SPINE AND ORTHOPEDIC PAIN CENTER, P.C.
WINIFRED D. BRAGG, M.D.

KNOCK OUT PAIN!

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial) ____________ Gender (M/F) ____
Home Address ____________ Phone (Home) ____
City________________ State________________ Zip code______________ Phone (Work) ____
Marital Status [ ] Single, [ ] Married, [ ] Divorced, [ ] Widowed DOB ______ Phone (Cell) ____
Email ____
Date of Injury, if applicable ______ Work Related Injury [ ] Yes, [ ] No SSN ____
Employer Name / Address ____________ Age ____
Current Problem ____________ Primary Physician ____

SPOUSE / GUARANTOR INFORMATION

Spouse / Guarantor ____________ Phone (Home) ____
Phone (Work) ____
Home Address ____________ Phone (Cell) ____
Relationship to Guarantor: [ ] Self, [ ] Spouse, [ ] Dependent Child, [ ] Other __________ SSN ____

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

Insurance Company Name ____________ Subscriber Name ____________
Subscriber Date of Birth ______ Subscriber SSN ______ Subscriber Gender: [ ] Male [ ] Female
Patient's Relationship to Insured: [ ] Self, [ ] Spouse, [ ] Dependent Child, [ ] Other __________
Policy # ______ Group # ______ Plan # ______ Effective Date ______

SECONDARY MEDICAL INSURANCE COMPANY

Insurance Company Name ____________ Subscriber Name ____________
Subscriber Date of Birth ______ Subscriber SSN ______ Subscriber Gender: [ ] Male [ ] Female
Patient's Relationship to Insured: [ ] Self, [ ] Spouse, [ ] Dependent Child, [ ] Other __________
Policy # ______ Group # ______ Plan # ______ Effective Date ______

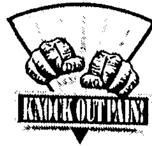
WORKERS' COMPENSATION / THIRD PARTY PAYER

Insurance Company Name ____________ Employer's Name ____________
Billing Address ____________
Patient's Relationship to Insured: [ ] Self, [ ] Spouse, [ ] Dependent Child, [ ] Other ____________
Claim No. ______ DOI ______ Body Part ______ Effective Date ______

IS THIS AN ACCIDENT? DATE:______ Fall? ______ Motor Vehicle Accident? ______
ATTORNEY'S NAME AND ADDRESS: ____________

IN CASE OF EMERGENCY, CONTACT: ____________ RELATIONSHIP ______
TELEPHONE ______

____________ ____________ ______
Patient/Guarantor Signature Witness Date



SPINE AND ORTHOPEDIC PAIN CENTER, PC

Winifred D. Bragg, MD, FAAPMR

6160 Kempsville Circle
Suite 303A
Norfolk, Virginia 23502

Telephone 757-333-3360

112 Gainsborough Square
Suite 100
Chesapeake, Virginia 23320

SUMMARY NOTICE OF PRIVACY PRACTICES

Effective August 4, 2005

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.

This notice describes the privacy practices of Spine and Orthopedic Pain Center, P.C.

OUR PLEDGE: We understand that medical information about you and your health is personal. We are committed to protecting it.

HOW WE USE OR DISCLOSE YOUR HEALTH INFORMATION: We may use your protected health information (PHI) in order to provide you with medical treatment, obtain payment for services provided to you and to conduct our health care operations to ensure all of our patients receive quality services.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding your medical information (some require your written request): You may request access to your medical record and billing information. You have the right to request restrictions regarding your PHI. You have the right to request an amendment if you think your PHI is incorrect. You have the right to an accounting of the disclosures we have made regarding your PHI. You have the right to revoke any former authorization you have given us regarding disclosure of your PHI. You have the right to receive confidential communications. You have the right to file a complaint if you feel we have violated your privacy rights.

You may receive a full paper copy of Spine and Orthopedic Pain Center, P.C.'s Notice of Privacy Practices by asking in person at our front desk or in writing to our privacy officer. For further information, please contact our privacy officer at (757)333-3360.

