PARAGON
SPORT SPINE & WELLNESS

New Patient Intake Forms

Please print clearly in black or blue ink and bring these pages to your first visit, along with your photo ID and insurance card. Skip anything that doesn't apply to you. Prefer to type? Fill these out online at **paragonssw.com** under New Patients.

1 Patient information

Last name | First name | Date of birth | Age

Street address | City | State | ZIP

Home phone | Cell phone | Work phone

Email

Preferred method of contact

☐ Home phone ☐ Cell phone ☐ Email

Gender | Sex assigned at birth | Pronouns

Employment

Work status

☐ Full-time ☐ Part-time ☐ Retired ☐ Not working

Occupation

Employer

Emergency contact

Name | Relationship to you | Phone

2 Insurance

Primary insurance

Insurance company

Subscriber name

Subscriber's relationship to you

Subscriber's date of birth

Employer of policy holder

Subscriber ID

Group number

Secondary insurance (if applicable)

Insurance company

Subscriber name

Subscriber's relationship to you

Subscriber's date of birth

Subscriber ID

Group number

I accept responsibility for the cost of this examination or treatment in the event that my insurance does not cover the services provided.

Signature of patient or responsible party

Date

3 What brings you in

Your physicians

Primary care physician

Phone

Referring physician

Phone

Who can we thank for this referral?

Your main concern

What is your chief complaint?

Date of injury or onset

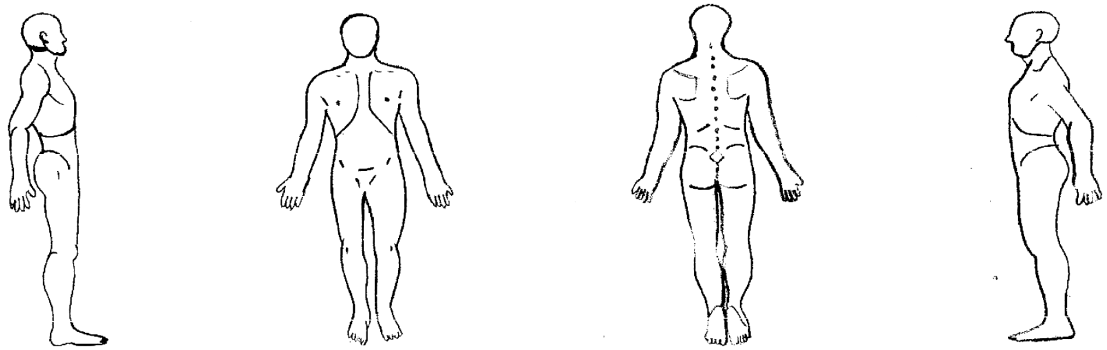
Work or auto related?

☐ Work related ☐ Auto accident ☐ Neither

How severe is it? Circle one number for each. 0 is none, 10 is the worst.

Pain	0	1	2	3	4	5	6	7	8	9	10
Decreased motion	0	1	2	3	4	5	6	7	8	9	10
Swelling	0	1	2	3	4	5	6	7	8	9	10
Stiffness	0	1	2	3	4	5	6	7	8	9	10
Loss of function	0	1	2	3	4	5	6	7	8	9	10

Where is the problem? Mark the body chart: X pain N numbness T tingling



Left side Front Back Right side

What does it feel like?

Check all that apply

☐ Sharp ☐ Dull ☐ Piercing ☐ Shooting ☐ Aching ☐ Deep ☐ Superficial ☐ Tingling ☐ Numbness
☐ Intermittent ☐ Burning ☐ Stabbing

How is your pain today?

☐ Mild ☐ Moderate ☐ Worst

Past 2 to 4 weeks?

☐ Mild ☐ Moderate ☐ Worst

What makes your pain or symptoms better?

What makes your pain or symptoms worse?

When are your symptoms the worst?

☐ Morning ☐ Afternoon ☐ Evening ☐ Inconsistent

How do you feel about your symptoms?

