AjayK.Masih,M.D. Inc
Center for Spine and Sports Rehabilitation Medicine

Patient Information

Date ____________________ Home Phone ______________________ Cell Phone ___________________

Name ____ Sex ❑ M ❑ F Age ___ Date of Birth __________

Address _____________________________________ City_____________________ State ____ Zip _____

Employer __________________________ Occupation______________ Drivers License #_______________

Email __________________________ Primary Treating Physician/Family Physician? __________________

In case of emergency, who should be notified? ________________________________ Phone ___________

Race ___________________ Ethnicity ___________________ Preferred Language ___________________

Preferred method of contact ❑ Mail ❑ Web Message

Insurance Information: Is this a Workers Compensation Claim? ❑ No ❑ Yes

Primary Insurance _____________________________ ID # _____________________ Group #__________

Subscriber Name_____________________________________ Relationship to patient _________________

Cardholder Date of Birth ______________________ Drivers License #______________________________

Secondary Insurance _________________________ ID # _______________ Group #_________________

Subscriber Name _____________________________________ Relationship to patient ________________

Cardholder Date of Birth ______________________ Drivers License #______________________________

Assignment & Release

I certify that I and/or my dependent(s) have insurance coverage with the above insurance listed and assign directly to **Dr. Masih** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I will be responsible for all collection/attorney fees if my account becomes delinquent. I authorize the use of my signature on all insurance submissions. The above-named physician may use my healthcare information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This release is valid until I notify the practice in writing with any changes.

____ ________________________
Signature of patient, guardian or legal representative Date

____ ________________________
Printed name of patient, guardian or legal representative Relationship to patient

2080 Century Park East Suite #1501
Los Angeles, CA 90067
Phone: 310-553-0123
Fax: 310-553-0124

Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intension of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services. ______________________________

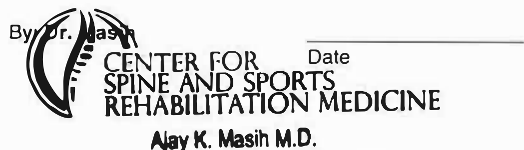
Patient's or Patient Representative's initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledgement that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: Dr. Masih ______________ Date



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Print or Stamp Name of Physician, Medical Group, or Association Name

By: ______________________________ ______________

Patient's or Patient Representative's Signature Date

By: ______________________________

Print Patient's Name

____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records. ©2007 J6815 6/07

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Payment Policy

We appreciate your confidence in our practice and we look forward to participating in your care. We realize that most medical problems are not foreseen; therefore, we wish to advise you of our payment policy.

1. We will file all insurance for your care. You will be responsible for all co-pays, co-insurance and deductibles at the time of visit.

2. All self pay patients will be expected to pay in full on their first visit.

3. All self pay patients and any patient with an outstanding balance over $250 will be required to apply for CareCredit prior to any payment arrangements being set up. You may elect not to apply for CareCredit, however, you will be responsible for all payments due at the time of service.

4. All self pay patients will be required to pay for elective surgery prior to surgery.

5. We will submit to all patients (2) statements of current patient balances by mail. If we receive no response to these statements, we will begin the collection process immediately. If your account is sent to an outside collection agency, you will be responsible for all collection and legal fees.

6. We encourage you to stay in contact with our office regarding financial issues, as we will attempt to work with you.

7. We accept MasterCard, Visa, American Express, Cash, Check and CareCredit.

8. Returned Check fee is $25.

9. If you cancel your appointment in less than 24 hours or ‘No Show’ for an appointment, you may incur a $25 fee.

I have read and understand the above payment policy.

______________________________ Patient’s Name

______________________ Account #

______________________________ Signature of Patient/Guardian

______________________ Date

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Covered CA, Narrow Network and Individually Purchased Polices

This letter is to educate our patients in the way that your insurance policy will affect you in our office. **These changes will only affect our CA Blue Shield Policy Patients.** Although our office is still in-network with “some” of the Blue Cross and Blue Shield plans, we are not in-network with the new Covered CA plans, Narrow Network, and Individually Purchased plans they are offering.

