DATE__/__/____FIRST AND LAST NAME:_____

HOW DID YOU HEAR ABOUT US? _____ DOB:___/____/_____

PHONE:_____ CELL:_____ EMAIL:_____

STREET:_____ CITY:_____ STATE:____ SEX:_____

SS#:_____ EMERGENCY CONTACT Name:_____ Number_____

WHY ARE YOU HERE?:_____

SURGICAL HISTORY: SURGERY NAME_____ DATE PERFORMED_____

SURGERY NAME_____DATE PERFORMED_____

SURGERY NAME_____DATE PERFORMED_____

SURGERY NAME_____DATE PERFORMED_____

ALLERGIES: ALLERGY NAME: _____DATE DETECTED:_____

ALLERGY NAME:_____ DATE DETECTED:_____

ALLERGY NAME:_____ DATE DETECTED:_____

CURRENT MEDICATIONS: -Do you take Blood thinners? Y N Do you take antibiotics? Y N

RX NAME:_____ REASON:_____

RX NAME:_____ REASON:_____

RX NAME:_____ REASON:_____

ACCIDENT HISTORY: PLEASE LIST ANY AUTO, SPORTS RELATED or MAJOR SLIPS AND FALLS

_____ DATE_____ TREATMENT: YES/NO

_____ DATE_____ TREATMENT: YES/NO

--Have you been diagnosed with a cardiovascular condition? Y N -- Do you have a pacemaker? Y N

FILL OUT ONLY ONE COMPLAINT PER SECTION

FIRST (Biggest) COMPLAINT:_____

WHEN DID IT START:_____ **PAIN INTENSITY 10= WORST**: 2 4 6 8 10

WHERE IS IT: RIGHT/ LEFT/ BOTH **WHAT CAUSED THE PROBLEM**:_____

FREQUENCY: ____CONSTANT ____INTERMITTENT ____OCCASIONAL

IS THE PAIN: ___SHARP ___SORE ___DULL ___TINGLING ___ACHING

WHAT TRIGGERS SYMPTOMS: ___WORK ___HOME ACTIVITIES ___RECREATIONAL ACTIVITIES

WHAT RELIEVES SYMPTOMS: ___COLD___HEAT___MASSAGE___MEDS___RECLINING___SITTING ___SLEEPING

WHAT WORSENS SYMPTOMS:

__BENDING __LIFTING__COUGHING__RUNNING__SITTING__STANDING__WALKING__WORK

WHAT HAVE YOU TRIED BEFORE TO HELP THIS: Met with an Orthopedist___, Cortisone shots___, Other (Please list):_____

SECOND COMPLAINT:_____

WHEN DID IT START:_____PAIN INTENSITY 10= WORST: 2 4 6 8 10

WHERE IS IT: RIGHT/ LEFT/ BOTH **WHAT CAUSED THE PROBLEM**:_____

FREQUENCY: ____CONSTANT ____INTERMITTENT ____OCCASIONAL

IS THE PAIN: ___SHARP ___SORE ___DULL ___TINGLING ___ACHING

WHAT TRIGGERS SYMPTOMS: ___WORK ___HOME ACTIVITIES ___RECREATIONAL ACTIVITIES

WHAT RELIEVES SYMPTOMS: ___COLD___HEAT___MASSAGE___MEDS___RECLINING___SITTING ___SLEEPING **WHAT WORSENS SYMPTOMS:**__BENDING__LIFTING__COUGHING__RUNNING__ SITTING__STANDING__WALKING__WORK

WHAT HAVE YOU TRIED BEFORE TO HELP THIS: Met with an Orthopedist___, Cortisone shots___,