☐ Improving ☐ Worse ☐ Stable

Has this problem affected your daily life or routine? Briefly describe how.

4 Health questions

Have you had past episodes of this problem? If yes, how were you treated? Check all that apply

☐ Physical therapy ☐ Acupuncture ☐ M.D. (meds, TPIs) ☐ Massage therapist ☐ Chiropractor ☐ Pilates
☐ General exercise ☐ Personal training ☐ Self medicated (NSAIDs) ☐ Ignored it ☐ Other

Did you have success with previous treatment?

☐ Yes ☐ No

Any testing for this condition (X-rays, MRI, etc.)? List the test and dates.

Please answer each question	Yes	No
1. Do the current problems interrupt your sleep?	☐	☐
2. Do you experience any dizziness or vertigo?	☐	☐
3. Have you noticed any shortness of breath or decrease in exercise tolerance?	☐	☐
4. Do you have any allergies?	☐	☐
5. Do you have high blood pressure?	☐	☐
6. Do you have any cardiac problems?	☐	☐
7. Have you had any skin changes, such as rashes or discoloration?	☐	☐
8. Have you had any recent change in your weight or appetite?	☐	☐
9. Have you had a recent episode of nausea or vomiting?	☐	☐
10. Are you pregnant?	☐	☐
11. Do you have any intolerance to hot or cold?	☐	☐
12. Do you have diabetes?	☐	☐
13. Do you have any bruising or bleeding disorders?	☐	☐
14. Have you had any recent changes in bowel or bladder function?	☐	☐
15. Are you having any pelvic pain, or pain with urination?	☐	☐
16. Do your symptoms change with coughing or sneezing?	☐	☐
17. Do you have a history of neck or back problems?	☐	☐
18. Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?	☐	☐
19. Do you have osteoporosis? Date of last bone scan: _____	☐	☐
20. Do you use any assistive devices? (cane, foot orthotics, hearing aid, etc.)	☐	☐
21. Have you ever had cancer of any sort?	☐	☐

Any other medical conditions your provider should be aware of?

5 Pain medications

Check any you've tried, are taking now, or found helpful. Leave the rest blank.

TCAs	Tried	Taking	Helpful
amitriptyline (Elavil)	☐	☐	☐
doxepin (Sinequan)	☐	☐	☐
nortriptyline (Pamelor)	☐	☐	☐

SSRIs	Tried	Taking	Helpful
citalopram (Celexa)	☐	☐	☐
escitalopram (Lexapro)	☐	☐	☐
fluoxetine (Prozac)	☐	☐	☐
paroxetine (Paxil)	☐	☐	☐
sertraline (Zoloft)	☐	☐	☐

SNRIs	Tried	Taking	Helpful
duloxetine (Cymbalta)	☐	☐	☐
venlafaxine (Effexor)	☐	☐	☐
desvenlafaxine (Pristiq)	☐	☐	☐

Membrane stabilizers	Tried	Taking	Helpful
carbamazepine (Tegretol)	☐	☐	☐
gabapentin (Neurontin)	☐	☐	☐
lamotrigine (Lamictal)	☐	☐	☐
phenytoin (Dilantin)	☐	☐	☐
pregabalin (Lyrica)	☐	☐	☐
topiramate (Topamax)	☐	☐	☐

Muscle relaxants	Tried	Taking	Helpful
baclofen	☐	☐	☐
carisoprodol (Soma)	☐	☐	☐
chlorzoxazone (Lorzone)	☐	☐	☐
cyclobenzaprine (Flexeril)	☐	☐	☐
metaxalone (Skelaxin)	☐	☐	☐
methocarbamol (Robaxin)	☐	☐	☐
tizanidine (Zanaflex)	☐	☐	☐

Benzodiazepines	Tried	Taking	Helpful
alprazolam (Xanax)	☐	☐	☐
clonazepam (Klonopin)	☐	☐	☐
diazepam (Valium)	☐	☐	☐
lorazepam (Ativan)	☐	☐	☐
temazepam (Restoril)	☐	☐	☐