For our CA Blue Shield Policy Holders, we will be able to accept your insurance at this time, however, you will be charged for what Blue Shield allows for your visit. You will be charged the rate that our current contract with Blue Shield allows and not the 30% fee reduction that the new Covered CA, Narrow Network, Individually Purchased plans allow. If you want an explanation as to what your out-of-network benefits are, you should contact your insurance for the most accurate explanation.

Dr. Masih apologizes for any inconvenience that this is causing you, but in order to provide the highest level of care without compromising patient care both physically and financially, this is the policy that we have to implement at this time.

If you have any other questions regarding this policy, you may speak with the billing department for further explanation. Thank you for your understanding and your patience during this transition period.

_______________________________ _______________________________
Patient Name Signature

____
Date

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HIPAA Protected Health Information

In general the Health Information Patient Accountability Act (HIPAA) privacy rule gives individuals the right to request a restriction on use or disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

This office will generally contact patients by written communication or phone calls. We will send letters or call the number the patient has provided on the Patient Information sheet.

Please verify your phone numbers and complete the following:

Home Telephone (______) __________- ____________________
❑ Okay to leave message with detailed information.
❑ Leave message with call-back number only.

Cellular Telephone (______) __________- ____________________
❑ Okay to leave message with detailed information.
❑ Leave message with call-back number only.

Work Telephone (______) __________- ____________________
❑ Okay to leave message with detailed information.
❑ Leave message with call-back number only.
❑ Okay to fax to (______) __________- ____________________.

Written Communication (______) __________- ____________________
❑ Okay to mail to my home address:
____
____

❑ Please mail to another address
____
____

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply for use or disclosures made pursuant to any authorization requests by the individual.

Record of Disclosures of Protected Health Information

I, ____, authorize the office of Dr. Masih to contact the following person(s) in regard to my medical information.

______________________________________ ______________________
Name/Relationship Telephone Number

______________________________________ ______________________
Name/Relationship Telephone Number

______________________________________ ______________________
Patient Name/Date of Birth Patient Signature

Today's Date: __________________________________

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Notice of Privacy Practices Acknowledgment

- ☐ I wish to receive a copy of the Notice of Privacy Practices at the time of my signature below.
- ☐ I decline to receive a copy of the Notice of Privacy Practices at this time. I understand I can obtain a copy at any time per my request.

Name ______________________ Date of Birth ______________________

Signature ______________________ Date ______________________

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DMEPOS Supplier Standards

DMEPOS = Durable Medical Equipment, Prosthetics, Orthotics and Supplies
Supplier = **Center for Spine and Sports Rehabilitation Medicine**
CMS = Centers for Medicare and Medicaid Services

Patient Name: ____ Date of Birth: ______________________

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any change to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections and ascertain the supplier's compliance with these standards. The supplier location must be accessible to the beneficiaries during reasonable business hours and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product-related liability and completed operations.
11. A supplier must agree to not initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral orders unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish the CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited, in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. Must meet the surety bond requirements specified in 42 CFR § 424.57(c).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice with certain Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

