



# **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

\_\_\_ 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.feelbetterva.com](http://www.feelbetterva.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: Subscriber SS#:	Subscriber Birth Date:	Policy #:	Group #/Name:
Secondary Insurance Name: Address:			
Subscriber Name: Subscriber 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 3<sup>rd</sup> party lab service. If you prefer another lab, let us know prior to collection. 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, case manager, 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

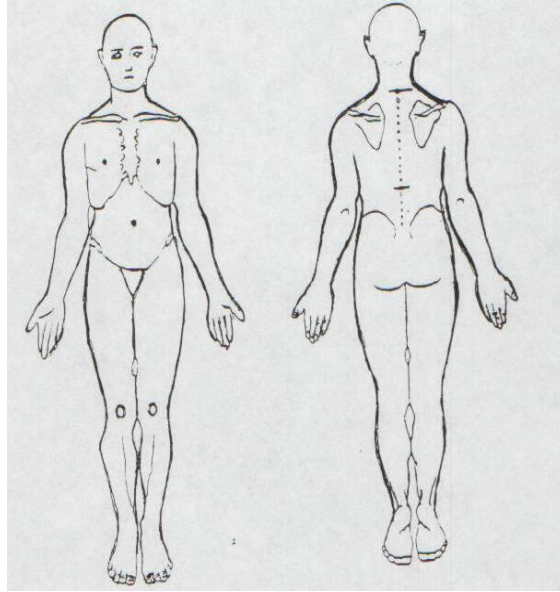
Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ ft \_\_\_\_\_ in Weight: \_\_\_\_\_ lbs

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
<b>No Pain</b>				<b>Moderate Pain</b>			<b>Most Severe</b>			

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)

<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Numbness and/or Tingling	<input type="checkbox"/> Headache	<input type="checkbox"/> Fever
<input type="checkbox"/> Inflammatory Pain	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Mental Status Changes	<input type="checkbox"/> Rash at the Site of Pain
<input type="checkbox"/> Weakness	<input type="checkbox"/> Gait Problems	<input type="checkbox"/> Bowel Dysfunction	<input type="checkbox"/> Bladder Dysfunction

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

<input type="checkbox"/> X-Rays	<input type="checkbox"/> MRI	<input type="checkbox"/> Bone Scan
<input type="checkbox"/> CT Scan	<input type="checkbox"/> Myelogram	<input type="checkbox"/> 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**:

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

**Past Medical History:**

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

Please check items below as they relate to your health.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ADD/ADHD                       | <input type="checkbox"/> Depression                          | <input type="checkbox"/> Pacemaker                       |
| <input type="checkbox"/> AIDS/HIV                       | <input type="checkbox"/> Device Implant (Type _____)         | <input type="checkbox"/> Parkinson's Disease             |
| <input type="checkbox"/> Alcohol Overuse/Alcohol Abuse  | <input type="checkbox"/> Diabetes (Type 1 ____; Type 2 ____) | <input type="checkbox"/> Peripheral Vascular Disease     |
| <input type="checkbox"/> Allergies                      | <input type="checkbox"/> Emphysema                           | <input type="checkbox"/> Physical/Sexual/Emotional abuse |
| <input type="checkbox"/> Alzheimer's/Dementia           | <input type="checkbox"/> Epilepsy/Seizures                   | <input type="checkbox"/> Pulmonary Disease               |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Fibromyalgia                        | <input type="checkbox"/> Reflux/GERD                     |
| <input type="checkbox"/> Aneurysm                       | <input type="checkbox"/> Gastrointestinal Disease            | <input type="checkbox"/> Restless Leg Syndrome           |
| <input type="checkbox"/> Ankylosing Spondylitis         | <input type="checkbox"/> Headaches/Migraines                 | <input type="checkbox"/> Rheumatoid Arthritis            |
| <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> Heart Attack/CVA                    | <input type="checkbox"/> Scoliosis                       |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Hepatitis                           | <input type="checkbox"/> Shingles                        |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> High Cholesterol                    | <input type="checkbox"/> Sleep Apnea                     |
| <input type="checkbox"/> Cancer (Type _____)            | <input type="checkbox"/> Hypertension                        | <input type="checkbox"/> Sleep Disorder                  |
| <input type="checkbox"/> Clotting Disorder              | <input type="checkbox"/> IBS (Irritable Bowel Syndrome)      | <input type="checkbox"/> Stomach Ulcers                  |
| <input type="checkbox"/> Congestive Heart Failure (CHF) | <input type="checkbox"/> Kidney/Bladder Problems             | <input type="checkbox"/> Stroke/TIA                      |
| <input type="checkbox"/> COPD                           | <input type="checkbox"/> Kidney/Renal Disease                | <input type="checkbox"/> Substance Abuse                 |
| <input type="checkbox"/> Coronary Artery Disease        | <input type="checkbox"/> Lupus                               | <input type="checkbox"/> Thyroid Dysfunction             |
| <input type="checkbox"/> Crohn's Disease                | <input type="checkbox"/> Osteopenia/Osteoporosis             |  |

