PATIENT MEDICAL HISTORY

Name _____ **Age** _____ **Date of Birth** _____ **Today's Date** _____
School (students only) _____ **Who referred you?** _____
Personal Physician _____ **Address** _____

What is the main problem for which you are seeking medical attention? _____

Date of injury or pain onset ? _____ **Date you first sought medical attention?** _____
My joint pain has associated (circle any)? joint swelling locking/catching giving way buckling
Is this problem a result of (circle one)? MVA Personal Injury Sports Work Other
For Trauma: Driver ? Y / N **Passenger ?** Y / N **Aware of impending Impact or fall ?** Y / N
I braced for impact with my ... body head right arm left arm right leg left leg
Please give details of how your pain/injury occurred: _____

List all previous medical provider(s) names seen & treatment(s) you have you tried for THIS problem?

	Who	Dates	Please Describe Imaging/Labs or Treatment given
ER			
PCP			
Specialist 1			
Specialist 2			
Specialist 3			
Manipulation			
Physical Therapy			
Medications			

What diagnostic studies have been done for THIS problem?

	Dates	Results		Dates	Results
X-rays			**MRI**		
Ultrasound			**CT Scan**		
Bone Scan			**other**		

CURRENT MEDICATIONS (including vitamins)	**ALLERGIES (describe reaction)**

Work Activity	
Job Description:	
Describe your activity level or any specific repetitive behaviors:	

Athletic / Sporting Activities		
	Amounts/Times per week	**Previous Injuries**
Sport 1:		
Sport 2:		
Sport 3:		

Do you currently smoke: _____ packs/day.
Have you ever smoked ? Y / N _____ packs/day. Year Quit _____.
Caffeine? _____ cups/day Alcohol? type _____ # Years amount _____

PAIN ASSESSMENT

How would you rate the SEVERITY of your pain on a BAD DAY or Time ? (circle all that apply):

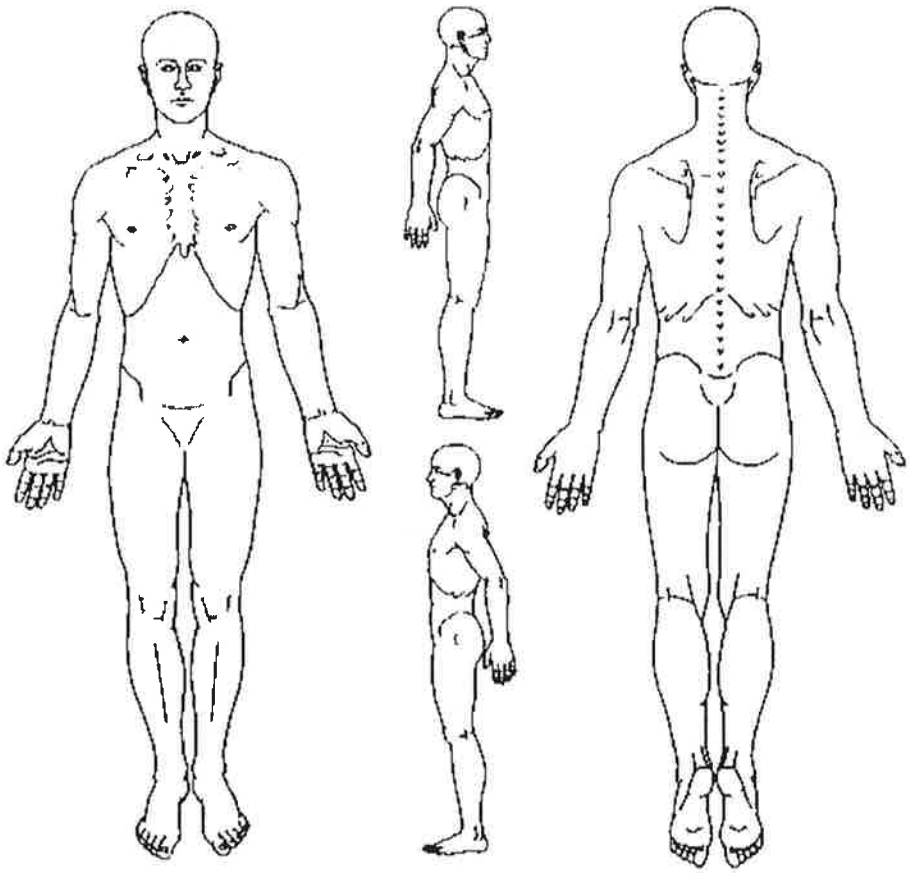
1 2	3 4	5 6	7 8	9 10
MILD PAIN	DISCOMFORTING	DISTRESSING	INTENSE	EXCRUCIATING
annoying	troublesome	miserable	dreadful / horrible	unbearable
nagging	irritating	agonizing	vicious	torturing
	numbing	gnawing	nauseating	crushing / tearing

