



Integrative Pain Specialists

Feel Better RVA

6900 Forest Avenue, Suite 310, Richmond, VA 23230 | 804.249.8888 phone | 804.249.7246 fax

We look forward to seeing you for your appointment on:

M T W TH F _____, 20__ @ _____ am/pm

We ask that you arrive 15-20 minutes early for your appointment, **as there will be additional forms for you to fill out once you are in the office.**

You are scheduled to see: _____ Dr. Benjamin Seeman, DO _____ Dr. Amy Miller, MD _____ Emily Leisy, PA-C
_____ Samantha Wood, MSN, ACNP-BC

Physical Therapy _____ Stephanie Musselman, DPT _____ Natalie Kryza, DPT _____ Stephanie Sfara, DPT

*****Please note: If you are more than 20 minutes late for your scheduled appointment you will need to be rescheduled.** If for any reason you are unable to keep your appointment, please call our office at 804-249-8888 at least 24 hours prior to your scheduled visit. **If you no show for your appointment, we reserve the right to charge a \$75.00 fee prior to rescheduling that appointment.**

Please bring your insurance cards and glasses, if needed, with you to your appointment. We will need a medication list. If you have a medication list please bring it with you and we can make a copy. Also if you have previously had any X-rays, CT's or MRI's, please bring with you or have those reports faxed to us at 804-249-7246, prior to your appointment. Please be aware that if you do not have your images and/or reports your appointment may have to be rescheduled. Be prepared to pay any co-pay(s) that are due at the time of your visit. You should contact your insurance carrier directly to make sure you have met all the requirements for seeing a specialist. If referrals are required, you are responsible for obtaining the documentation prior to your appointment. We are unable to obtain a referral once you have arrived at our office and your appointment may be rescheduled or you will have to sign a waiver making you responsible for the full cost of the visit.

Our practice specializes in the alleviation of pain in the spine and in other locations in the body using a non-surgical approach. We use Osteopathic Manipulation Technique (OMT), Physical Therapy, Bracing, Pain Psychology, Injection Therapy, as well as other functional pain management options.

*****Please note our practice does not use narcotic (medications) therapy.*****

Please take a moment to access our website at www.feelbetterrva.com, to read information about our services as well as our providers.

Thank you in advance for your cooperation.

Sincerely,
Dr. Benjamin Seeman and Associates

Patient Registration

Today's Date: _____

Welcome to our office. In order to serve you properly, we will need the following information. All information will be strictly confidential. (Please Print)				
Patient Name:	Sex: M F	Birth Date: Age:	Marital Status: Single [] Widowed [] Married [] Divorced [] Spouse's Name:	
Residence Address:		Home Phone:	Patient's Social Security #:	
Email Address:		Cell Phone:		
Person Financially Responsible for Account:	Self Spouse Parent	Responsible Party's Birthdate:	Responsible Party Social Security #:	
Primary Care Physician:		Referred By:		
Person to Contact in Case of Emergency:		Relationship to Patient:	Phone:	
Workers Compensation: []Yes []No Name of Employer:	Accident Date:	Treatment Authorized By:	Claim #: WC Contact Phone #:	
Primary Insurance Name: Address:			Employer:	
Subscriber Name: SS#:	Subscriber Birth Date:	Policy #:	Group #/Name:	
Secondary Insurance Name: Address:				
Subscriber Name: SS#:	Subscriber Birth Date:	Policy #:	Group #/Name:	

Assignment of Benefits/Insurance Lifetime Signature

I hereby authorize payment directly to the provider of the surgical or medical benefits, if any, for services. I realize I/we am responsible for non-covered services, copayments and deductibles. I/we are aware if a referral is required by my/our insurance, that it is my/our responsibility to obtain one. I/we promise to pay my/our account when due and if my/our account is referred to collections, that I/we agree to pay all costs of collections and expense including, but not limited to, any attorney fees, plus court costs, whichever is applicable.

Signature _____ Date _____

Patient Registration

Consent for Treatment

_____, the patient and/or legal guardian of said patient do hereby give my consent for medical examination and treatment under the care of the practice and deemed necessary.

Signature _____ Date _____

Urine Screen Consent

A urine screen will be done on all new patients. This is billed by a 3rd party company. If you have a question about your bill for this service, please contact the lab at the number provided on the statement.

Signature _____ Date _____

Notice of Privacy Practices

I received a copy* of the IPS Notice of Privacy Practices - information about how we use and disclose health information.

Signature _____ Date _____

*If you are completing this form prior to your scheduled appointment please note that the Notice of Privacy Practices will be made available to you upon arrival to our office. It is also posted on our website.