**Family Medical History:** Please check items below as they relate to your close family member's health.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Aneurysm                         | <input type="checkbox"/> Disease of Liver                | <input type="checkbox"/> Neuropathy                  |
| <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Disorder of Back                | <input type="checkbox"/> Osteoarthritis              |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Disorder Musculoskeletal System | <input type="checkbox"/> Osteopenia                  |
| <input type="checkbox"/> Atrial Fibrillation              | <input type="checkbox"/> Disorder of Thyroid Gland       | <input type="checkbox"/> Osteoporosis                |
| <input type="checkbox"/> Back Problems                    | <input type="checkbox"/> Diverticular Disease            | <input type="checkbox"/> Parkinson's Disease         |
| <input type="checkbox"/> Blood Coagulation Disorder       | <input type="checkbox"/> Dyslipidemia                    | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Chronic Obstructive Lung Disease | <input type="checkbox"/> Fibromyositis                   | <input type="checkbox"/> Pulmonary Embolism          |
| <input type="checkbox"/> Congestive Heart Failure         | <input type="checkbox"/> Gout                            | <input type="checkbox"/> Restless Leg Syndrome       |

Family medical history, continued:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Crohn's Disease        | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Deep Venous Thrombosis | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Scoliosis            |
| <input type="checkbox"/> Dementia               | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Substance Abuse      |
| <input type="checkbox"/> Depressive Disorder    | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Sudden Cardiac Death |
| <input type="checkbox"/> Diabetes Mellitus      | <input type="checkbox"/> Leukemia             |   |

**Surgical History:** Please check items as they relate to your health.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Amputation             | <input type="checkbox"/> Cholecystectomy          | <input type="checkbox"/> Knee Replacement        |
| <input type="checkbox"/> Ankle/Foot Surgery     | <input type="checkbox"/> Elbow Surgery            | <input type="checkbox"/> Knee Surgery            |
| <input type="checkbox"/> Appendectomy           | <input type="checkbox"/> ENT Surgery              | <input type="checkbox"/> Lumbar Spine Surgery    |
| <input type="checkbox"/> Arm Surgery            | <input type="checkbox"/> Eye Surgery              | <input type="checkbox"/> Lumpectomy              |
| <input type="checkbox"/> Arthroscopic Surgery   | <input type="checkbox"/> Fracture Surgery         | <input type="checkbox"/> Neck Surgery            |
| <input type="checkbox"/> Back Surgery           | <input type="checkbox"/> Gastrointestinal Surgery | <input type="checkbox"/> Orthopedic Surgery      |
| <input type="checkbox"/> Bariatric Surgery      | <input type="checkbox"/> General Surgery          | <input type="checkbox"/> Plastic Surgery         |
| <input type="checkbox"/> Breast Surgery         | <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Shoulder Surgery        |
| <input type="checkbox"/> Caesarean Section      | <input type="checkbox"/> Hernia Repair            | <input type="checkbox"/> Thyroid Surgery         |
| <input type="checkbox"/> Cardiovascular Surgery | <input type="checkbox"/> Hip Replacement          | <input type="checkbox"/> Tonsillectomy/Adenoids  |
| <input type="checkbox"/> Carpal Tunnel Surgery  | <input type="checkbox"/> Hysterectomy             | <input type="checkbox"/> Wisdom Teeth Extraction |
| <input type="checkbox"/> Cataract Surgery       | <input type="checkbox"/> Joint Replacement        | <input type="checkbox"/> Wrist/Hand Surgery      |

Other Diagnoses Not Listed Above: \_\_\_\_\_

**Review of Systems:** Please check items as they relate to your health.

**CONSTITUTIONAL**

- Fever
- Night Sweats
- Weight Gain /  Weight Loss
- Exercise Intolerance
- Sedation
- Lethargy
- Chills
- Malaise

**CARDIOVASCULAR**

- Chest Pain
- Arm Pain on Exertion
- Shortness of Breath When Walking
- Shortness of Breath When Lying
- Palpitations
- Heart Murmur
- Ankle Swelling
- Chest Pain on Exertion
- Arm Pain on Exertion

