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SPINE AND ORTHOPEDIC PAIN CENTER, P.C.

Winifred D. Bragg, M.D., FAAPMR

6160 Kempsville Circle, Suite 303 A
Norfolk, Virginia 23502

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)

Date of injury, if applicable Work Related Injury Yes No Email

SSN

Employer Name / Address Age

Current Problem Primary Physician

SPOUSE/GUARANTOR INFORMATION

Spouse / Guarantor Phone (Home)

Home Address Phone (Work)

Relationship to guarantor Self Spouse Dependent Child Other Phone (Cell)

SSN

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

Insurance Company Name Subscriber Name

Subscriber Date of Birth Subscriber SSN Subscriber Gender M F

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 M F

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



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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 <input type="checkbox"/> Financial <input type="checkbox"/>
.....	Medical <input type="checkbox"/> Financial <input type="checkbox"/>
.....	Medical <input type="checkbox"/> Financial <input type="checkbox"/>

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



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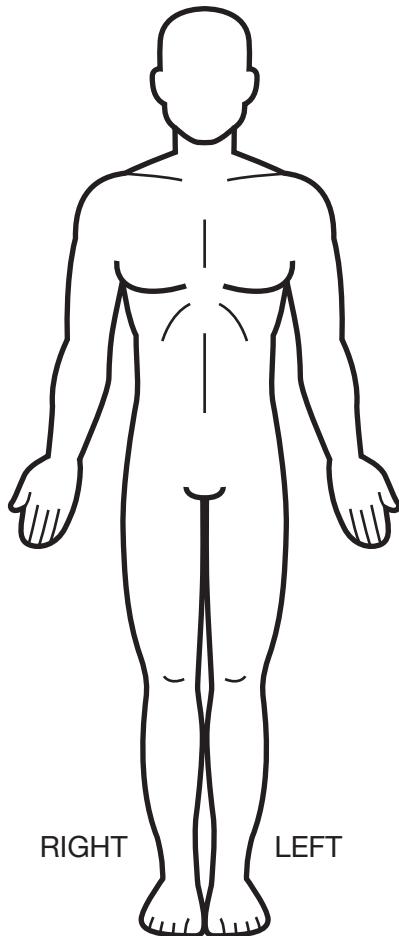
INITIAL MEDICAL QUESTIONNAIRE

Patient: Date: Chart No.:

WHERE IS YOUR PAIN NOW?

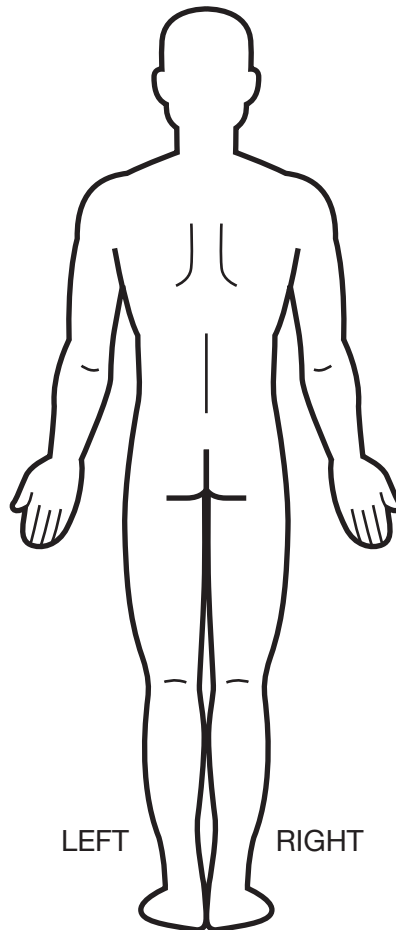
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.

ACHING	NUMBNESS	PINS AND NEEDLES	BURNING	STABBING
△△△	===	○○○	xxx	///



RIGHT LEFT

FRONT



LEFT RIGHT

BACK

HOW BAD IS YOUR PAIN NOW?

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



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Where is the pain today?

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

What activities make it worse?

- | | | |
|--|---|-----------------------------------|
| Exercise (during) <input type="checkbox"/> | Standing <input type="checkbox"/> | Coughing <input type="checkbox"/> |
| Exercise (after) <input type="checkbox"/> | Walking <input type="checkbox"/> | Sneezing <input type="checkbox"/> |
| Sitting <input type="checkbox"/> | Bending forward <input type="checkbox"/> | Reaching <input type="checkbox"/> |
| Driving <input type="checkbox"/> | Bending backward <input type="checkbox"/> | Lifting <input type="checkbox"/> |

What reduces the pain?

- | | | |
|--|--|--|
| Lying down <input type="checkbox"/> | Manipulation <input type="checkbox"/> | Muscle relaxant pills <input type="checkbox"/> |
| Sitting <input type="checkbox"/> | Home exercises <input type="checkbox"/> | Aspirin/Anti-inflammatory pills <input type="checkbox"/> |
| Standing <input type="checkbox"/> | Exercises in physical therapy <input type="checkbox"/> | Nothing <input type="checkbox"/> |
| Walking <input type="checkbox"/> | Pain pills <input type="checkbox"/> | Heat / Ice <input type="checkbox"/> |
| Injections for pain <input type="checkbox"/> | Other <input type="checkbox"/> | <input type="checkbox"/> |

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



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Patient Name: **Date:**

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

LIST ANY SURGERIES

DATE:

TYPE OF SURGERY:

.....

.....

.....

.....

.....

.....

.....

.....



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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

MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNER

LIVE ALONE OR WITH OTHERS

SMOKING STATUS

SMOKING-HOW MUCH?

ALCHOL INTAKE

ILLCIT 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:

ARTHRITIS

HEART DISEASE

MUSCULAR DISEASE

CANCER

HIGH BLOOD PRESSURE

HIGH CHOLESTEROL

DIABETES

RELATIONSHIP TO YOU:

.....
.....
.....
.....
.....



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REVIEW OF SYSTEMS

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/Hyperactivity
- Growth/Hair Changes