Phone: 725.239.3200 | Fax: 725.239.3090

New Patient Packet

Welcome to Private Practice!

Our goal is to deliver exceptional care to our patients. By completing this packet, you provide the physician with essential information needed to deliver the highest quality care. The information you provide in this packet will become part of your legal medical record for your personal injury case. Accurate and thorough details are essential, as your prior medical history may significantly influence the course of your treatment. Please ensure all information is complete and correct. Please complete the documents prior to arrival for your first appointment. If you need assistance completing the forms, please arrive 20 minutes early to your scheduled appointment and we will be happy to assist.

Thank you for trusting our team with your care. We look forward to working with you and providing the highest quality medical treatment to help you return to your health and well - being prior to the accident.

Private Practice Team

Private Practice
Concierge
Pain Management

Patient Information

First Name	Last Name	Middle	Birth Date	Gender ☐ Male ☐ Female

Address	Apt/Unit	City	State	Zip Code

Preferred Phone	Email	Social Security Number

Employer	Occupation	Employer Phone

Preferred Method of Contact ☐ Email ☐ Call ☐ Text - Private Practice has your consent to text your appointment information

Emergency Contact Name	Relationship to Patient	Emergency Contact Phone Number

Attorney Information

Attorney Name	Attorney Email

Please check the details that apply to you in the categories below

Motor Vehicle Accident/Slip and Fall

☐ Driver ☐ Passenger ☐ Wearing seatbelt ☐ Not wearing seatbelt

☐ Airbags deployed ☐ Airbags did not deploy

☐ Rear ended ☐ T-boned ☐ Sideswiped ☐ Front/Head on collision

☐ Lost consciousness ☐ Ambulance arrived on scene ☐ Police arrived on scene

☐ Evaluated at the hospital/urgent care ☐ Tripped/slipped lost consciousness

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Present Complaint

Where is your pain located?

What makes your symptoms feel better?	What makes your symptoms feel worse?

Circle words that describe your pain:

Aching	Continuous	Gnawing	Occasional	Sharp	Tender
Burning	Cramping	Deep	Dull	Miserable	Numb/Tingling
Penetrating	Sore	Shooting	Stabbing	Throbbing	Unbearable

Which other providers have you seen for this problem?

Chiropractor Other_____
Urgent care Other_____
Physical therapist Other_____
Hospital Which one?

Have you had any imaging studies performed?

~~X-rays~~ Facility:_____ Body Part (s):_____
MRI's Facility:_____ Body Part (s):_____
CT Scan Facility:_____ Body Part (s):_____
Other _____ Body Part (s):_____

Before the injury for which we are treating you for today, did you ever experience and seek treatment for pain for the same body parts? Yes or No

If yes, which body parts?

Who is your Primary Care Physician?	Phone Number:

Medications & Drug Allergies

Please list any prescription or over-the-counter medicine you are taking:

☐ **I am not taking any medication**

Please list any drug allergies

☐ **No known drug allergies**

Medication/Dose	Frequency

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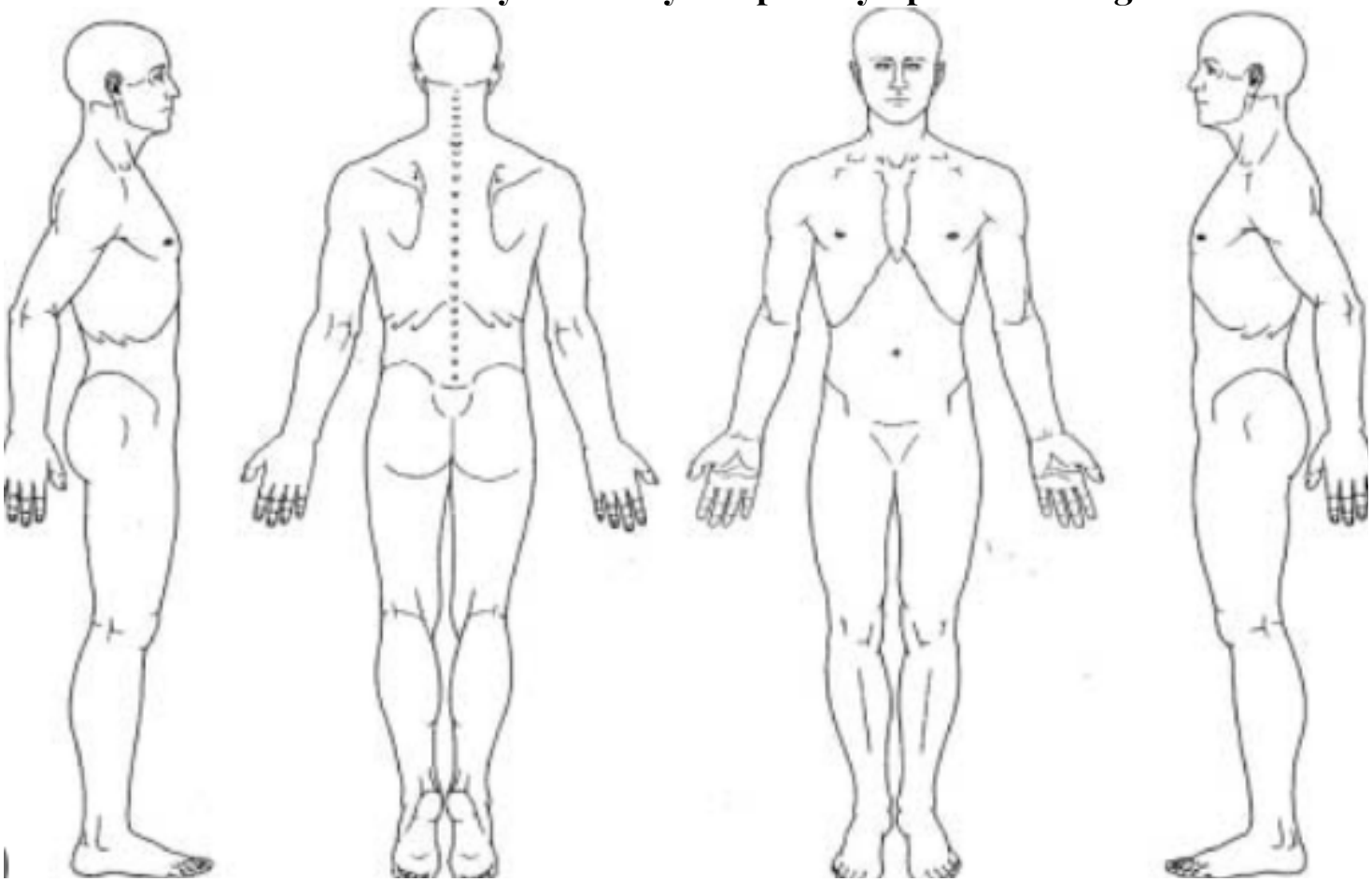
Please circle where you usually feel pain/symptoms on diagram.



