

DAVID S BASTAWROS DPM PA

Today's Date: _____

PATIENT REGISTRATION FORM

MR Number: _____

PATIENT INFORMATION:

Mr / Mrs / Ms / Dr _____
First M.I. Last Suffix Nickname

Gender: M F Date of Birth: ___ / ___ / ___ Ethnicity: Hispanic Non-Hispanic Race: _____

SSN: _____ Language(s) Spoken: _____

Primary Care Physician: _____ Referring Physician: _____

HOME Address _____
Street

City State Zip Code

HOME Phone: _____ Work: _____ Mobile: _____

Preferred Method of Communication: Home Work Mobile Other _____

Marital status: Divorced Married Separated Single Widowed

Employment Status: Employed Not Employed Retired Self-Employed. Religion: _____

Employer _____

Address _____
Street

City State Zip Code

Emergency contact _____ Relationship _____ Mobile: _____

RESPONSIBLE PARTY (if patient is under 18 or disabled): Patient Relationship to Guarantor: _____

Mr / Mrs / Ms / Dr _____
First M.I. Last Suffix Nickname

Gender: M F Date of Birth: ___ / ___ / ___ Ethnicity: Hispanic Non-Hispanic Race: _____

SSN: _____ Language(s) Spoken: _____

Address _____
Street

City State Zip Code

Home Phone: _____ Work: _____ Mobile: _____

INSURED (if different from patient): Patient Relationship to Guarantor: _____

Mr / Mrs / Ms / Dr _____
First M.I. Last Suffix Nickname

Gender: M F Date of Birth: ___ / ___ / ___ Ethnicity: Hispanic Non-Hispanic Race: _____

SSN: _____ Language(s) Spoken: _____

Address _____
Street

City State Zip Code

Home Phone: _____ Work: _____ Mobile: _____

Patient Name: _____

MR Number: _____

CONSENT TO TREAT:

I hereby authorize employed physician(s) of **David S Bastawros DPM PA** to render routine podiatric medical care of the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

If the patient is a minor:

I consent for _____ to authorize evaluation and treatment of my child named herein when I am not available. I understand that this authorizes the person(s) named above to consent to medial and surgical procedures for the child name herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Signature of Patient, Parent, or Legal Guardian: _____ Date ___ / ___ / _____

FINANCIAL RESPONSIBILITY:

I hereby authorize payment of medical benefits directly to **David S Bastawros DPM PA** for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to **David S Bastawros DPM PA**. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of **David S Bastawros DPM PA**, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this authorization, I am financially responsible for payment of services in full before the services are rendered.

Signature of Patient, Parent, or Legal Guardian: _____ Date ___ / ___ / _____

Printed Name (if other than Patient): _____ *Relationship:* _____

CANCELLATION POLICY:

It is the office policy to bill the patient (not the insurance company) a \$25.00 fee for any missed appointments without 24-hour prior cancellation. This amount must be paid in full prior to scheduling another appointment. As a courtesy to the patient, we will made reasonable attempts to confirm appointments. Since this is not always possible, it is the patient's responsibility for keeping tracking of the appointment. *Please call us as early as possible if you need to reschedule your appointment.* As a courtesy to those patients who arrive for their appointment early or on time, patients who arrive **more than 5 minutes** late will most likely be asked to reschedule.

Signature of Patient, Parent, or Legal Guardian: _____ Date ___ / ___ / _____

SERVICE & FORMS CHARGE:

A **\$30** service charge will be assess for returned checks and must be paid in cash or certified funds.

A **\$25** charge will be assessed for any disability forms or other forms not directly related to the payment of your insurance claim.

Signature of Patient, Parent, or Legal Guardian: _____ Date ___ / ___ / _____

Patient Name: _____

MR Number: _____

COMMUNICATION OF HEALTH INFORMATION WITH FAMILY, RELATIVES, PERSONAL FRIENDS:

I hereby give permission to **David S Bastawros DPM PA** to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s), and/or close personal friend(s):

Name Relationship

Name Relationship

Name Relationship

Name Relationship

[] I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition(s).

