PARAGON
SPORT SPINE & WELLNESS

Patient Information

Name: _____ DOB: ___/___/___ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

Email: _____

Preferred method of contact: [ ] Home Phone [ ] Cell Phone [ ] Email

Gender: _____ Sex assigned at birth: _____ Pronoun: _____

Employment Information

Work Status: Full-Time Part-Time Retired Occupation: _____

Employer: _____ Work Phone: _____

Emergency Contact Information

Name: _____

Relationship to you: _____ Phone Number: _____

Insurance Information- Primary

Insurance Company: _____ Subscriber Name: _____

Relationship to you: _____ Date of Birth: ___/___/___

Employer of Policy Holder: _____

Subscriber ID: _____ Group Number: _____

Secondary Insurance Information (If applicable)

Insurance Company: _____ Subscriber Name: _____

Relationship to you: _____ Date of Birth: ___/___/___

Subscriber ID: _____ Group Number: _____

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

Patient Signature: _____ Date: _____

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Primary Care & Referring Physician Information

Primary Care Physician Name: _____ Phone Number: _____

Referring Physician Name: _____ Phone Number: _____

Who can we thank for this referral? _____

What is your chief complaint?

_____

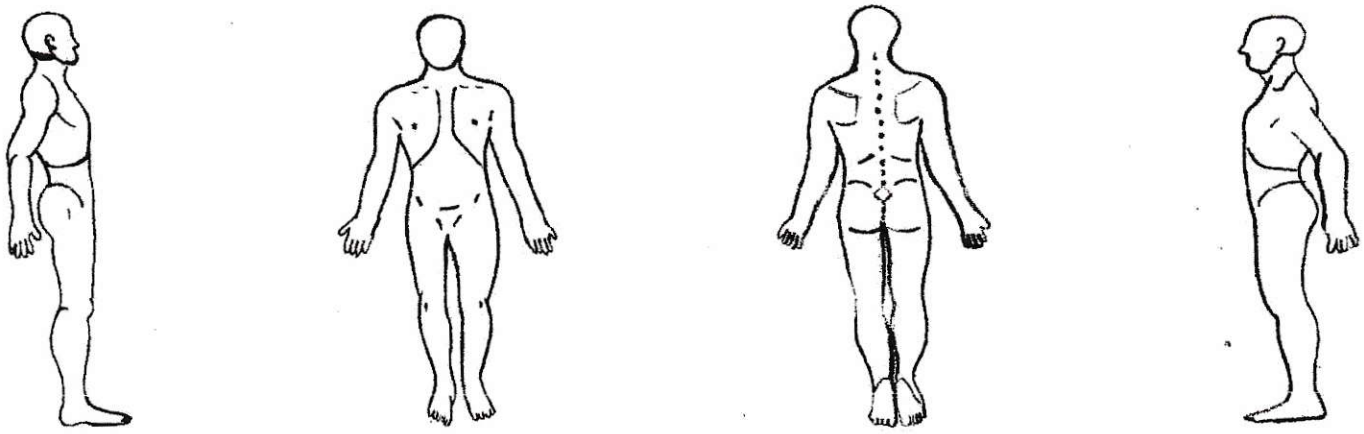
_____

Date of Injury or Onset of Condition: _____
Work or Auto Related? _____

Please rate your complaint in severity on a scale of 0 (none) -10 (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 your problem located? Indicate on the body chart below: X for Pain; N for Numbness; T for Tingling



Indicate the nature of your pain and symptoms (please circle what applies to you).

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

How is your pain today? Mild Moderate Worst **How was your pain in the past 2-4 weeks?** Mild Moderate Worst

What makes your pain / symptoms better? _____

What makes your pain / 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 in what ways.