Opioids and similar	Tried	Taking	Helpful
buprenorphine	☐	☐	☐
codeine	☐	☐	☐
fentanyl	☐	☐	☐
hydrocodone	☐	☐	☐
hydromorphone	☐	☐	☐
levorphanol	☐	☐	☐
meperidine	☐	☐	☐
methadone	☐	☐	☐
morphine	☐	☐	☐
oxycodone	☐	☐	☐
Suboxone	☐	☐	☐
tapentadol	☐	☐	☐
tramadol	☐	☐	☐

Topicals	Tried	Taking	Helpful
Compounded topical creams	☐	☐	☐
lidocaine (Lidocaine gel, Lidoderm)	☐	☐	☐
diclofenac (Voltaren, Flector patch)	☐	☐	☐

NSAIDs and acetaminophen	Tried	Taking	Helpful
aspirin	☐	☐	☐
celecoxib (Celebrex)	☐	☐	☐
diclofenac (Cambia, Voltaren, Zipsor)	☐	☐	☐
etodolac (Lodine)	☐	☐	☐
ibuprofen (Motrin, Advil)	☐	☐	☐
indomethacin (Indocin)	☐	☐	☐
meloxicam (Mobic)	☐	☐	☐
naproxen (Aleve, Naprosyn)	☐	☐	☐
acetaminophen (Tylenol)	☐	☐	☐

Other (please list)	Tried	Taking	Helpful
	☐	☐	☐
	☐	☐	☐

6 Care you've tried

Have you ever done any of these? Check it, then circle how much it helped: 1 not at all, 4 very helpful.

Treatment	1	2	3	4
☐ Physical therapy	(1)	(2)	(3)	(4)
☐ Massage therapy	(1)	(2)	(3)	(4)
☐ Chiropractic	(1)	(2)	(3)	(4)
☐ Acupuncture	(1)	(2)	(3)	(4)
☐ Bracing Body part(s): _____	(1)	(2)	(3)	(4)

Interventional pain procedures Check any you've had.

Procedure	Body part(s)	Date(s)
☐ Epidural injections		
☐ Medial branch blocks / RFA		
☐ Sacroiliac joint injections		
☐ Occipital nerve block		
☐ Trigger point injections		
☐ Joint injections		
☐ Nerve blocks		
☐ Other		

7 Review of systems

Check anything you're experiencing now.

Constitutional

- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Sweating
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected weight change

Head, ears, nose and throat

- ☐ Congestion
- ☐ Ear pain
- ☐ Facial swelling
- ☐ Hearing loss
- ☐ Runny nose
- ☐ Sore throat
- ☐ Tinnitus
- ☐ Trouble swallowing
- ☐ Voice change

Eyes

- ☐ Eye redness
- ☐ Light sensitivity
- ☐ Visual disturbance
- ☐ Eye pain

Respiratory

- ☐ Chest tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Apnea

Cardiovascular

- ☐ Palpitations
- ☐ Chest pain
- ☐ Leg swelling

Gastrointestinal

- ☐ Abdominal distension (bloating)
- ☐ Abdominal pain
- ☐ Anal bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

Endocrine

- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive urination

Genitourinary

- ☐ Difficulty urinating
- ☐ Painful intercourse
- ☐ Painful urination
- ☐ Incontinence
- ☐ Flank pain
- ☐ Blood in urine
- ☐ Pelvic pain
- ☐ Urine decreased

Musculoskeletal

- ☐ Joint pain
- ☐ Back pain
- ☐ Gait problem
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Neck pain
- ☐ Neck stiffness

Skin

- ☐ Color change
- ☐ Pallor
- ☐ Rash
- ☐ Wound

Allergy and immunology

- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Immunocompromised

Neurological

- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech difficulty
- ☐ Fainting (syncope)
- ☐ Tremors
- ☐ Weakness
- ☐ Dizziness

Hematologic

- ☐ Swollen glands
- ☐ Bruises or bleeds easily

Psychiatric

- ☐ Behavior problem
- ☐ Confusion
- ☐ Decreased concentration
- ☐ Uneasy or low mood
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervous or anxious
- ☐ Self-injury
- ☐ Sleep disturbance
- ☐ Suicidal thoughts
- ☐ Agitation

8 Health history

Medical history

Check all that apply.