COMMUNICATION OF HEALTH INFORMATION WITH OTHER PHYSICIANS OR HEALTH CARE PROVIDERS:

I hereby give permission to **David S Bastawros DPM PA** to disclose, discuss, and/or forward any information related to my medical condition(s) with the following physicians or health care providers:

Name Specialty

Name Specialty

Name Specialty

Name Specialty

Name Specialty

Name Specialty

Name Specialty

Name Specialty

DAVID S BASTAWROS DPM PA
NOTICE OF HEALTH INFORMATION PRACTICES

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.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **January 1, 2012**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, We may also call you by your first name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing clearinghouse, collection agency) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you **\$25** for the first twenty (20) pages and \$0.15 per page for every copy thereafter. In addition, a reasonable fee may include actual costs for mailing, shipping

or delivery of the records. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past five (5) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, and such may cause harm to you, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: Susan B. – Compliance Officer
Address: 4708 Alliance Blvd, Suite 750; Plano, TX 75093
Telephone: (972) 964-3668
Fax: (972) 964-4810
E-mail: OfficeManager@Bastawros.com

DAVID S BASTAWROS DPM PA

**ACKNOWLEDGEMENT OF THE RECEIPT OF
DAVID S BASTAWROS DPM PA'S
NOTICE OF HEALTH INFORMATION PRACTICES**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

By signing this form, you acknowledge that you have received a copy of David S Bastawros DPM PA's *Notice of Health Information Practices*.

Signature of Patient or Legal Representative

Date

January 1, 2012
Effective Date of Notice

PATIENT NAME: _____

Date of Visit ___ / ___ / ___

Referring Physician: _____

Current Pharmacy: _____

MEDICAL HISTORY:

SURGICAL HISTORY:

CURRENT MEDICATIONS (name, amount):

DRUG ALLERGIES/REACTIONS (type of reaction, e.g. rash, anaphylaxis):

No Known Drug Allergies

- Penicillin _____
- Aspirin/Ibuprofen _____
- Tape/Adhesives _____
- Sulfa drugs (type) _____
- Codeine _____
- Others _____

FAMILY (not personal) HISTORY: (whom- mother, father, brother, sister, paternal/maternal grandparents, aunts, uncle)

- Mother _____
- Aunts/Uncles _____
- Father _____
- Grandparents _____
- Brothers/Sisters _____
- Adopted – No known family history

SOCIAL HISTORY:

Alcohol use: No Quit Yes – Type, Amt., How Long _____

Caffeine use: No Yes – Type, Amt., How Often _____

Substance Use: No Quit Yes – Type, Amt., How Long _____

Tobacco use: No Quit Yes – Type, Amt., How Long _____

Occupation (employed / unemployed / retired): _____

Lives with: no one / spouse / parents / family / significant other / roommate *Living accommodations:* apt. / home / condo / dorm

Relationship status: Single / Married / Divorced / Widowed / Legally Separated / With Partner *Number of Children* _____

