Carolina Pain Relief Center
4146 Mendenhall Oaks Parkway, Suite 105
High Point, NC 27265
336.740.9580

Name________________________________ Nickname_______________________________
Address____
City________________________ State ________________________ Zip _____________________
Date of Birth______________________________ E-mail___________________________________
Home Phone______________________________ Cell Phone________________________________
Sex at Birth: ☐Male ☐Female ☐Prefer Not To Say
Height_________ Weight____________________

Chief Complaint

Reason you are being seen today: ____
When did it start?____
Is it: ☐Sharp ☐Burning ☐Dull ☐Aching ☐Throbbing
Is it: ☐Mild ☐Moderate ☐Severe
When Does it Occur? ☐Morning ☐Night ☐Constant ☐After Exercise
☐During Exercise ☐Intermittent
Has it: ☐Improved ☐Stayed The Same ☐Worsened
Do you have any of the following: ☐Swelling ☐Numbness ☐Bruising ☐Tingling
What have you tried to improve your condition?
☐Exercise ☐Weight Loss ☐NSAIDs ☐Prescription Medication ☐Knee Braces
☐Physical Therapy ☐Cortisone Injections ☐Hyaluronic Acid Injections ☐Surgery
Which Hyaluronic Acid did you try?
☐Synvisc ☐Synvisc One ☐Hyalgan ☐Supartz ☐Orthovisc ☐Trivisc
☐Durolane ☐Gelsyn ☐Genvisc 850 ☐None ☐Not Sure
Do you have any of the following allergies?
☐Lidocaine ☐Chicken ☐Feathers ☐Shellfish ☐Iodine ☐Sulfa
☐Latex ☐Eggs ☐Other ____
Do you smoke? ☐Yes ☐No ☐Quit How much?______________
How many years? ____________________________
Do you drink alcohol?☐Yes ☐No ☐Quit ☐How much/often ______________________

Please list your medications and dosages (If you have a list you may give it to the front desk to scan or you may e-mail it to painreliefcarolina@gmail.com with your name as the Subject Line)

Medication	Dosage

CONTINUED ON BACK

Please list any surgeries you have had

Type of Surgery/Date____

Type of Surgery/Date____

Type of Surgery/Date____

COMPREHENSIVE HISTORY

Review of Symptoms: What are you experiencing today?

☐Fatigue	☐Vomiting	☐Muscle Weakness	☐Limping
☐Fever	☐Heartburn	☐Stiffness	☐Headache
☐Night Sweats	☐Change in Bowel habits	☐Neck Pain	☐Migraine
☐Weight Gain		☐Leg Pain	☐Numbness
☐Difficulty Swallowing	☐Constipation	☐Muscle Spasm	☐Tingling
☐Hoarsenss	☐Diarrhea	☐Gout	☐Seizures
☐Chest Pain	☐GERD	☐Groin Pain	☐Slurred Speech
☐Irregular Heartbeat	☐Incontinence	☐Hair Changes	☐Frequent Falls
☐Fainting	☐Bladder Infection	☐Changes in Moles	☐Confusion
☐Leg ulcers	☐Urinary Frequency	☐Skin Changes	☐Dropping Things Frequently
☐Swelling in hands	☐Back Pain	☐Itchiness	☐Depression
☐Swelling in Feet	☐Joint Pain	☐Rash	☐Anxiety
☐Nausea	☐Joint Swelling	☐Bruises	☐Mental Illness
	☐Muscle Aches	☐Bleeding	☐Anemia

☐Other ____

Past Medical History

☐Hypertension	☐Blood Disorders	☐Osteoporosis
☐Diabetes	☐Arrhythmia	☐Substance Abuse
☐Kidney Disease	☐Hepatitis	☐Alcoholism
☐Stroke	☐High Cholesterol	☐Multiple Sclerosis
☐Arthritis	☐Ulcers	☐HIV
☐Previous Blood Clot	☐Skin Infection	☐Aids
☐Asthma	☐Joint Infection	☐Past Blood Transfusions
☐Seizure Disorder	☐Bladder Infections	
☐Thyroid Disease	☐MRSA	☐Fractures
☐Coronary Artery Disease	☐Sleep Apnea/CPAP	☐Gout

☐Cancer(type)________________________ ☐Mental Illness ________________________

Family History Does anyone in your family have any of the following? ***Please list relative***

☐Diabetes ________________________	☐Kidney Disease ________________________
☐Depression ________________________	☐Thyroid Disease ________________________
☐Stroke ________________________	☐Substance Abuse ________________________
☐Asthma ________________________	☐Blood Clots ________________________
☐Osteoporosis ________________________	☐High Cholesterol ________________________
☐Seizures ________________________	☐Cancer ________________________
☐Heart Failure ________________________	☐High Blood Pressure ________________________
☐Heart Disease ________________________	☐Alcoholism ________________________

☐Other ____

Was this form filled out by: ☐Patient ☐Parent/Guardian ☐Significant Other ☐Other

Signature:________________________________ Date:________________________

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ YES ☐ NO

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

If YES, please name the members allowed:
____
____
____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date:__________________

Witness: ____ Date:__________________