Please direct all written correspondence to our Norfolk office as indicated above.

______________________________ [Patient Signature]

______________________________ [Date]

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PATIENT INFORMATION RELEASE

The Spine and Orthopedic Pain Center recognizes and respects a patients' right to privacy of their medical records and billing matters. Your medical and/or billing matters will not be discussed with anyone without permission. This includes your spouse, family members, friends and others. In order for us to speak with anyone regarding you, **even in the event of an emergency**, you must specify to whom we may speak.

If you wish for us to be able to release information regarding you, please indicate below.

I give permission for the physician and staff of the Spine and Orthopedic Pain Center to discuss information indicated, regarding myself to:

Name	Relationship	Type of Information To Be Released
____________________	____________________	Medical/Financial
____________________	____________________	Medical/Financial
____________________	____________________	Medical/Financial

In the event of an emergency, please contact:

Name: ____________________ Relationship: ____________________

Home Phone: ________________ Cell Phone: ____________________

Patient Name: ______________________________

Signature: ______________________________

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Missed Appointments

I understand that if I fail to give 48 hours notice for cancellation of my appointments, I will be charged $25.00 for that missed appointment.

Patient Signature (Parent or Guardian) ____________________ Date ____________

Witness ____________________ Date ____________

Policy effective April 4, 2007