Please circle the description(s) that best describes your symptoms and ability to function most days

0-No Pain 1-Minimal Discomfort

2-Mild Discomfort – Only notice pain if I focus on it. I only avoid the most rigorous activities.

3-Mild Pain – Pain is annoying, but I can mostly ignore it. Stops some productive activities.

4-Mild to Moderate – Short intervals of pain, but I can do most normal daily activities and work tasks. Sometimes interferes with daily activities..

5 - Moderate – Pain is troubling and breaks my concentration. Pain is always on my mind, but I push through the day.

6. - Moderate to Severe – Pain significantly limits my normal daily life functions.

7 - Severe – Pain is impossible to tolerate for long periods. Frequent crying. I cannot perform basic tasks due to pain.

8 - Debilitating – I no longer do ANY normal activities due to pain.

9 - Disabling – Uncontrollable screaming and crying due to pain. I can barely function or talk. I feel like I should go to the emergency room.

10 - Worst imaginable – Call an ambulance. I need immediate emergency medical attention.

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Past Medical History
Do you have any medical issues? Please circle them below.

☐ **I do not have any known medical problems at this time**

Cardiovascular

Atrial fibrillation/arrhythmia
Congestive heart failure
Coronary artery disease
Deep vein thrombosis(DVT/blood clot)
Heart Attack,
when:_____
Hypertension
(high blood pressure) Peripheral
vascular disease

Musculoskeletal

Arthritis/osteoarthritis
Fibromyalgia
Gout
Muscular Dystrophy
Osteoporosis
Rheumatoid Arthritis

Psychiatric

Anxiety disorder
Bipolar disorder
Major Depressive Disorder
Obsessive Compulsive Disorder
Schizophrenia

Gastrointestinal

Gastric ulcer
GERD/heartburn/acid reflex
Inflammatory Bowel Disease

Neurologic

Migraine
Multiple sclerosis
Peripheral neuropathy
Parkinson Disease
Seizure: last seizure_____
Stroke/TIA, when _____

Hematologic

Anemia
Bleeding disorder
Blood clotting disorder
Cancer: Type & Treatment

Endocrine/Metabolic

Diabetes: Type I / Type II
Diabetic Neuropathy
High Cholesterol
Hyperthyroid (high thyroid)
Hypothyroid (low thyroid)
Obesity

Infectious/Integument/Immunity

Herpes simplex (HSV 1 / 2)
Herpes zoster (shingles)
Hepatitis: A / B / C
HIV/AIDS
Impaired Immunity

Respiratory

Asthma
COPD/Chronic bronchitis
Pulmonary hypertension
Sleep apnea

Kidney/Urinary

Chronic Kidney Disease
Kidney Stones

Eyes

Glaucoma

Other

_____

_____

_____

_____

_____

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Past Surgical History Have you had any surgery in the past? (please include dates)	
☐ **I have never had a surgery**	
Appendix Removal _____	Tonsillectomy_____
C-Section _____	Tubal Ligation _____ _____
D & C _____	Vasectomy_____ _____
Gallbladder Removal _____	Other:_____
Hysterectomy _____	Other: _____
Joint Replacement _____	Other: _____

Family and Social History

Do any diseases run in your family? _____

_____

Tobacco use: Never Sometimes Daily

Current Smoker: Packs/day: ____ # of years: ____

Areyou pregnant or nursing? Yes No

Number of Children: _____

Marital Status: Married Divorced

Single Widowed

Alcohol Use? Yes No

If so, how much?_____

Recreational drug use?

If so, which ones?_____

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~~Authorization to Request Medical Records~~

Patient Information			
Name	Birth Date	Phone	
Address	City	State	Zip Code

My signature below authorizes Private Practice to request ALL of my medical records on my behalf INCLUDING the following:

- ☐ MentalHealth
- ☐ Lab Work
- ☐ Xray/MRI/Imaging
- ☐ Report Office Notes
- ☐ Operative Reports
- ☐ Other:_____

I understand that I am entitled to a copy of this authorization.

_____ _____

Patient/Guardian Signature Date

Notes:

_____

_____

_____

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5185 S. Durango Drive Suite 1
Las Vegas, NV 89113

Authorization to Release Medical Records

~~Information to be disc~~losed: I authorize the release of the following health information:

☐ All of my health information that the provider has in their possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

Only the following records or types of health information_____

I authorize my medical records to be released to:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

_____
Patient/Guardian Signature

_____
Date

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