____ ______________________________
Patient Signature Today's Date

Copy to Patient ____________________

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CENTER FOR
SPINE AND SPORTS
REHABILITATION MEDICINE

Name: ____ Date: ____________________

Age: ______________

Weight: ___________

Height: ___________

- ○ Right- handed
- ○ Left - handed

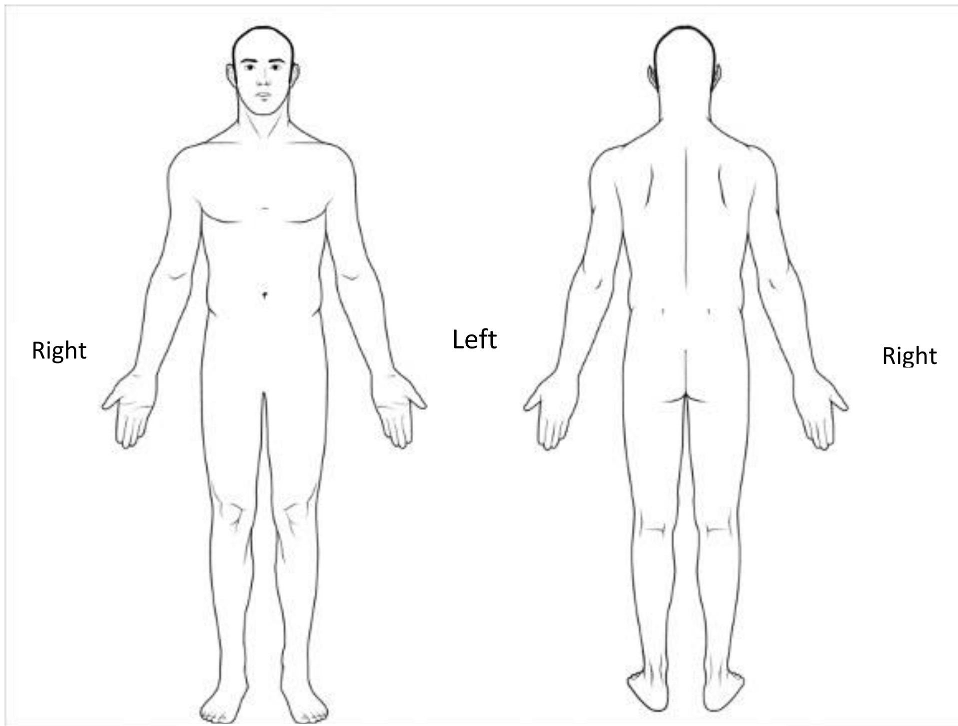
PAIN DRAWING

INSTRUCTIONS

Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the right side of the neck, ect.) Please indicate which sensations you feel by referring to the key below.

KEY:

//// Stabbing	XXXX Burning	0000 Pins & Needles	==== Numbness	++++ Aching



Neck Pain ____%
Arm Pain ____%
Back Pain ____%
Leg Pain ____%

Total ____%

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

(Circle your current pain level)

0	No Pain
1	Mild pain, you are aware of it, but it doesn't bother
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain, you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain it makes you contemplate suicide

Please feel free to ask any questions you would like answered during today's visit:

1. ____
2. ____
3. ____

Pain Management

This is an agreement between (patient name) ____ and Dr. Masih regarding my pain management/chiropractic care. The purpose of this agreement is to establish clear conditions for the prescription and use of pain controlling medications prescribed by my pain physician.

I understand that there are alternative treatments which include but are not limited to: physical therapy/occupational therapy (PT/OT), home exercises and modalities, devise trials, injections, non-opioid pharmacotherapy, holistic treatment, pain counseling, chiropractic care, and acupuncture.

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of narcotics increases certain risks, which include but are not limited to:

Addiction

- Allergic reactions, overdose, and/or fatal complications
- Breathing problems
- Drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Development of tolerance

I agree to the following guidelines:

1. I will take my medication only as prescribed and I will not change the amount or frequency without authorization from my physician. Unauthorized changes may result in my running out of medication early, and early refills will not be allowed. (see #2)

2. I understand that due to the high potential for abuse of these medications, the following rules apply: I will NOT be allowed to obtain early refills or receive replacement of lost or stolen medication. Refills will only be provided during regular office hours.

3. I will obtain ALL of my pain prescriptions through **Dr.Masih** and will fill ALL of my prescriptions at (pharmacy name) ____. In an acute emergency, another provider may prescribe medications for me. If this occurs, I will notify **Dr.Masih** as soon as possible.

4. I will submit to random urine and/or blood tests if requested by my physician or nurse practitioner to access my compliance.