**MUSCULOSKELETAL**

- Muscle Aches
- Muscle Weakness
- Joint Pain
- Back Pain
- Swelling in Extremities
- Neck Pain
- Difficulty Walking
- Cramps

**INTEGUMENTARY**

- Abnormal Mole
- Jaundice
- Rashes
- Lacerations
- Itching
- Growth/Lesions
- Psoriasis
- Change in Skin Color
- Breast Lump
- Non-Healing Areas

**GASTROINTESTINAL**

- Abdominal Pain
- Nausea
- Vomiting
- Constipation
- Diarrhea
- GERD
- Vomiting Blood
- Dyspepsia

**GENITOURINARY**

- Incontinence
- Difficulty Urinating
- Hematuria
- Increased Frequency
- Urinary Loss of Control

**HEMATOLOGIC/LYMPHATIC**

- Swollen Glands
- Bruising
- Excessive Bleeding
- Anemia
- Phlebitis

**PSYCHIATRIC**

- Depression
- Sleep Disturbances
- Alcohol Abuse
- Anxiety
- Hallucinations
- Suicidal Thoughts
- Mood Swing
- Agitation
- Dementia
- Delirium

**RESPIRATORY**

- Cough
- Wheezing
- Shortness of Breath

**ENT**

- Difficulty Hearing
- Ear Pain
- Bleeding Gums
- Snoring
- Dry Mouth
- Oral Abnormalities
- Mouth Ulcer
- Teeth Abnormalities
- Mouth Breathing
- Ringing in Ears
- Sinusitis
- Difficulty Hearing
- Ear Pain
- Nosebleeds
- Nose Problems
- Sinus Problems
- Sore Throat

**ALLERGIC / IMMUNOLOGIC**

- Runny Nose
- Sinus Pressure
- Itching
- Hives
- Frequent Sneezing

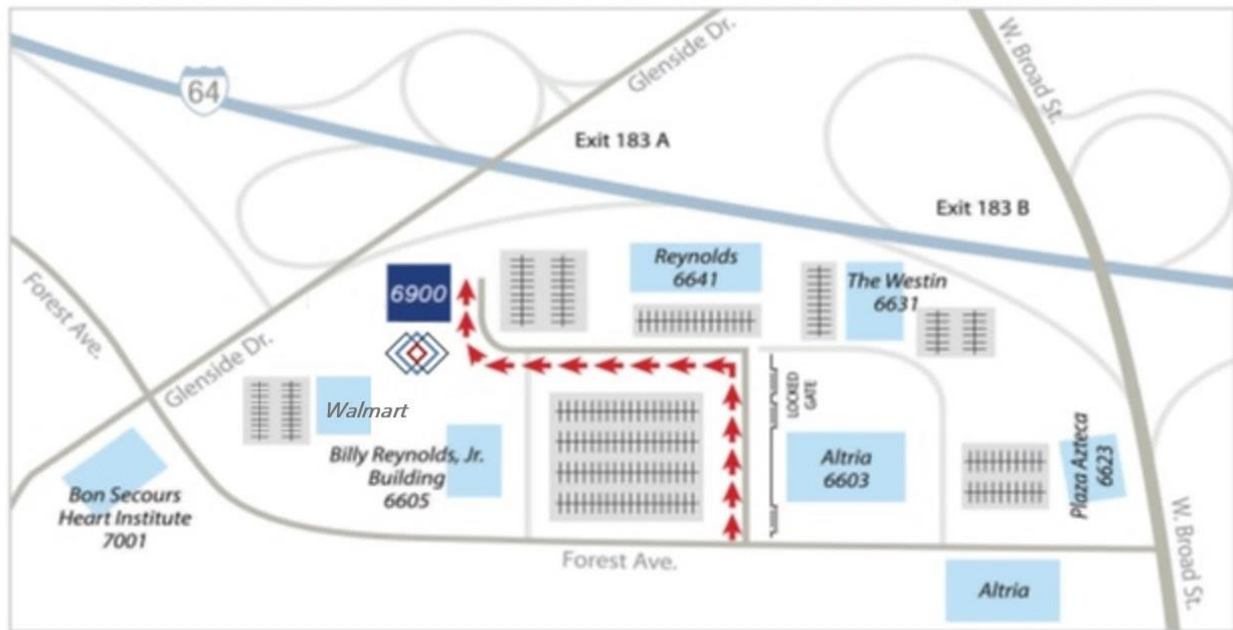
**NEUROLOGIC**

- Loss of Consciousness
- Weakness
- Numbness
- Seizures
- Dizziness
- Migraines
- Headaches
- Tremors
- Gait Dysfunction
- Paralysis



## 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 3<sup>rd</sup> 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 3<sup>rd</sup> 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.