Other (Please list):_____

THIRD COMPLAINT:_____

WHEN DID IT START:_____PAIN INTENSITY 10= WORST: 2 4 6 8 10

WHERE IS IT: RIGHT/ LEFT/ BOTH **WHAT CAUSED THE PROBLEM**:_____

FREQUENCY: ____CONSTANT ____INTERMITTENT ____OCCASIONAL

IS THE PAIN: ___SHARP ___SORE ___DULL ___TINGLING ___ACHING

WHAT TRIGGERS SYMPTOMS: ___WORK ___HOME ACTIVITIES ___RECREATIONAL ACTIVITIES

WHAT RELIEVES SYMPTOMS: ___COLD___HEAT___MASSAGE___MEDS___RECLINING___SITTING ___SLEEPING

WHAT WORSENS SYMPTOMS:

__BENDING __LIFTING__COUGHING__RUNNING__SITTING__STANDING__WALKING__WORK

WHAT HAVE YOU TRIED BEFORE TO HELP THIS: Met with an Orthopedist___, Cortisone shots___,

Other (Please list):_____

FOURTH COMPLAINT:_____

WHEN DID IT START:_____ PAIN INTENSITY 10= WORST: 2 4 6 8 10

WHERE IS IT: RIGHT/ LEFT/ BOTH **WHAT CAUSED THE PROBLEM**:_____

FREQUENCY: ____CONSTANT ____INTERMITTENT ____OCCASIONAL

IS THE PAIN: ___SHARP ___SORE ___DULL ___TINGLING ___ACHING

WHAT TRIGGERS SYMPTOMS: ___WORK ___HOME ACTIVITIES ___RECREATIONAL ACTIVITIES

WHAT RELIEVES SYMPTOMS: ___COLD___HEAT___MASSAGE___MEDS___RECLINING___SITTING ___SLEEPING

WHAT WORSENS SYMPTOMS:

__BENDING __LIFTING__COUGHING__RUNNING__SITTING__STANDING__WALKING__WORK

WHAT HAVE YOU TRIED BEFORE TO HELP THIS: Met with an Orthopedist___, Cortisone shots___,

Other (Please list):_____

Circle any that apply to you:

ADD/ ADHD
Alcohol/ Drug Addiction
Anemia
Appendicitis
Arrhythmia
Arteriosclerosis
Arthritis
Asthma
Atrial Fibrillation
Backaches
Bleeding disorder
Blood Clots
Blood transfusion
Blurred Vision
Bowel Problems
Broken Bones
Cancer
Carpal Tunnel
Cataracts
Chickenpox
Cold Sores
Colitis
Collagen Vascular Disease
Constipation
Depression/ Anxiety
Diabetes
Digestive Disorders
Dizziness
Eating Disorder
Emphysema
Epilepsy
Fatigue
Female Health Challenges
Fibromyalgia
Gallbladder Disease
Genital Herpes
Glaucoma
Gluten Intolerance
Goiter
Gout
Headaches
Hearing Loss
Heart Disease/ Attacks
Heart murmur
Hemorrhoids
Hepatitis
High Blood Pressure
High Cholesterol
HIV/AIDS
Joint/ Back Pain
Kidney Infections
Kidney stones
Lichen Sclerosis
Liver Disease/ problems
Lung disease
Measles
Menstrual Cramps
Mental Disorder
Migraines
Multiple Sclerosis
Neck Pain
Nervousness
Night Sweats
Osteoporosis
Paralysis
Peyronie's
Pneumonia
Polio
Prostate Problems
Reflux/ Ulcers
Rheumatic Fever
Scoliosis
Seizures/epilepsy
Sexual Dysfunction
Sickle Cell
Sinus Trouble
Stress Tension
Stroke
Suicidal Tendencies
Thyroid Disease
Tuberculosis
Tumors
Ulcers
Urine Discoloration
Vertigo
Whooping Cough

Social History **check any that apply**

___Smoking/Tobacco
how often? _____
___ Alcohol
how often?_____
___ Illegal Drugs
how often?_____
___ Exercise
how often? _____

Family History **check any that apply**

___Heart Attack Who? _____
___ Stroke Who?_____
___ Diabetes Who?_____
___ High Blood Pressure Who? _____
___High Cholesterol Who? _____

Notice of Privacy Practices

In accordance with the PHI our office will, without asking your express consent or authorization, use and disclose your PHI for the purposes of:
Treatment, Payment, Health Care Options, Advise of Appointments and Services, Directory Sign in, Court Orders/Subpoenas and Government investigations, Advise family/Friends directed by you to receive information regarding your health or to assist in the payment of your bill.