5. I agree to see **Dr.Masih** for ongoing case management and will keep regularly scheduled appointments as long as I am taking any narcotic medication.

6. If I do not follow these guidelines, I understand that my treatment may be terminated.

I understand and consent to the above requirements for continued treatment. I will discuss the risks, benefits, and alternatives to narcotic treatment with my provider. I will have an opportunity to ask questions and receive answers to those questions to my satisfaction.

____ ______________________

Patient's Name Date

____

Patient's Signature

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Health History Questionnaire
Pain Management

Patient's Name ____ MR # ________________

Today's Date ________________________ Date of Birth ______________ Age ____

Referring Physician ____

Please describe the problem you are being seen for (if this is a visit following discharge from a hospital, please include your date of discharge and diagnosis).

____

____

____

____

____

Did this problem/pain come on ❑ suddenly ❑ gradually

Please mark how the following affects your problem or pain.

	Better	Worse	No Change
Sitting	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Bending Forward	❑	❑	❑
Bending Backward	❑	❑	❑
Driving	❑	❑	❑
Sleeping	❑	❑	❑
Lying Flat	❑	❑	❑

If you have any back pain, please answer the following question:

1. Do you have pain rising from a seat/seated position? ❑ No ❑ Yes
2. Do you have pain with coughing or sneezing? ❑ No ❑ Yes
3. Do you lean on a shopping cart at the store to relieve your back pain? ❑ No ❑ Yes
4. Are you awakened from sleep due to pain? ❑ No ❑ Yes
5. Do you have morning stiffness? ❑ No ❑ Yes
6. Do you have fevers or sweats accompanying your pain? ❑ No ❑ Yes

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Health History Questionnaire
Pain Management(continued)

What medications have you tried for this problem, if any? Please include any over-the-counter or herbal supplements.

Were any of these effective? If so, please describe.

What is the character of your pain? For example: is it dull, aching, sharp, throbbing, or "pins and needles."

If you are experiencing pain, please rate your pain on a scale of 0-10, with 0 being no pain and 10 being the most.

Pain at best (0-10) ____________ Pain at worst (0-10) ____________

How long has this been going on? __________________________ Is this a work-related injury? ❑ No ❑ Yes

Have you had any previous therapy for this problem, including injections or treatments? If so, please describe.

Have you seen a physician previously for this? If so, who?

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Health History Questionnaire

Pain Management(continued)

Have you had any recent special testing done for this problem? If so, please describe (For example: MRI, CT scan, bone scan, EMG, etc.).

____

____

____

Please list all current medications including over-the-counter medications, vitamins, and supplements.

____

____

Please list all drug allergies. ____

____

Family Medical History

	You	Family	Never
Heart Disease	❑	❑	❑
High Blood Pressure	❑	❑	❑
Kidney or Urine Problems	❑	❑	❑
Skin Problems	❑	❑	❑
Breathing Problems (Asthma, etc.)	❑	❑	❑
Neurological (Stroke, etc.)	❑	❑	❑
Diabetes	❑	❑	❑
Cancer	❑	❑	❑
Arthritis	❑	❑	❑
Mental Disorders	❑	❑	❑

Please clarify any You or Family positives.

____

____

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Health History Questionnaire

Pain Management(continued)

List any past surgeries.

____

____

____

Social History

Do you live in a one or two story home? ❑ one story ❑ two story

How many stairs to enter? ____________ Who do you live with? ____

Do you use tobacco? ❑ No ❑ Yes If yes, how many packs per day? _____

Do you drink alcohol? ❑ No ❑ Yes If yes, how much per day? ___________

Do you any illegal drugs? ❑ No ❑ Yes If yes, what? ___________

Are you currently employed? ❑ No ❑ Yes If no, when was your last day of work? _____________________

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Health History Questionnaire

Pain Management(continued)

Review of Systems

☐ Any unmarked boxes are otherwise negative.

