	Rash	Skin infections	MRSA	

NORTHSTAR
JOINT + SPINE

NEUROLOGIC:	Seizures	Poor Memory	Weakness/numbness/tingling
ENDOCRINE:	Increased sensitivity to cold		Increased sensitivity to heat
HEMATOLOGY:	Easy Bruising	Easy Bleeding	
IMMUNE:	Frequent infections		
MENTAL HEALTH:	Anxiety/Depression		Thoughts of hurting self or others

If female, is there a possibility you are pregnant? Yes No

SOCIAL HISTORY

- **What is your current marital status?**
  ____ Single ____ Married ____ Divorced ____ Widowed

- **With whom do you live?**
  __ Alone
  __ With Parents
  __ With Spouse
  __ With Children
  __ With Others (Significant Other, friends, Roommate, etc.)

- **What is the highest level of education you have completed?** _____High School _____College _____ Postgraduate

- **Do you currently smoke cigarettes?** ____ Yes ____ No

- **Do you currently drink alcoholic beverages?** ___ Yes ___ No
  If yes, how often? _____

- **Have you ever been diagnosed with or treated for drug or alcohol abuse?** ____ Yes ____ No
  - **If yes, when?** _____ **Please describe** _____

- Do you currently use **illicit drugs?** ___ Yes ___ No
- Have you ever used **illicit drugs?** ___ Yes ___ No
  - If yes, what drugs and when? _____

WORK HISTORY

- **What is your employment status?**
  ___ Retired
  ___ Able to work but currently unemployed
  ___ Wanting to work, but unable due to current health reason
  ___ Not working - on Workers Comp. On leave from my job since _____
  ___ Working Full Time
  ___ Working Part Time
  ___ Not working - on Disability since _____
  ___ Student

___ Homemaker
___ Other

- **What is (was) your occupation or job title?**
  - _____

What diagnostic studies have been performed to evaluate your pain? If you have had any imaging, please bring copies of the reports to your office visit.

Blood Tests _____ X-Rays _____
MRI Scan _____ CT scan _____
EMG / Nerve Conduction Studies _____ Bone Scan _____

Please list any other providers that have treated your pain:

Pain Specialist _____ Spine (orthopedic or neuro) Surgeon _____
Chiropractor _____ Orthopedic Surgeon _____
Neurologist _____ Other: _____

What treatments have you had for your pain?

Injections _____ Chiropractic _____
Acupuncture _____ Orthotics _____
Physical Therapy _____ Psychological Counseling _____
Bracing _____ Other _____

I have answered all the above questions truthfully and to the best of my ability

Print Patient Name: _____ Date: _____

Patient Signature: _____