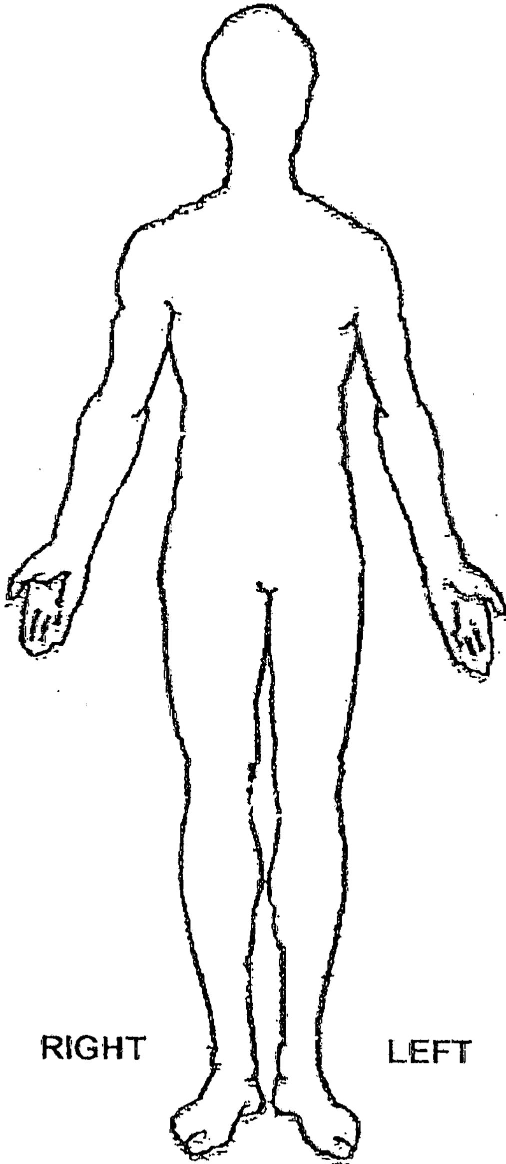
INITIAL MEDICAL QUESTIONAIRRE

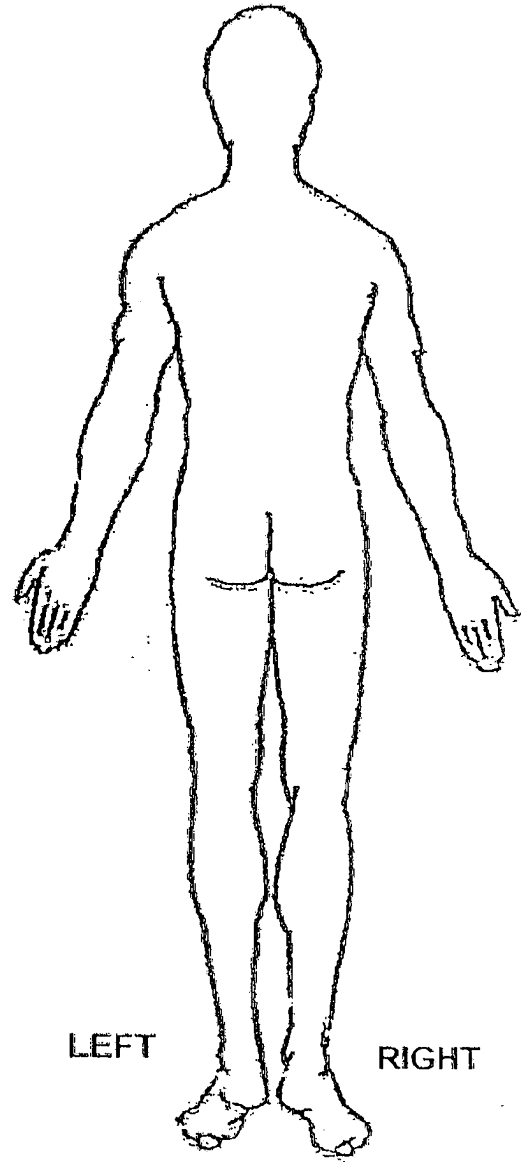
Patient: ________________________________ Date: ____________ Chart No.: ____________

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.

ACHING	NUMBNESS	PINS AND NEEDLES	BURNING	STABBING
▲▲▲	= = =	O O O	X X X	/ / /





HOW BAD IS YOUR PAIN NOW?

Please mark with an **X** on the pain drawing where the pain is worst now.

Where is the pain today? ____

Is your pain today: Same Better Worse compared to when it began?

What activities make it worse? (Please Circle)

Exercise (during)	Standing	Bending backward	Reaching
Exercise (after)	Walking	Coughing	Lifting
Sitting	Bending forward	Sneezing	
Driving			

What reduces the pain? (Please Circle)

Lying down	Manipulation	Muscle relaxant pills
Sitting	Home exercises	Aspirin/Anti-inflammatory pills
Standing	Exercises in physical therapy	Nothing
Walking	Pain pills	Heat / Ice
Injections for pain	Other ______________	

What is the time interval between attacks of pain?

Constantly Daily Weekly Monthly Yearly

Have you been in constant pain since it began or is your pain intermittent? Describe ______________

____

____

Have you noticed any: Numbness Tingling

Do your arms/legs get weak with your pain? ______________________________

Do you have full control of your bladder and bowels? ______________________________

Do you experience pain with sexual activity? Yes NO

Choose the number of the word which best describes your pain:

0	2	4	6	8	10
NONE	MILD	DISCOMFORTING	DISTRESSING	HORRIBLE	EXCRUCIATING

Patient Name: ______________________________ **Date:** ______________

Circle "YES" if you currently or previously suffered from the following conditions. If not, circle "NO".