Constitutional Symptoms

❑ No ❑ Yes....... Weight gain or loss
Amount _______________
Time span _____________
❑ No ❑ Yes....... Fever, Chill, Night sweats

Skin

❑ No ❑ Yes....... Change in color
❑ No ❑ Yes....... Wounds
❑ No ❑ Yes....... Itching
❑ No ❑ Yes....... Temperature changes
❑ No ❑ Yes....... Change in nails
❑ No ❑ Yes....... Easy bleeding/Bruising
❑ No ❑ Yes....... Lymphatic problems

Head & Neck

❑ No ❑ Yes....... Headache/Facial pain
❑ No ❑ Yes....... Neck pain/Stiff neck

Eyes

❑ No ❑ Yes....... Change in vision
❑ No ❑ Yes....... Light sensitivity/Pain
❑ No ❑ Yes....... Visual loss

Ears

❑ No ❑ Yes....... Loss of hearing
❑ No ❑ Yes....... Ringing in ears
❑ No ❑ Yes....... Recurrent infections
❑ No ❑ Yes....... Vertigo/Dizziness

Nose

❑ No ❑ Yes....... Change in ability to smell
❑ No ❑ Yes....... Bloody noses
❑ No ❑ Yes....... Snoring
❑ No ❑ Yes....... Frequent colds

Mouth & Throat

❑ No ❑ Yes....... Change in taste
❑ No ❑ Yes....... Sore throat
❑ No ❑ Yes....... Difficulty swallowing
❑ No ❑ Yes....... Difficulty speaking
❑ No ❑ Yes....... Voice change

Psychiatric

❑ No ❑ Yes....... History of delusions
❑ No ❑ Yes....... Hallucinations
❑ No ❑ Yes....... Depression
❑ No ❑ Yes....... Anxiety
❑ No ❑ Yes....... Hospitalization for above

Gastrointestinal

❑ No ❑ Yes....... Abdominal pain
❑ No ❑ Yes....... Nausea/Vomiting
❑ No ❑ Yes....... Peptic Ulcer disease
❑ No ❑ Yes....... Rectal bleeding
❑ No ❑ Yes....... Black tarry stools
❑ No ❑ Yes....... Heartburn/Acid reflux
❑ No ❑ Yes....... Diarrhea/Constipation

Cardiovascular

❑ No ❑ Yes....... Chest/Jaw/Arm pain
❑ No ❑ Yes....... Palpitation
❑ No ❑ Yes....... Shortness of breath
☐ At rest ☐ With exertion
❑ No ❑ Yes....... Lightheadedness
❑ No ❑ Yes....... Passing out
❑ No ❑ Yes....... Ankle swelling
❑ No ❑ Yes....... Fatigue
❑ No ❑ Yes....... Cold extremities

Respiratory

❑ No ❑ Yes....... Cough
☐ Productive ☐ Dry ☐ Bloody
❑ No ❑ Yes....... Night sweats
❑ No ❑ Yes....... History of asthma/wheezing
❑ No ❑ Yes....... Bronchitis
❑ No ❑ Yes....... Pneumonia

Musculo-Skeletal & Neurologic

❑ No ❑ Yes....... Muscle problems
☐ Pain ☐ Atrophy
❑ No ❑ Yes....... Joint problem
☐ Swelling ☐ Heat
❑ No ❑ Yes....... Bone problem
☐ Fracture ☐ Deformity
❑ No ❑ Yes....... Numbness or tingling
❑ No ❑ Yes....... Weak in arms or legs
❑ No ❑ Yes....... Balance problems
❑ No ❑ Yes....... Memory problems
❑ No ❑ Yes....... Trouble concentrating

Genito-Urinary

❑ No ❑ Yes....... Frequency
❑ No ❑ Yes....... Urgency
❑ No ❑ Yes....... Hesitancy
❑ No ❑ Yes....... Dribbling
❑ No ❑ Yes....... Incontinence
❑ No ❑ Yes....... Blood in your urine
❑ No ❑ Yes Inability to completely empty bladder

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