Religious Beliefs that directly affect Medical Care: _____

<p>PERSONAL HISTORY OF:</p> <p>Skin: <input type="checkbox"/> None <input type="checkbox"/> eczema <input type="checkbox"/> psoriasis</p> <p>Head: <input type="checkbox"/> None <input type="checkbox"/> migraine headaches <input type="checkbox"/> previous head injury/trauma</p> <p>Eye: <input type="checkbox"/> None <input type="checkbox"/> glaucoma <input type="checkbox"/> cataract <input type="checkbox"/> macular degeneration</p> <p>Ear: <input type="checkbox"/> None <input type="checkbox"/> hearing loss <input type="checkbox"/> vertigo</p> <p>Mouth, Nose, Throat, Neck: <input type="checkbox"/> None <input type="checkbox"/> nose bleeds <input type="checkbox"/> hoarseness <input type="checkbox"/> problems swallowing <input type="checkbox"/> goiter</p> <p>Respiratory: <input type="checkbox"/> None <input type="checkbox"/> asthma <input type="checkbox"/> COPD <input type="checkbox"/> pneumonia <input type="checkbox"/> emphysema <input type="checkbox"/> tuberculosis <input type="checkbox"/> pulmonary fibrosis</p> <p>Cardiovascular: <input type="checkbox"/> None <input type="checkbox"/> heart disease <input type="checkbox"/> high blood pressure <input type="checkbox"/> angina <input type="checkbox"/> mitral valve prolapse <input type="checkbox"/> atrial fibrillation <input type="checkbox"/> elevated cholesterol/lipids <input type="checkbox"/> rheumatic fever <input type="checkbox"/> congestive heart failure <input type="checkbox"/> prior heart attacks</p> <p>Peripheral Vascular: <input type="checkbox"/> None <input type="checkbox"/> stroke <input type="checkbox"/> peripheral arterial disease <input type="checkbox"/> intermittent claudication <input type="checkbox"/> leg cramps <input type="checkbox"/> Raynaud disease <input type="checkbox"/> varicose veins <input type="checkbox"/> blood clots in deep veins/DVT <input type="checkbox"/> transient ischemic attacks (TIA)</p>	<p>Gastrointestinal: <input type="checkbox"/> None <input type="checkbox"/> anorexia/bulimia <input type="checkbox"/> gastric reflux <input type="checkbox"/> hepatitis A, B, C, D <input type="checkbox"/> liver disease <input type="checkbox"/> hernia <input type="checkbox"/> gastric ulcer <input type="checkbox"/> pancreatitis</p> <p>Genitourinary (general): <input type="checkbox"/> None <input type="checkbox"/> urinary incontinence <input type="checkbox"/> kidney stones <input type="checkbox"/> kidney failure <input type="checkbox"/> kidney disease</p> <p>Female Genitourinary <input type="checkbox"/> None <input type="checkbox"/> currently pregnant <input type="checkbox"/> currently breastfeeding</p> <p>Male Genitourinary <input type="checkbox"/> None <input type="checkbox"/> erectile dysfunction <input type="checkbox"/> prostate enlargement</p> <p>Musculoskeletal: <input type="checkbox"/> None <input type="checkbox"/> osteoarthritis/DJD <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> psoriatic arthritis <input type="checkbox"/> gout <input type="checkbox"/> low back problems <input type="checkbox"/> sciatica <input type="checkbox"/> Charcot-Marie-Tooth disease <input type="checkbox"/> muscular dystrophy <input type="checkbox"/> lupus</p> <p>Neurological: <input type="checkbox"/> None <input type="checkbox"/> seizures <input type="checkbox"/> short-term memory loss <input type="checkbox"/> long-term memory loss <input type="checkbox"/> peripheral neuropathy <input type="checkbox"/> carpal tunnel syndrome <input type="checkbox"/> spinal stenosis <input type="checkbox"/> numbness <input type="checkbox"/> balance problems <input type="checkbox"/> paralysis <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> cerebral palsy <input type="checkbox"/> polio <input type="checkbox"/> multiple sclerosis</p>	<p>Hematologic: <input type="checkbox"/> None <input type="checkbox"/> anemia <input type="checkbox"/> excessive postoperative bleeding <input type="checkbox"/> hemophilia <input type="checkbox"/> Sickle cell condition <input type="checkbox"/> polycythemia vera</p> <p>Endocrine: <input type="checkbox"/> None <input type="checkbox"/> type I diabetes mellitus <input type="checkbox"/> type II diabetes mellitus <input type="checkbox"/> gestational diabetes <input type="checkbox"/> osteopenia <input type="checkbox"/> osteoporosis <input type="checkbox"/> hypothyroidism <input type="checkbox"/> hyperthyroidism <input type="checkbox"/> hyperparathyroidism</p> <p>Psychiatric: <input type="checkbox"/> None <input type="checkbox"/> anxiety <input type="checkbox"/> insomnia <input type="checkbox"/> depression <input type="checkbox"/> dementia</p> <p>Infectious: <input type="checkbox"/> None <input type="checkbox"/> HIV <input type="checkbox"/> herpes simplex I (cold/fever sores) <input type="checkbox"/> herpes simplex II (genital) <input type="checkbox"/> sexually transmitted disease</p> <p>Immunity/Allergic: <input type="checkbox"/> None <input type="checkbox"/> seasonal allergies <input type="checkbox"/> allergic to bee stings <input type="checkbox"/> allergic to shellfish</p> <p>Cancers: <input type="checkbox"/> None <input type="checkbox"/> squamous cell carcinoma <input type="checkbox"/> basal cell carcinoma <input type="checkbox"/> malignant melanoma <input type="checkbox"/> brain cancer <input type="checkbox"/> throat cancer <input type="checkbox"/> stomach cancer <input type="checkbox"/> colon cancer <input type="checkbox"/> pancreatic cancer <input type="checkbox"/> colon cancer <input type="checkbox"/> kidney cancer <input type="checkbox"/> liver cancer <input type="checkbox"/> breast cancer <input type="checkbox"/> cervical / uterine cancer <input type="checkbox"/> ovarian cancer <input type="checkbox"/> prostate cancer <input type="checkbox"/> bone cancer <input type="checkbox"/> leukemia <input type="checkbox"/> Hodgkin's disease <input type="checkbox"/> Non-Hodgkin's lymphoma <input type="checkbox"/> thyroid cancer <input type="checkbox"/> other cancer _____</p>
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CONSENT: I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature _____ Relationship _____ Date ____ / ____ / _____