You have the right to revoke, request special limits of conditions, to receive communication by more confidential means or at alternate locations, to inspect and copy your PHI, and to amend your PHI.

Copies of the NPP may be obtained upon request. Our office strive to maintain HIPPA compliance.

I understand that by signing the above statement I have been notified of my rights in compliance with HIPPA regulations. I have been advised that I may request a complete copy of these rights available through front desk.

Signature:_____ Date:_____

Consent Form

I certify that the information I have provided is true and correct. I hereby authorize the release of any information that is required to secure payment for services rendered. I understand that any services rendered will not be covered by insurance and that they will not be submitted to insurance. I understand I will not be given a “super bill” or treatment codes to submit my own insurance claim. I understand and agree that I am financially responsible for and will promptly pay any non covered services including, but not limited to, deductible and co-pay.

Signature:_____ Date:_____

Cancellation/ No Show Policy

In an effort to provide effective and efficient treatment to all of our patients, it is the policy of this office that all appointment cancellations are made at least 24 hours prior to your scheduled appointment. If any appointment is not cancelled or the patient fails to show up for appointment, Modern Health & Wellness reserves the right to charge a $25 fee per occurrence. As this fee is not billed to any insurance company, patient accepts the full responsibility to pay this fee.

If you have questions about this please ask before signing

Signature:_____ Date:_____

Consent of Treatment

In an effort to provide effective care Dr. Patrick Gorman will recommend therapies to help your condition. Some of these therapies have side effects which may include, soreness and swelling, petechiae and bruising and pain. These side effects generally abate after 5-10 days. By signing below you acknowledge that you understand and accept the risks, benefits and costs, and consent to the recommended therapies.

Signature:_____ Date:_____

Pregnancy Affirm

I affirm to the best of my knowledge that I am not currently pregnant and should this condition change I will notify the Doctor and/or his staff as soon as possible.

Signature:_____ Date:_____

A. Notifier: Modern Health / Ohio Stem Cell

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Chiropractic Adjustments, Cold Laser Therapy, Myofacial Release, Shockwave Therapy, PRP Therpay , Stem Cell Therapy Stem Cell IV Therapy, Biophotonic Therpay HBOT, X rays, Supplements, Sexual Wellness, Vampire Facial, PRP for Acne	Not covered/ Not submitted	Costs vary

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

FRI - Funtional Rating Index

For each item below, please mark the box which most closely describes your condition right now.

Pain Intensity

❑ No Pain ❑ Mild Pain ❑ Moderate Pain ❑ Severe Pain ❑ Worst Possible Pain

Sleeping

❑ Perfect Sleep ❑ Mildly disturbed sleep ❑ Moderately disturbed sleep ❑ Greatly disturbed sleep ❑ Totally disturbed sleep

Personal Care [washing, dressing etc.]

❑ No Pain; no restrictions ❑ Mild pain; no restrictions ❑ Moderate pain; need to go slowly ❑ Moderate Pain; need some assistance ❑ Severe Pain; need 100% assistance

Travel [driving, etc.]

❑ No Pain on long trips ❑ Mild Pain on long trips ❑ Moderate Pain on long trips ❑ Moderate Pain on short trips ❑ Severe Pain on short trips

Work

❑ Can do usual work; unlimited extra work ❑ Can do usual work; no extra work ❑ Can do 50% of ususal work ❑ Can do 25% of usual work ❑ Cannot work

Recreation

❑ Can do all activities ❑ Can do most activities ❑ Can do some activities ❑ Can do a few activities ❑ Cannot do any activities

Frequency of pain

❑ No Pain ❑ Occasional pain; 25% of the day ❑ Intermittent pain; 50% of the day ❑ Frequent pain; 75% of the day ❑ Constant pain 100% of the day