How would you rate the SEVERITY of your pain on a GOOD DAY or Time ? (circle one):

1 2 3 4 5 6 7 8 9 10

Please indicate both the location and nature of your pain on the diagram below:

Numbness = = = Pins & Needles O O O Burning X X X Ache Λ Λ Λ Stabbing ///



Please rate your typical pain in these specific situations below: (circle closest response)

↑↑ = markedly increased
↑ = increased,
↓ = decreased,
↓↓ = markedly decreased

First thing AM: ↑↑ ↑ +/- ↓ ↓↓

Mid-day: ↑↑ ↑ +/- ↓ ↓↓

Evening: ↑↑ ↑ +/- ↓ ↓↓

Middle night: ↑↑ ↑ +/- ↓ ↓↓

Prolonged Sitting: ↑↑ ↑ +/- ↓ ↓↓

Prolonged Standing: ↑↑ ↑ +/- ↓ ↓↓

Walking: ↑↑ ↑ +/- ↓ ↓↓

Running: ↑↑ ↑ +/- ↓ ↓↓

Overall ... my pain is getting (circle one): Getting Better Getting Worse Staying the Same

What makes your pain worse? _____

What makes your pain better? _____

How would you describe the QUALITY (NATURE or CHARACTER) of your pain ? (circle all apply)

lacerating		electrical	burning	aching	*intermittent*	throbbing	punishing
stinging	*deep*	shocking	shooting	heavy		pounding	pulling
sharp		cramping	flashing	hot	*variable*	aching	tugging
knife-like	*on surface*	squeezing	tingling	itching		numb	prickling
piercing		tight		cold	*constant*	tender	pins /needles

Does your pain or symptoms travel or radiate to other areas? Yes No (circle one)

If yes, describe ... is the QUALITY and DEPTH of the pain different than the primary area ?

_____

_____

FAMILY HISTORY

	If Living		If Deceased	
	Age	Health Problems	Age	Cause of Death / Health Problems
Father				
Mother				
Brother(s)				
Sister(s)				

CURRENT MEDICAL PROBLEMS (FOR WHICH YOU ARE UNDER TREATMENT WITH OTHER PHYSICIANS)

HOSPITALIZATIONS AND SURGERIES

Date	Reason	Date	Reason

MEDICAL HISTORY (please CHECK all PRESENT conditions – "X" all PAST conditions):

HEENT		RESPIRATORY		MUSCULOSKELETAL	
Headaches		Asthma		Herniated Disc	
Migraines		Bronchitis		Location:	
Concussion		Pneumonia		Broken bones	
Head injury		Shortness of breath w/exercise		(specify)	
Eye problems		Coughing during / after exercise		Chronic back pain	
Wear glasses / contacts		Use an inhaler		Chronic neck pain	
- last eye exam:		**GASTRO-INTESTINAL**		Joint pain	
Hearing problems		Heartburn / indigestion		(specify):	
Sinus problems		Ulcers		Whiplash injury	
Frequent colds / illnesses		Diarrhea		Shoulder injury	
CARDIOVASCULAR		Constipation		Knee injury	
High blood pressure		Gall bladder problems		Sprained ankle	
Angina		Use antacids		Wear orthotics in shoes	
Chest pain with exertion		Hemorrhoids		Scoliosis	
Palpations		Irritable bowel		Tendonitis	
Irregular heart beat		Colitis / Crohn's disease		Bursitis	
Heart failure		Blood in stool/black tarry stool		Rheumatoid arthritis	
Get lightheaded / faint w/exercise		Diverticulosis / Diverticulitis		Degenerative arthritis	
Heart murmur		Excess gas / bloating		Short leg	
High cholesterol		**GENITOURINARY**		Osteoporosis	
Stroke		Frequent urinary infections		**ENDOCRINE**	
Aneurysm		Kidney stones		Diabetes (insulin-dependent)	
Phlebitis / blood clots in legs		Prostate trouble (men only)		Diabetes (non-insulin depend)	
Varicose veins		Burning while urinating		Hypothyroid (underactive)	
NEUROLOGICAL/PSYCHIATRIC		**FEMALE ONLY**		Hyperthyroid (overactive)	
Nerve injury (specify)		Age first menstrual period:		Gout	
		Age menopause:		Easily fatigued	
Anxiety		Frequency of periods:		**OTHER**	
Depression		Irregular menstrual cycles		Cancer	
Panic attacks		Irregular bleeding / spotting		Type:	
Dizziness		Frequent yeast infections		Anemia	
Convulsions / seizures		# of pregnancies			
Anorexia / Bulimia		# of deliveries			

