Integrative Pain Specialists

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 ____ Samantha Wood, MSN, ACNP-BC
____ Daniel S. Feivor, PA-C ____ Amber N. Manche, MSN, FNP

***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), 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, 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: ______________

<table>
<tr><td colspan="6">Welcome to our office. In order to serve you properly, we will need the following information.
All information will be strictly confidential. (Please Print.)</td></tr>
<tr><td colspan="2">Patient Name:</td><td>Sex:
M
F</td><td colspan="2">Birth Date:

Age:</td><td>Marital Status:
Single [ ] Widowed [ ]
Married [ ] Divorced [ ]
Spouse's Name:</td></tr>
<tr><td colspan="3">Residence Address:</td><td colspan="2">Home Phone:</td><td>Patient's Social Security #:</td></tr>
<tr><td colspan="3">Email Address:</td><td colspan="3">Cell Phone:</td></tr>
<tr><td colspan="2">Person Financially Responsible for Account:</td><td>Self
Spouse
Parent</td><td colspan="2">Responsible Party's Birthdate:</td><td>Responsible Party Social Security #:</td></tr>
<tr><td colspan="4">Primary Care Physician:</td><td colspan="2">Referred By:</td></tr>
<tr><td colspan="4">Person to Contact in Case of Emergency:</td><td>Relationship to Patient:</td><td>Phone:</td></tr>
<tr><td>Workers Compensation: [ ]Yes [ ]No Name of Employer:
______________________________</td><td colspan="3">Accident Date:</td><td>Treatment Authorized By:</td><td>Claim #:

WC Contact Phone #:</td></tr>
<tr><td colspan="5">Primary Insurance
Name:
Address:</td><td>Employer:</td></tr>
<tr><td>Subscriber Name:
Subscriber SS#:</td><td colspan="3">Subscriber Birth Date:</td><td>Policy #:</td><td>Group #/Name:</td></tr>
<tr><td colspan="5">Secondary Insurance
Name:
Address:</td><td></td></tr>
<tr><td>Subscriber Name:
Subscriber SS#:</td><td colspan="3">Subscriber Birth Date:</td><td>Policy #:</td><td>Group #/Name:</td></tr>
</table>

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 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 History

Name: ____ DOB:___________ Height:_____ft______in Weight:_________lbs

Primary Care Physician:___________________________ Who referred you here today?______________________________

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:____

____

____

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.

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

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

GASTROINTESTIONAL
- ☐ 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

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

- ☐ Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Back Problems
- ☐ Blood Coagulation Disorder
- ☐ Chronic Obstructive Lung Disease
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Deep Venous Thrombosis
- ☐ Dementia
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ Disease of Liver
- ☐ Disorder of Back
- ☐ Disorder Musculoskeletal System
- ☐ Disorder of Thyroid Gland
- ☐ Diverticular Disease
- ☐ Dyslipidemia
- ☐ Fibromyositis
- ☐ Gout
- ☐ Heart Disease
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Pulmonary Embolism
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Substance Abuse
- ☐ Sudden Cardiac Death

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

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

Other Diagnoses Not Listed Above: ____

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.

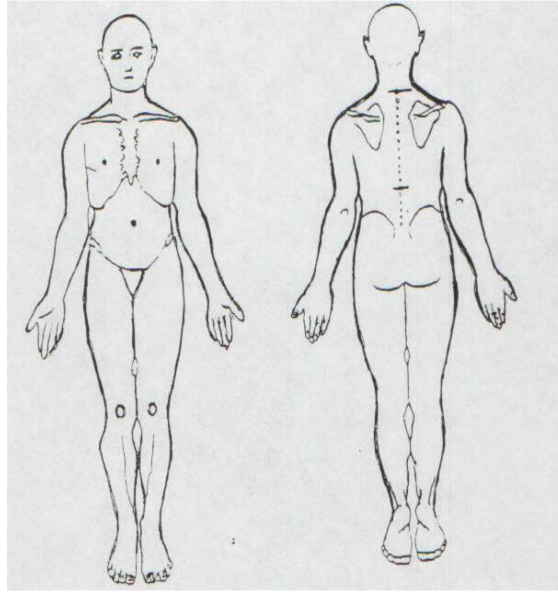
From 95N or 95S to 64W to Broad Street Road:
Take Exit 183 B to Broad Street and make the first right onto Forest Ave., near Altria. You will pass Plaza Azteca. We are the 3rd entrance on the right in Reynolds Crossing. Look for the signs to follow for our building # 6900. We will be the newer building 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.

Where is your pain?

(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 <u>worker's compensation</u>? _____ Yes ______ No

Is this accident / injury <u>under lawsuit or litigation</u>? _____ Yes ______ No

What makes the pain <u>MORE SEVERE</u>?

_____ 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 <u>LESS SEVERE</u>?

_____ 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 <u>related to this problem</u> (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?____

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

List any previous treatments you have received in the last 12 months <u>related to this problem</u>:

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, Klonipin, 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