Dr. Suzanne Duncan MD [Tel:508-680-4864](tel:508-680-4864) Mail: POB 10825, Pensacola, FL 32514

Pain Diagnosis and Injury Rehabilitation Medicine Clinic

ADDRESS: 3298 Summit Blvd, Suite 4, Pensacola, FL 32503

NEW PATIENT REGISTRATION

DATE: _____

NAME: (Last, First, Middle) _____

DOB: _____ Age: _____ Primary Care Physician: _____ Pharmacy: _____

Mailing Address: _____

(If the above is a PO Box, what is your physical address? _____

Tel: _____

Do we have permission to leave a voice message? Yes___ No___ May we to leave test results by voice message? Yes___ No___

PRIMARY INSURANCE HOLDER/PERSON RESPONSIBLE FOR BILL ☐Check here if is the same as above

**(If different)NAME: (Last, First, Middle) _____Mailing Address: _____

(If the above is a PO Box, what is the physical address? _____Tel: _____

PRIMARY INSURANCE: _____ POLICY# _____

CO-PAY: _____ SECONDARY INSURANCE: _____POLICY# _____

EMERGENCY CONTACT: NAME: _____RELATIONSHIP: _____

TELEPHONE: _____

AUTHORIZATION, ASSIGNMENT OF BENEFITS, and REFERRAL MEDICAL RELEASE

I hereby authorize the release of medical information including complete medical records, test results and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant resolution. I authorize payment directly to this physician practice for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

THE PATIENT AGREES TO PAY ALL COLLECTION CHARGES INCLUDING REASONABLE ATTORNEY'S FEES IF IT IS NECESSARY TO PURSUE PAYMENT OF THE ACCOUNT.

Signed: _____ Date: (Month/Date/Year)_____/_____/_____

PATIENT MEDICAL CONSENT FOR TREATMENT

I (for) undersigned patient, do hereby voluntarily consent to such physician care involving routine diagnostic procedures and medical treatment by Suzanne T. Duncan, MD. These treatments may or may not include rehabilitation counseling; injections such as joint, trigger point or prolotherapy (with solutions such as lidocaine, cortisone or dextrose); and osteopathic manipulative treatment. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this visit. Risks may include pain, bleeding, infection, and changes in skin pigmentation.

NOTE: Pt understands that cancellations made within 24h of appt will be billed $75. Initial please: _____

Signed:_____ Date: (Month/Date/Year)_____/_____/_____

VACCINATIONS: (circle) Yearly: Pneumonia Influenza Past: Tetanus MMR Shingle/Zoster Other_____

PAST MEDICAL HISTORY: _____

_____

CAR / BIKE / HORSE / SKATING ACCIDENTS / BONE FRACTURES:

_____

_____

FALLS/OTHER INJURIES: _____

SURGERIES (icluding plastic): _____

_____

FAMILY HISTORY: Mother's Age now_____ or Age at Death; Illness/orCause of Death:_____

Father's Age now _____or Age at Death; Illness/Cause of Death:_____

Any Siblings, Aunts, Uncles, Grandparents with: Cancer (type): _____ Neurological Diseases: _____

OTHER Medical Conditions (acquired or at birth):_____ _____

SOCIAL HISTORY: Employed? Yes / No Disabled? Yes / No Retired? Yes / No In School/Level attained? _____

Present Occupation: _____ Past Occupation/s: _____

Marital Status: S____ M ____ D____ W ____ Living with significant other/s: _____

Are you a victim of domestic violence? Yes / No Are you afraid to go home today? Yes / No Do you need help today? Yes / No

Do you live in a: House ___ Apartment ___ Rented room ___ Retirement Community___ Assisted Living ___ Nursing Home___ Other ___

Are there stairs to get into your home? Yes / No If Yes, how many? _____ Any stairs/flights inside your house? Yes / No

What do you use your stairs for? (circle): Bedroom Laundry Kitchen Basement Other _____