- ☐ Angina (heart attack)
- ☐ Anxiety disorder
- ☐ Asthma
- ☐ Bipolar disorder
- ☐ Migraine headaches
- ☐ Osteoarthritis
- ☐ COPD
- ☐ Panic disorder
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gastritis
- ☐ Cancer
- ☐ Hepatitis A, B, or C
- ☐ Seizure
- ☐ Depression
- ☐ Tuberculosis
- ☐ Irregular heartbeat
- ☐ Irritable bowel syndrome
- ☐ Kidney failure
- ☐ Cirrhosis
- ☐ Mitral valve prolapse
- ☐ Stress incontinence
- ☐ Hypertension
- ☐ Peptic ulcer disease
- ☐ Reflux disorder
- ☐ Rheumatoid arthritis
- ☐ Heart failure
- ☐ HIV infection
- ☐ Stroke
- ☐ Hyperthyroidism

Family medical history

Cancer ☐ Yes ☐ No **Diabetes** ☐ Yes ☐ No **Heart disease** ☐ Yes ☐ No **Arthritis** ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Current medications

Medication and reason	Dose (mg) and frequency

Medication allergies

Medication	Reaction

Surgical history

Surgery	Date

9 Lifestyle and opioid risk

Are you on disability?
☐ No ☐ Yes

If yes, cause _____

Marital status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Children?
☐ Yes ☐ No

Ages _____

Family history of addiction?
☐ No ☐ Yes

If yes, who and what kind? _____

Alcohol use?
☐ Yes ☐ No

Drug use?
☐ Yes ☐ No

If yes, what kind? _____

Smoking
☐ Never ☐ Quit ☐ Yes

Year quit _____

Packs per day _____

Opioid risk assessment

Standard for every new patient. Check yes or no for each.

	Yes	No
Family history of substance abuse:		
Alcohol	☐	☐
Illegal drugs What kind? _____	☐	☐
Prescription drugs	☐	☐
Personal history of substance abuse:		
Alcohol	☐	☐
Illegal drugs What kind? _____	☐	☐
Prescription drugs	☐	☐
Other risk factors:		
Age between 16 and 45 years	☐	☐
History of preadolescent sexual abuse	☐	☐
Psychological disease:		
ADD, OCD, bipolar, schizophrenia	☐	☐
Depression	☐	☐

10 Cancellation policy

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notice allows us to fulfill other patients' scheduling needs and respects our providers' time. Because of the one-on-one nature of your appointments (sometimes with multiple providers), missed appointments are a significant inconvenience to your providers, the clinic and other patients.

This policy is in place out of respect for our therapists AND our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

We kindly request contacting our office with 24-hour notice to change or cancel an appointment. Patients who do not regularly attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a **$25.00 service charge**. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

1. We reserve your appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to offer that time to a wait-listed patient.
2. If appointments are missed or cancelled on a regular basis it will affect your outcome. Your treatment plan has been established by your medical provider(s) to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.
3. After two missed or cancelled appointments without the appropriate 24-hour notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

Note: You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time. Thank you for providing our office and our patients with this courtesy.

> **I have read, understand, and agree to abide by the policy above.**

Print name

Signature of patient or responsible party

Date

11 Release of information and assignment of benefits

Authorization to release information

Paragon Sport Spine & Wellness is authorized to release all or any part of the medical record and other information of the patient named on this form to such insurance companies, organizations or agencies including, if applicable, The Centers for Medicare & Medicaid Services and its agents, as may be concerned with payment of the services rendered and as needed to determine benefits payable for services furnished. A copy of this authorization will be sent to The Centers for Medicare & Medicaid Services, if applicable, my insurance company or other entity if requested. The original authorization will be kept on file by Paragon Sport Spine & Wellness.