PHYSICIANS NOTES:

VCOM Sports & Osteopathic Medicine

Patient Name: Last:_____ First: _____ Middle Initial:_____
Preferred Name: _____ SS#: _____ DOB: _____ Sex: M / F / T
Address: _____City: _____ State: _____ Zip: _____
Home #: _____ Cell#: _____ Work#: _____
Email address: _____

Preferred method of communication (circle one): ◯ Voice ◯ SMS/TEXT Message ◯ Email (for appt reminder only)

Marital Status: Married Single Divorced Widowed Partner
Race: African American American Indian Asian White Hispanic Pacific Islander Other
Ethnicity: Hispanic Non-Hispanic Prefer Not to Report Preferred Language: _____
Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____
Occupation: _____ Employer: _____
Student Status: Full Time / Part Time Location/ School:_____

Responsible Party Info: (if patient is a minor):
Name: _____ SS#: _____ DOB: _____
Relation to Patient: _____ Home #: _____ Cell #:_____
Mailing Address: _____ City: _____ State: _____ Zip: _____

Is this a foster child? Yes / No If yes, Primary Caregiver/Legal Guardian's Name: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Do you have Medical Insurance? Yes / No
Primary Insurance Company: _____
Policy Holder Name: _____ DOB: _____
Policy Holder's Info: (if different from the patient):
Address: _____City: _____ State: _____ Zip: _____

Secondary Insurance Company: _____
Policy Holder Name: _____ DOB: _____
Policy Holder's Address: (if different from the patient):
Address: _____City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ Location: _____

Patient / Legal Guardian Signature: _____ Date:_____

1691 Innovation Dr, Ste 2100 • Blacksburg, Virginia 24060 • Phone: (540) 232-8405 • Fax: (540) 232-8429

VCOM Sports & Osteopathic Medicine

Consent for Treatment

I hereby consent to medical treatment, diagnostic tests, laboratory, and other medical procedures, which the physician(s) or healthcare provider(s) of VSOM may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing.

Patient / Legal Guardian Signature: _____ Date:_____

Notice of Privacy Practices

I acknowledge that I have access to a copy of VSOM Privacy Practices and that it is my responsibility to read the notice to understand how my or my child(ren)'s Protected Health Information may be used.

I understand no authorization is required from me for VSOM to use my or my child(ren)'s Protected Health Information for purposes of treatment, payment or health care operations. Other uses or disclosures may require my written authorization. **If you would like a copy of VSOM's Privacy Practices, please ask the receptionist.**

Patient / Legal Guardian Signature: _____ Date:_____

Acknowledgement of Deemed Consent for HIV / Hepatitis B or C Virus Blood Testing

Virginia Law authorizes health care providers to test their patients for HIV antibodies or Hepatitis B or C viruses when the health care provider is exposed to body fluids (ie: needlestick) of a patient in a manner which may transmit HIV or Hepatitis B or C viruses. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for these antibodies pursuant to this provision, the testing would be explained, and the testing would be explained, and you would be given the opportunity to ask any questions you might have. Patients who test positive will also be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

Patient / Legal Guardian Signature: _____ Date:_____

Payment Agreement

I agree to be financially responsible for costs incurred in my or my dependents care. I understand that charges for services provided shall be paid for at the time of each visit. If medical claims are submitted to an insurance company by VSOM on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to VSOM (assignment of benefits). I understand and agree that I am financially responsible for all deductible amount s, co-insurance, non-covered services or services deemed as "non-medically necessary" by my insurance carrier. I agree that I am responsible for satisfying any conditions (referrals) necessary for insurance or health benefits.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received services rendered by VSOM and agree to pay for said medical services according to such terms.