Do use a cane? Yes / No If Yes, in which hand? RIGHT LEFT Do you use orthotics? Yes / No If yes, RIGHT LEFT Type: _____

Currently Smoke: Yes / No How long have you smoked? _____How Much: _____Type: _____ QUIT: _____

Drink Alcohol: Yes / No If Yes, how much? _____ Type: _____ QUIT: _____

Use IV Drugs? Yes / No If Yes, how much? _____ Type: _____ QUIT: _____

Use Recreational Drugs? Yes / No If Yes, how much? _____ Type: _____ QUIT: _____

Exercise Regularly? Yes / No If Yes, how much? _____ Type: _____ QUIT: _____

REVIEW OF SYSTEMS: (check/circle those that apply): Vision changes per age: _____ Vision changes other: _____

Headache ___ Fever ___ Chills ___ Vomiting ___ Diarrhea ___ Chest Pain ___ Heart Palpitations ___Shortness of breath ___ Asthma ___

Fatigue ___ Night sweats ___ Dizziness ___ Vertigo ___ Panic attacks___ Insomnia___ Anxiety___ Depression___ Anger___ Guilt___

URINARY urgency ___ retention ___ incontinence ___ STOOL urgency ___ retention ___ incontinence ___

PAIN: Hand___R / L Wrist___R / L Forearm___R / L Elbow___R / L Shoulder___ Neck___ Upper Back___ Lower Back Flanks___R / L
Buttocks___R / L Thighs___R / L Knees___R / L Feet___R / L Toes-R 1 2 3 4 5 Toes-L 1 2 3 4 5
Chest___R / L Abdomen-Upper Right__Upper Left__ Abdomen-Lower Left__Lower Right___ Abdomen-Center___

Numbness: Hand___R / L Wrist___R / L Forearm___R / L Elbow___R / L Shoulder___R / L Neck___R / L Upper Back___ Lower Back
Flanks___R / L Buttocks___R / L Thighs___R / L Knees___R / L Feet___R / L Toes-R 1 2 3 4 5 Toes-L 1 2 3 4 5
Chest___R / L Abdomen-Upper Right__Upper Left__ Abdomen-Lower Left__Lower Right___ Abdomen-Center___

Weakness: Hand___R / L Wrist___R / L Forearm___R / L Elbow___R / L Shoulder___ Neck___R / L Upper Back___ Lower Back Flanks___R / L Buttocks___R / L Thighs___R / L Knees___R / L Feet___R / L Toes-R 1 2 3 4 5 Toes-L 1 2 3 4 5 Chest___R / L Abdomen-Upper Right___Upper Left___ Abdomen-Lower Left___Lower Right___ Abdomen-Center___

What area of your body is your priority today: _____

When did it Start? (Month/Date/Year)_____/_____/_____ How did it start? _____

What makes your pain Worse? _____ Better? _____

Makes Numbness Worse?_____Better?_____

Did your pain start Gradually?___ Suddenly?___ From a: Car / Bike / Horse / Skate / Fall / Lifting / Bending / Waking up / Trip / Unknown / OTHER: _____

Does it feel?: Aching___ Stabbing___ Throbbing___ Burning___ Shooting___ Tingling___at:_____ Other_____

In your words, what does your symptoms feel like? _____

_____

How brings it on?_____ How long does it last?_____ Is it Constant? Yes / No If Yes, for how long?_____

What treatments have worked?(circle): Physical Therapy Occupational Therapy Massage Icing Heat Acupuncture Reiki Chiropracter OTHER: _____