ANEMIA	YES	NO	HIGH CHOLESTEROL	YES	NO
ANXIETY	YES	NO	HYPERTENSION	YES	NO
ASTHMA	YES	NO	HYPERTHYROIDISM	YES	NO
BLEEDING DISORDER	YES	NO	KIDNEY DISEASE	YES	NO
BLOOD CLOTS	YES	NO	KIDNEY STONE	YES	NO
COPD	YES	NO	LEG OR FOOT ULCER	YES	NO
CANCER	YES	NO	LIVER DISEASE	YES	NO
CORONARY ARTERY DISEASE	YES	NO	LUNG DISEASE	YES	NO
DEPRESSION	YES	NO	MIGRAINES	YES	NO
DIABETES	YES	NO	OSTEOPOROSIS	YES	NO
DIVERTICULITIS	YES	NO	PACEMAKER	YES	NO
FIBROMYALGIA	YES	NO	PULMONARY EMBOLISM	YES	NO
GERD/REFLUX	YES	NO	RHEUMATOID ARTHRITIS	YES	NO
GOUT	YES	NO	SEIZURES/EPILEPSY	YES	NO
HIV/AIDS	YES	NO	STROKE	YES	NO
HEART ATTACK	YES	NO	THYROID PROBLEMS	YES	NO
HEART DISEASE	YES	NO	TUBERCULOSIS	YES	NO
HEART PROBLEMS	YES	NO	ULCERS	YES	NO
HEPATITIS	YES	NO	VASCULAR DISEASE	YES	NO
HERNIA	YES	NO			

LIST ANY SURGERIES

DATE:	TYPE OF SURGERY:
______________	______________________________
______________	______________________________
______________	______________________________
______________	______________________________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS: YES NO

PLEASE LIST ALL MEDICATIONS:

____

____

____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS: YES NO

PLEASE LIST ANY ALLERGIES MEDICATION	REACTION:
________________	________________
________________	________________
________________	________________
________________	________________

I AUTHORIZE THE REVIEW OF ANY REPORT GENERATED UNDER MY NAME IN THE VA PRESCRIPTION MONITORING PROGRAM. ____________ (INITIAL HERE_

WHO IS YOUR CURRENT PRIMARY CARE PHYSICIAN?
NAME:____________________________ PHONE:____________________

SOCIAL HISTORY:

EDUCATION LEVEL ________________________________
OCCUPATION ________________________________
MARITIAL STATUS SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNER
LIVE ALONE OR WITH OTHERS ________________________________
SMOKING STATUS ________________________________
SMOKING-HOW MUCH? ________________________________
ALCHOL INTAKE ________________________________
ILLICIT DRUG USE ________________________________
CHEWING TOBACCO ________________________________
SEAT BELTS USED ROUNTINELY YES NO
NUMBER OF CHILDREN ________________________________
HAND DOMINANCE RIGHT LEFT BILATERAL
WORK RELATED INJURY YES NO
AUTO RELATED INJURY YES NO
ABLE TO CARE FOR SELF YES NO

FAMILY HISTORY:

	RELATIONSHIP TO YOU
ARTHRITIS	________________
HEART DISEASE	________________
MUSCULAR DISEASE	________________
CANCER	________________
HIGH BLOOD PRESSURE	________________
HIGH CHOLESTEROL	________________
DIABETES	________________

REVIEW OF SYSTEMS

CIRCLE ANY THAT APPLY:

Constitutional Systems:

Fever/Chills
Weight Loss
Fatigue

Eyes:

Double Vision
Blurring
Trauma
Glasses/Contacts

ENT & Mouth:

Deafness
Sinusitis
Tinnitus
Hoarseness
Vertigo

Cardiovascular:

Chest Pain
Palpitations
Hypertension
Irregular Beats

Hematologic/Lymphatic:

Bleeding Tendency
Lymph Node Pain
Lymph Node Enlargement

Respiratory:

Shortness of Breath
Asthma
COPD
Cough
Coughing up Blood

GI:

Loss of Appetite
Weight Change
Diarrhea
Constipation
Abdominal Pain
Bloody Stools

GU:

Incontinence
Pain with Urination
Sexual Dysfunction
Hesitancy

MS:

Fracture
Sprains
Pain
Swelling
Arthritis
Stiffness
Muscle Wasting

Skin/Breast:

Lesions
Scars
Masses

Neurological:

Speech
Trouble Swallowing
TIA/CVA
Numbness
Tingling
Seizures
Weakness
Balance/coordination
Memory

Psychological:

Depression
Anxiety
Hallucinations
Sleep Disturbances

Endocrine:

Increase in thirst
Increase in appetite
Hypo/Hyeractivity
Growth/Hair Changes