Lifting

❑ No pain with heavy weight ❑ Increased pain w/ heavy weight ❑ Increased pain w/ moderate weight ❑ Increased pain w/ light weight ❑ Increased pain with any weight

Walking

❑ No Pain at any distance ❑ Increased pain after 1 mile ❑ Increased pain after 1/2 mile ❑ Increased pain after 1/4 mile ❑ Increased pain with all walking

Standing

❑ No pain after several hours ❑ Increased pain after several hours ❑ Increased pain after 1 hour ❑ Increased pain after 1/2 hour ❑ Increased pain with any standing

MRN # _____ Date _____

The joint/ area I am completing this form about.A. _____

For the following questions think about the **PAIN , STIFFNESS or** DIFFICULTY in your A that has been caused in the last 48 hours:

How much pain have you had… … 0=none 1=mild 2=moderate 3=severe 4=extreme

1. when walking on a flat surface? 0 1 2 3 4
2. when going up or down stairs? 0 1 2 3 4
3. at night while in bed? (that is – pain that disturbs your sleep) 0 1 2 3 4
4. while sitting or lying down? 0 1 2 3 4
5. while standing? 0 1 2 3 4

Please think about the PAIN symptoms you just rated above. Which one pain item do you hope your treatment will improve the most

Stiffness is a sensation of decreased ease in moving your joint.
0=none 1=mild 2=moderate 3=severe 4=extreme

6. How **severe** has your stiffness been **after you first woke up** in the morning? 0 1 2 3 4
7. How **severe** has your stiffness been after sitting or lying down or while resting **later in the day**? 0 1 2 3 4

Please think about the STIFFNESS symptoms you just rated above. Which one stiffness item do you hope your treatment will improve the most? Please circle that stiffness item above.

The **difficulty** you had in doing the following daily (**your ability to move around/ take care of yourself**)
0=not difficult 1=mild 2=moderate 3=severe 4=extremely difficult

How much difficulty have you had…

8. when going down the stairs? 0 1 2 3 4
8. when going up the stairs? 0 1 2 3 4
9. when getting up from a sitting position? 0 1 2 3 4
10. while standing? 0 1 2 3 4
11. when bending to the floor? 0 1 2 3 4
12. when walking on a flat surface? 0 1 2 3 4
13. getting in or out of a car, or getting on or off a bus? 0 1 2 3 4
14. while going shopping? 0 1 2 3 4
15. when putting on your socks or panty hose or stockings? 0 1 2 3 4

How much Difficulty have you had…

17.when getting out of bed? 0 1 2 3 4

18. When taking off your socks or panty hose or stockings? 0 1 2 3 4

16. while lying in bed? 0 1 2 3 4

17. when getting in or out of the bathtub? 0 1 2 3 4

18. while sitting? 0 1 2 3 4

19. when getting on or off the toilet? 0 1 2 3 4

20. while doing heavy household chores? 0 1 2 3 4

21. while doing light household chores? 0 1 2 3 4

Please think about the PHYSICAL FUNCTION symptoms you just rated. Which one physical function item do you hope your surgery/treatment will improve the most? Please circle that physical function item.

Sexual Wellness

If you are interested in how our sexual wellness services may help you please complete the following questions:

Men Circle Any: Erectile Performance ED Peyronie's Increase Size Increase Strength

Are you interested in how your hormones may effect your sexual function as well as physique and mood?

Yes No

Women Circle Any: Incontinence Lack of Climax Lack of Sensation Dryness Lichen Sclerosis

Are you interested in how your hormones may effect your sexual functions as well as physique and mood?

Yes No

Check any of the following you would like to learn more about:

Stem Cell Therapy____ Weight Loss____ Vampire Facelift____

Biophotonic Therapy ____ IV Therapies (Chelation, Vitamin C, Stem Cell Infusion)____

Neurofeedback Therapy (for depression, anxiety, PTSD) ____

Is there anyone you would us to send information about our services? Please list their name, phone number and address/email:_____