_____

_____

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Have you had past similar episodes of this current problem? If yes, how were you treated? (Circle all that apply to you)

Physical Therapy Acupuncture M.D (Meds, TPIs) Massage Therapist Chiropractor Pilates General Exercise Personal Training Exercise Self Medicated (NSAIDs) Ignored it Other

Did you have success with previous treatment? Y or N

Have you undergone any testing for this condition? (X-Rays, MRI, Etc.) If yes, please list the test and dates.

_____

_____

Please answer the following questions:

	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/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 your last bone scan:		
20) Do you use any assistive devices? (cane, feet orthotics, hearing aid, etc)		
21) Have you ever had cancer of any sort?		

Any other medical conditions that the provider should be aware of? _____

_____

TCAs	Tried	Taking	Helpful	N/A
amitriptyline (Elavil)	0	0	0	
doxepin (Sinequan)	0	0	0	
nortriptyline (Pamelor)	0	0	0	

SSRIs	Tried	Taking	Helpful	N/A
citalopram (Celexa)	0	0	0	
escitalopram (Lexapro)	0	0	0	
fluoxetine (Prozac)	0	0	0	
paroxitine (Paxil)	0	0	0	
sertraline (Zoloft)	0	0	0	

SNRIs	Tried	Taking	Helpful	N/A
duloxetine (Cymbalta)	0	0	0	
venlafaxine (Effexor)	0	0	0	
desvenlafaxine (Pristiq)	0	0	0	

Membrane Stabilizers	Tried	Taking	Helpful	N/A
carbamazepine (Tegretol)	0	0	0	
gabapentin (Neurontin)	0	0	0	
lamotrigine (Lamictal)	0	0	0	
phenytoin (Dilantin)	0	0	0	
pregabalin (Lyrica)	0	0	0	
topiramate (Topamax)	0	0	0	

Muscle Relaxants	Tried	Taking	Helpful	N/A
baclofen	0	0	0	
carisoprodol (Soma)	0	0	0	
chlorzoxazone (Lorzone)	0	0	0	
cyclobenzaprine (Flexeril)	0	0	0	
metaxolone (Skelaxin)	0	0	0	
methocarbamol (Robaxin)	0	0	0	
tizanidine (Zanaflex)	0	0	0	

Opioids and similar	Tried	Taking	Helpful	N/A
buprenorphine	0	0	0	
codeine	0	0	0	
fentanyl	0	0	0	
hydrocodone	0	0	0	

hydromorphone	0	0	0	N/A
levorphanol	0	0	0	
meperadine	0	0	0	
methadone	0	0	0	
morphine	0	0	0	
oxycodone	0	0	0	
Suboxone	0	0	0	
tapentadol	0	0	0	
tramadol	0	0	0	

Benzodiazepines	Tried	Taking	Helpful	N/A
alprazolam (Xanax)	0	0	0	
clonazepam (Klonopin)	0	0	0	
diazepam (Valium)	0	0	0	
lorazepam (Ativan)	0	0	0	
temazepam (Restoril)	0	0	0	

Topicals	Tried	Taking	Helpful	N/A
Compounded topical creams	0	0	0	
lidocaine (Lidocaine gel, Lidoderm)	0	0	0	
diclofenac (Voltaren, Flector patch)	0	0	0	

NSAIDs	Tried	Taking	Helpful	N/A
aspirin	0	0	0	
celecoxib (Celebrex)	0	0	0	
diclofenac (Cambia, Voltaren, Zipsor)	0	0	0	
etodolac (Lodine)	0	0	0	
ibuprofen (Motrin, Advil)	0	0	0	
indomethacin {Indocin)	0	0	0	
meloxicam (Mabie)	0	0	0	
naproxen (Aleve, Naprosyn)	0	0	0	
acetaminophen (Tylenol)	0	0	0	

Other (Please list):	Tried	Taking	Helpful
	0	0	0
_____	0	0	0

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Have you ever done the below?	Did it help? (On a scale from 1-4, 4 being it was very helpful)
☐ Physical Therapy	1 2 3 4
☐ Massage Therapy	1 2 3 4
☐ Chiropractic	1 2 3 4
☐ Acupuncture	1 2 3 4
☐ Bracing-- List body part(s):	1 2 3 4