Assignment of insurance benefits

I request that payment for authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Paragon Sport Spine & Wellness LLC for any services provided to me by it. I assign to Paragon Sport Spine & Wellness, LLC all my rights, entitlements and interest under any policy under which I have benefits and to medical insurance, automobile personal injury protection, workers compensation or other third-party payer benefits, otherwise payable to me for those services provided. I obtained any pre-certification or authorization required and have fulfilled other requirements or conditions of my insurance coverage that are my responsibility.

I further authorize Paragon Sport Spine & Wellness and its designated agents to pursue all appeal and settlement options available to me. In addition, I authorize Payer to communicate with PSSW and/or its agents with all pertinent documentation that I am entitled to, including but not limited to: 1) plan language; 2) certificate of benefits; 3) documentation of how the allowable amounts were calculated.

Print name of patient

Signature of patient or responsible party

Date

Authorized representative's name and relationship to patient (if applicable)

12 Financial agreement and responsibility

Paragon Sport Spine & Wellness, LLC (PSSW) is an out of network practice and submits claims to insurance carriers as a convenience for the patient. These benefits will be verified prior to any services being rendered and you will be made aware of any and all charges that you may be responsible for. Complete and current insurance information is required in order for our office to submit a claim to your primary insurance plan. It is the patient's responsibility to notify Paragon Sport Spine & Wellness of any changes in your coverage or termination of coverage.

PSSW will provide rehabilitation services to you. Below is a list of possible charges you may be responsible for.

1. **Deductible.** Depending on your insurance plan, you may have a deductible that is considered your responsibility. We will confirm your deductible as part of our patient intake and insurance verification process. Medicare beneficiaries and/or their secondary insurance carriers will be billed for the annual Medicare Part B deductible.
2. **Co-insurance.** Most insurance carriers do not cover 100% of the services that are rendered here at Paragon Sport Spine & Wellness. They will only pay a percentage of the "allowable charges" and the remaining balance is considered "co-insurance." If you have secondary insurance, this will likely be covered by that entity. If you do not have secondary insurance, you are responsible for this charge; however, in most cases we are willing to work with you if you are having financial difficulties with the balance after claims have been processed.
3. Your insurance carrier may pay PSSW directly for services rendered. However, in some cases such as with Horizon Blue Cross Blue Shield and other carriers, they will remit payment to you, the patient, instead. Please keep in mind that PSSW bills your insurance company as a courtesy to you rather than charging you up front. **In these instances, it is your responsibility to hand those checks in to Paragon Sport Spine & Wellness and sign the check and write "payable to Paragon Sport Spine & Wellness" above your signature. Cashing these checks made to you on behalf of services provided by PSSW is insurance fraud and tax evasion. PSSW reserves the right to take appropriate action, including collections and notifying appropriate authorities.** If you do not comply with the above financial policies, PSSW will no longer be able to extend these courtesies to you and will bill you for charges in full.

By signing below, you acknowledge and agree that, in consideration of these services to be rendered, you are financially responsible for all, or any unpaid portion of the fees incurred for services rendered. Further, you understand that, subject to the terms of your insurance policy, if any, the unpaid portion may be insurance deductibles, coinsurance, or the entire bill for services not covered by insurance or health care benefits. The undersigned certifies that they have read the above terms, understood the above terms and accepted and consent to the above terms.

Print name of patient or responsible party

Signature of patient or responsible party

Date

13 Financial policy acknowledgment

Completed with a member of our front desk team.

I, _____, have been advised of Paragon Sport Spine & Wellness's financial policy, my insurance plan's out of network benefits and what my financial responsibilities will be.

Date financial policy and insurance education completed

Paragon representative name

Signature of patient or responsible party

Date