Patient / Legal Guardian Signature: _____ Date:_____

Self-Pay Agreement

I agree to pay for medical services rendered at VSOM. I understand that there are payment plans available at my request. I understand that these plans will be based on my financial income and will be reviewed prior to approval.

Patient / Legal Guardian Signature: _____ Date:_____

VCOM Sports & Osteopathic Medicine

Patient Name: _____ **DOB:** _____

Authorization to Treat in Absence of Parent or Guardian (optional)

If my child(ren) is/are brought in to the office by _____, I consent for my child(ren) to be treated and agree to be financially responsible for the cost of such care. I understand that by not signing this section my child(ren) cannot be seen at VSOM without myself or another legal guardian present.

Patient / Legal Guardian Signature: _____ Date:_____

Authorized Person(s) for Protected Health Information Disclosure

I hereby authorize VSOM to disclose my medical and Protected Health Information to the person(s) indicated below:

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____

Patient / Legal Guardian Signature: _____ Date:_____

Authorization for Release of Confidential Health Care Information

This authorizes VSOM to request and receive from the Virginia Department of Health Professions any and all records held by the department relating to schedule 2-5 controlled substances dispensed to the patient named above. I understand that this authorization permits the Dept. of Health Professions to disclose confidential health care records to the prescriber named above (VSOM). A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law. I understand that, if not previously revoked, this consent will expire one year after the date of my signature, unless otherwise specified.

Patient / Legal Guardian Signature: _____ Date:_____

Notification of Appointments /Treatments

VSOM makes every effort to use your preferred method of communication for appointment reminders, clinical care including laboratory results or any other issues regarding your account with us. With this consent, VSOM may call home, cell or other designated location and leave message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results among others. We will use the information you have provided, and may consist of leaving messages on voicemail, email, letters, etc.

By signing below, you are giving permission for VSOM to leave messages on voicemail and speak with the designated person(s) that are listed on the PHI Disclosure.

Patient / Legal Guardian Signature: _____ Date:_____

VCOM Sports & Osteopathic Medicine

Late Cancellation and No-Show Policy

Late cancellation and no-shows for appointments unnecessarily delay the delivery of health care to other patients.

Late Cancellation and No-Show Policy:

- A late cancellation is defined as failure to contact the office at least 24 hours in advance to cancel the appointment. There will be a $50 charge for late cancellations all patients. This is not billable to the insurance and is due prior to scheduling another appointment.
- A no-show is defined as missing a scheduled appointment. There will be a $50 charge for no-show appointments. This is not billable to the insurance and is due prior to scheduling another appointment.
- NEW PATIENTS who miss TWO consecutive initial office without giving the office at least 24-hour notice may not be permitted to schedule another appointment.
- ESTABLISHED patients who miss THREE scheduled appointments (within a year) without giving the office at least 24-hour notice may be dismissed from the practice.

Late Arrivals Policy:
If you are more than ten minutes late, you may be asked to reschedule your appointment. Every effort will be made to see the patient the same day but is not always an option.

Patient / Legal Guardian Signature: _____ Date:_____

VSOM Notice

VSOM is a teaching facility. This practice is a place where medical students come to learn how to be doctors. It is important for them to talk to people about their health and illnesses. This helps them understand how illnesses affect people and how they cope. We would be grateful if you could help us in this teaching. However, this is entirely voluntary. No one will mind if you would rather not see a student, change your mind, or want the student to leave at any time. You can also refuse to see particular students, such as those of a different sex or those you have met outside of the practice. Of course, the care provided to you by the practice will not be affected in any way. By signing this section, I understand my rights as a patient regarding medical students being involved in my care. I also understand that said medical students and physicians may use my medical information (may include but is not limited to medical notes, x-ray, photo, ultrasound) may be de-identified and used for the purpose of case presentations, lectures, poster presentations or papers for further teaching.

Patient / Legal Guardian Signature: _____ Date:_____

Are you (or the person being seen) a VCOM student or a VCOM student family member? Yes____ No____

Please note: If you answered yes to the above question, it is the policy of VSOM that no other medical student be involved in your or your dependents care. Please notify your nurse upon triage.