Release of Information

I hereby authorize the provider to release any information acquired in the course of my treatment, to my primary and/or referring provider and my insurance company(ies).

Signature _____ Date _____

Attendance Policy

I understand that this office has a no-show or a same day cancellation policy for which I will be charged \$75 if 24 hours' notice is not given to cancel an appointment.

Signature _____ Date _____

Authorization for Release of Healthcare Information

Please list individuals IPS would have permission to speak with regarding your medical chart and/or billing status.

1. _____

2. _____

Please check here _____ if there is no one you allow IPS to speak with about your medical chart and/or billing status.

Patient Health History

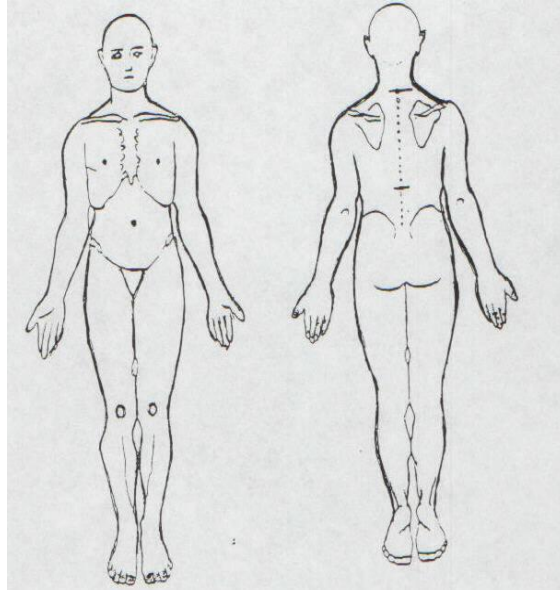
Name: _____ DOB: _____ Height: _____ ft _____ in Weight: _____ lbs

Primary Care Physician: _____ Who Referred you here today? _____

Where is your most severe pain / What are you being seen here for today? _____

Is the pain on your: _____ Right Side _____ Left Side _____ Both Sides

(Please mark where your primary pain is on the diagram below.)



How would you describe the pain?

Aching Burning Cramping Numbness Pins & Needles
 Sharp Shooting Stabbing Tightness Tingling

Using the scale below, how would you rate your pain?

0	1	2	3	4	5	6	7	8	9	10
No Pain			Moderate Pain				Most Severe			

What is the Effect on your Daily Function? Mild Moderate Severe Very Severe

Does the Pain Interfere with Sleep? Yes No

How long have you had this pain / When did the pain start? _____

What were you doing when the pain first occurred?

Physical Activity Motor Vehicle Accident Physical Trauma Other Mechanism Unknown

If additional details, please explain: _____

Is this accident / injury covered under a work claim or **worker's compensation**? Yes No

Is this accident / injury **under lawsuit or litigation**? Yes No

What makes the pain **MORE SEVERE**?

Physical Activity Walking Standing Sitting / Driving Getting up from a Chair
 Lying Down Sleep Work / Job Stress Household Chores

Other, please explain: _____

What helps make the pain **LESS SEVERE**?

Applying Cold Changing Position Walking / Moving Stopping Activity Sitting Down
 Applying Heat Standing Lying Down Massage Bowel Movement

Please note any symptoms that occur with the pain? (Associated Manifestations)

Joint Pain Numbness and/or Tingling Headache Fever
 Inflammatory Pain Dizziness Mental Status Changes Rash at the Site of Pain
 Weakness Gait Problems Bowel Dysfunction Bladder Dysfunction

Please list any previous tests **related to this problem** (tests received in the last 12 months):

X-Rays MRI Bone Scan
 CT Scan Myelogram Nerve Conduction Study or EMG

What physician ordered the above test(s) or where did you have the test(s) done? _____

List any previous treatments you have received in the last 12 months **related to this problem**:

Medications: Medrol Dose Pack or Prednisone	Improved	Worse	No Change
NSAIDs (Mobic, Voltaren, Diclofenac, Ibuprofen, Aleve, etc...)	Improved	Worse	No Change
Muscle Relaxants (Flexeril, Skelaxin, Baclofen, Robaxin, etc...)	Improved	Worse	No Change
Pain Analgesics (Tramadol or Tylenol)	Improved	Worse	No Change
Narcotics (Hydrocodone, Oxycodone, Morphine, Dilaudid, etc....)	Improved	Worse	No Change
Anticonvulsants (Gabapentin, Neurontin, Lyrica, Klonopin, etc....)	Improved	Worse	No Change
Antidepressants (Cymbalta, Savella, Amitriptyline, etc..)	Improved	Worse	No Change
Physical Therapy	Improved	Worse	No Change
Injection Treatments (Epidurals, Facet Joint Injections, Joint Injections, etc..)	Improved	Worse	No Change
Chiropractic Therapy or Osteopathic Manipulation	Improved	Worse	No Change
Brace	Improved	Worse	No Change
TENS Device	Improved	Worse	No Change
Spinal Cord Stimulator	Improved	Worse	No Change
Surgery	Improved	Worse	No Change