DAVID S BASTAWROS DPM PA

Name: _____

Date: _____

What foot/ankle problem brings you in? _____

- Type of pain:
- | | | | |
|-----------------------------------|--|---|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Soreness | <input type="checkbox"/> Tightness |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Numbness | <input type="checkbox"/> Aching | <input type="checkbox"/> Pressure |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Tingling | <input type="checkbox"/> Throbbing | |
| <input type="checkbox"/> Pulling | <input type="checkbox"/> Radiating | <input type="checkbox"/> Cramping | |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Electric shocks | <input type="checkbox"/> Pins & needles | |

Pain Level (0-10): _____

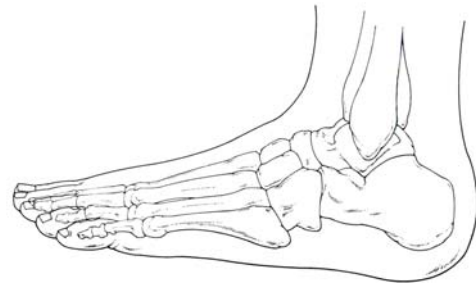
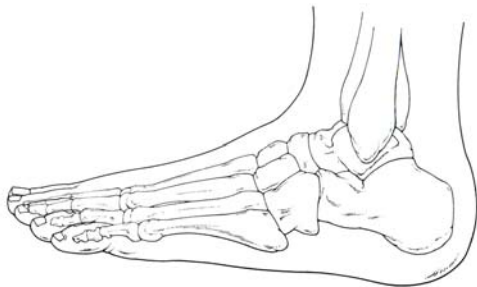
CIRCLE AREA(S) OF SYMPTOMS:

Left

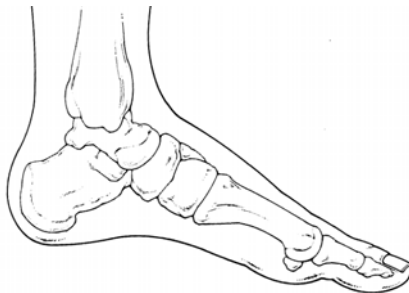
Right



TOP/BOTTOM



OUTSIDE



INSIDE

REVIEW OF SYSTEMS: None of below

Constitutional

- Chills
- Fatigue
- Fever
- Weakness
- Loss of appetite
- Malaise
- Weight changes

Cardiovascular

- Chest pain
- Cold extremity
- Dizziness
- Edema/swelling
- Leg pain
- Shortness of breath
- Palpitation
- Varicosities

Musculoskeletal

- Back pain
- Bone pain
- Joint pain
- Joint stiffness
- Joint swelling
- Muscle aches
- Muscle cramping
- Muscle pain

Neurological

- Alertness problems
- Vertigo
- Fainting
- Gait problems
- Headache
- Involuntary movements
- Lightheadedness
- Speech problems
- Weakness
- Sensory problems

Endocrine

- Body size change
- Bruising easily
- Change in vision
- Change in weight
- Excessive nervousness
- Excessive thirst
- Excessive urination