Have you ever had any of these Interventional Pain procedures?	Please List the date
☐ Epidural injections - List body part(s):	
☐ Medial branch blocks/RFA - List body part(s):	
☐ Sacroiliac Joint Injections	
☐ Occipital Nerve Block	
☐ Trigger Point Injections	
☐ Joint injections - List body part(s):	
☐ Nerve blocks - List body part(s):	
☐ Other - Please list:	

Constitution

- □ Activity Change
- □ Appetite change
- □ Chills
- □ Sweating
- □ Fatigue
- □ Fever
- □ Unexpected weight change

HENT

- □ 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

GI

- □ 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

- □ Environmental Allergies
- □ Food Allergies
- □ Immunocompromised

Neurological

- □ Headaches
- □ Light-headedness
- □ Numbness
- □ Seizures
- □ Speech difficulty
- □ Syncope
- □ Tremors
- □ Weakness
- □ Dizziness

Hematologic

- □ Swollen Glands
- □ Bruises/bleeds easily

Psychiatric

- □ Behavior problem
- □ Confusion
- □ Decreased concentration
- □ Dysphoric Mood (uneasy)
- □ Hallucinations
- □ Hyperactive
- □ Nervous/anxious
- □ Self-injury
- □ Sleep disturbance
- □ Suicidal ideas
- □ Agitation

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Psychosocial History

Occupation: *Are you on disability?* ☐ *No* ☐ *Yes-Cause:*

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐

Other Children: ☐ *Yes* ☐ *No* *Ages:*

Family History of addiction? ☐ *No* ☐ *Yes, whom and what kind?*

Alcohol use? ☐ *Yes* ☐ *No* *Drug use?* ☐ *Yes* ☐ *No* _____

Smoking: ☐ *Never* ☐ *Quit/ Year:* _____ ☐ *Yes / Packs per day:*

Opioid Risk Assessment

Mark each box that applied	Yes	No
Family History of substance abuse		
Alcohol		
Illegal drugs & What kind		
RX Drugs		
Personal history of substance abuse		
Alcohol		
Illegal drugs & What kind		
RX drugs		
Age between 16-45 years		
History of preadolescent sexual abuse		
Psychological disease		
ADD, OCD, Bipolar, Schizophrenia		
Depression		

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General Medical History – Please mark all that apply:

- o Angina (Heart Attack)
- o Anxiety Disorder
- o Asthma
- o Bi-Polar Disorder
- o Migraine Headaches
- o Osteoarthritis
- o COPD
- o Panic Disorder
- o Emphysema
- o Fibromyalgia
- o Gastritis
- o Cancer
- o Hepatitis A, B, or C
- o Seizure
- o Depression
- o Tuberculosis
- o Irregular Heart Beat
- o Irritable Bowel Syndrome
- o Kidney Failure
- o Cirrhosis
- o Mitral Valve Prolapse
- o Stress Incontinence
- o Hypertension
- o Peptic Ulcer Disease
- o Reflux Disorder
- o Rheumatoid Arthritis
- o Heart Failure
- o HIV Infection
- o Stroke
- o Hyperthyroidism

Allergies (Medication)

Medication Name:	Reaction:

Current Medications

Medication Name & Reason:	Dose (MG)/Frequency:

Surgery History – Please List with Date:

Family Medical History:

Cancer Y N
Diabetes Y N
Heart Disease Y N
Arthritis Y N
Stroke Y N

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Name: _____ DOB: ___/___/___

Current Medications and Vitamins

Medication Name: _____ Dosage: _____ Reason: _____
Medication Name: _____ Dosage: _____ Reason: _____
Medication Name: _____ Dosage: _____ Reason: _____
Medication Name: _____ Dosage: _____ Reason: _____
Medication Name: _____ Dosage: _____ Reason: _____