Past Medical History:

Do you have any surgically implanted devices such as a pacemaker, defibrillator, spinal cord stimulator, etc.... Yes No

Please indicate if you have ever been diagnosed with the below disorders?

Cancer (Any Type) Stomach Ulcer(s) Mental Retardation
 Recurrent Headache IBS / Irritable Bowel Syndrome Parkinson's Disease
 Heart Attack / CVA Kidney / Renal Disease Progressive Neurological Disorder
 Congestive Heart Failure Arthritis (Osteo, Rheumatoid or Other) Restless Leg Syndrome
 DVTs / Deep Vein Thrombosis Ankylosing Spondylitis Sleep Disorder / Sleep Dysfunction
 Elevated Cholesterol Fibromyalgia Alcohol or Drug Abuse
 Hypertension Osteopenia / Osteoporosis Physical, sexual, or emotional abuse
 Peripheral Vascular Disease Scoliosis Anxiety
 Stroke / TIA Lupus Depression
 Asthma Shingles Diabetes (Type I or Type II)
 Pulmonary Disease Dementia / Alzheimer's Thyroid Dysfunction
 GERD / Acid Reflux Epilepsy / Seizures Clotting Disorder or Anemia

Other Diagnoses Not Listed Above: _____

Social History:

Occupation: _____

Employed Unemployed Disabled Retired Temporarily out of Work due to Current Pain

Do you smoke? Yes No Do you drink alcohol? Yes No Do you use illegal drugs? Yes No
 (this includes Marijuana)

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication(s)	Dosage	How Often Taken

Are you allergic to any of the following?

Shellfish Yes ___ No ___
Contrast Dye Yes ___ No ___
Latex Yes ___ No ___

ARE YOU ALLERGIC TO ANY MEDICATION? ___ YES ___ NO If yes, please list below:

Name of Medication(s)	Type of Reaction

Preferred Pharmacy: Name & Address: _____

SURGERIES: PLEASE LIST SURGERIES YOU HAVE HAD IN THE PAST OTHER THAN FOR YOUR SPINE CONDITION:

SURGERY	DATE

Our new office at Reynolds Crossing!

6900 Forest Avenue, Suite 310 · Richmond, VA 23230 · Phone: (804) 249-8888



From 95N or 95S to 64W to Glenside Drive:

Take Exit 183 A to Glenside Drive, make the first left onto Forest Ave at the stop light. Make a left turn into Reynolds Crossing & look for the signs to follow for our building # 6900. We will be the newer building in the back left hand corner, MOB II. On top of our building will be signs that say "Virginia Urology", "Virginia Physicians", and "Bon Secours". It will also have building # 6900 on top of the building.

From 95N or 95S to 64W to Broad Street Road:

Take Exit 183 B to Broad Street and make the first right onto Forest Ave., near Altria. You will pass Plaza Azteca. We are the 3rd entrance on the right in Reynolds Crossing. Look for the signs to follow for our building # 6900. We will be the newer building in the back left hand corner, MOB II. On top of our building will be signs that say "Virginia Urology", "Virginia Physicians", and "Bon Secours". It will also have building # 6900 on top of the building.

From 288 to 64E to Glenside Drive:

Take Exit 183 A to Glenside Drive & make a right off of the exit. Make the first left at Forest Ave. Make a left turn into Reynolds Crossing & look for the signs to follow for our building # 6900. We will be the newer building in the back left hand corner, MOB II. On top of our building will be signs that say "Virginia Urology", "Virginia Physicians", and "Bon Secours". It will also have building # 6900 on top of the building.

From 288 to 64E to Broad Street Road:

Take Exit 183B to Broad Street and stay in right lane to make first right onto Forest Ave., near Altria. You will pass Plaza Azteca. We are the 3rd entrance on the right in Reynolds Crossing. Look for the signs to follow for our building # 6900. We will be the newer building in the back left hand corner, MOB II. On top of our building will be signs that say "Virginia Urology", "Virginia Physicians", and "Bon Secours". It will also have building # 6900 on top of the building.