What Medications have worked / for how long?_____

What do you feel is the cause of your pain?_____

What are you prevented from doing by the pain?_____

What would you like to do if the pain got better?_____

What negative statements do you say to yourself? _____

What positive statement do you say to yourself?_____

Are there any other special concerns you have today?_____

PLEASE MARK FIGURE WITH a PAIN NUMBER

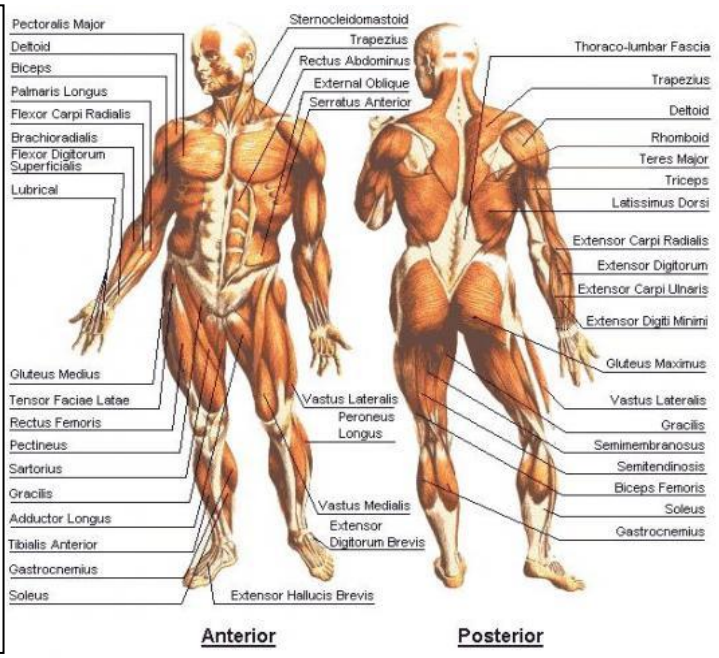
Scale: 0-10, 10=MOST PAIN

This is your personal scale,it is not compared to anyone else's.

PLEASE DESCRIBE PAIN: Aching
Stabbing
Burning
Other

PLEASE MARK AREAS OF NUMBNESS with a 'N'

MARK ANY OTHER AREAS OF CONCERN with a 'X'



C4-R L ,C5-R L ,C6-R L ,C7-R L ,C8-R L ,T1-R L ,L2-R L ,L3-R L ,L4-R L ,L5- R L ,S1-R L

PATIENT MEDICATION RECONCILIATION FORM

NAME:_____ DOB: _____

PRIMARY DOCTOR: _____ PHARMACY: _____

ALLERGIES (Plus Reaction): _____

_____

FOOD/MOLD/DUST/ANIMAL ALLERGIES:_____

MEDICATION NAME	DOSAGE	WHEN TAKEN (AM / PM)	REASON
-			
-			
-			
-			
-			
-			
-			
-			
-			
-			
-			
-			
-			
-			
-			

The Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC)

Name:_____ Date:_____

Instructions: Please rate the activities in each category according to the following scale of difficulty:

0 = None, 1 = Slight, 2 = Moderate, 3 = Very, 4 = Extremely

Circle one number for each activity:

Pain

1. Walking	0 1 2 3 4
2. Stair Climbing	0 1 2 3 4
3. Nocturnal	0 1 2 3 4
4. Rest	0 1 2 3 4
5. Weight bearing	0 1 2 3 4

Stiffness

1. Morning stiffness	0 1 2 3 4
2. Stiffness occurring later in the day	0 1 2 3 4

Physical Function

1. Descending stairs	0 1 2 3 4
2. Ascending stairs	0 1 2 3 4
3. Rising from sitting	0 1 2 3 4
4. Standing	0 1 2 3 4
5. Bending to floor	0 1 2 3 4
6. Walking on flat surface	0 1 2 3 4
7. Getting in / out of car	0 1 2 3 4
8. Going shopping	0 1 2 3 4
9. Putting on socks	0 1 2 3 4
10. Lying in bed	0 1 2 3 4
11. Taking off socks	0 1 2 3 4
12. Rising from bed	0 1 2 3 4
13. Getting in/out of bath	0 1 2 3 4
14. Sitting	0 1 2 3 4
15. Getting on/off toilet	0 1 2 3 4
16. Heavy domestic duties	0 1 2 3 4
17. Light domestic duties	0 1 2 3 4

Total Score: _____ / 96 = _____% Comments / Interpretation (to be completed by medical professional only):