Allergies: _____
_____

Height: _____ **Weight:** _____ **Shoe Size:** _____ **(Podiatry Use)**

Social History

Tobacco Use: Never Smoker Daily Smoker Past Smoker **Alcohol Use:** Never Daily Social

Overall Activity Level: Sedentary Light Moderate Heavy Very Heavy

Circle all the words that describe how you feel today / recently:
Happy Sad Stressed Overwhelmed Tired Worried Lonely Afraid Anxious Weak
Energetic Content Overworked Optimistic

I enjoy learning by:
[] Listening (discussions, lectures, etc)
[] Visual (videos/pictures)
[] Doing (practicing skills)
[] Reading
[] Not sure

Please list your goals for treatment:
1. _____
2. _____
3. _____

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Name: _____ DOB: ___/___/___

Ob/Gyn History (females only):

	Yes	No
1) Childbirth vaginal deliveries		
2) Vaginal dryness		
3) Episiotomy		
4) Painful periods		
5) C-section		
6) Menopause - when?		
7) Difficult childbirth		
8) Painful vaginal penetration		
9) Prolapse or organ falling out		
10) Pelvic pain		
11) Other/describe		

Males only:

	Yes	No
1) Prostate disorders		
2) Erectile dysfunction		
3) Shy bladder		
4) Pain ejaculation		
5) Pelvic Pain		
6) Other/describe		

Bladder / Bowel Habits / Problems

	Yes	No
1) Trouble initiating urine stream		
2) Blood in urine		
3) Urinary intermittent/slow stream		
4) Painful urination		
5) Trouble feeling bladder urge/fullness		
6) Current laxative use		
7) Straining or pushing to empty bladder		
8) Constipation/straining		
9) Dribbling after urination		
10) Trouble holding back gas/feces		
11) Constant urine leakage		
12) Recurrent bladder infections		

Medical History

Has this problem affected your daily life or routine? Briefly describe in what ways.

_____

_____

PELVIC CANCELLATION POLICY

Please Allow 24-hours

Due to the high demand for specialized pelvic health services, Paragon SSW frequently has a waiting list of patients needing treatment. We have a 24-hour cancellation policy during the week. This enables our office to have adequate time to fill your cancelled or re-scheduled appointment with another patient in need.

Associated Fees

Appointments cancelled without this notice from you will be automatically charged a cancellation fee of $100. This fee is not charged to your insurance but to you directly. (A credit card is required to hold patient appointments. In the event of a missed initial evaluation or insufficient time frame for cancellation, the credit card will be charged the initial evaluation cancellation fee of $200).

Case-by-Case Basis

We understand that there may be extenuating circumstances resulting in a cancellation or reschedule with less than 24 hours' notice. These incidents will be handled on a case-by-case basis.

By signing below, you acknowledge, agree and consent to the above terms.

_____
Patient Name or Responsible Party (Print)

_____
Patient Name or Responsible Party (Signature)

_____
Date

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Cancellation Policy

To our valued patients: We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advanced notice allows us to fulfill other patient's scheduling needs and respects our provider's time. Due to our one-on-one nature of your appointments (sometimes multiple providers), missed appointments are a significant inconvenience to your provider(s), the clinic and other patients.

This policy is in place out of respect for our therapist 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 _____

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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/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.

Date: _____

Signature of Patient/Authorized Representative

_____

Print Name of Patient

_____

Print Name of Authorized Representative and Relationship to Patient [if applicable]

PARAGON
SPORT SPINE & WELLNESS

Financial Agreement and Responsibility Form

PLEASE READ THIS DOCUMENT CAREFULLY AND SIGN AT THE BOTTOM

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 in-take 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 he/she has read the above terms, understood the above terms and accepted and consents to the above terms.

_____ _____

Patient Name or Responsible Signature Date

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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: _____

_____
Patient or Responsible Party Signature