PRS
PAIN AND REHABILITATION SPECIALISTS OF ST. LOUIS

Welcome to Pain and Rehabilitation Specialists. Our physicians provide exceptional medical care and, in the spirit of partnership, ask their patients to become active participants in developing and working their individual treatment plan.

Our office is located in Chesterfield, Missouri at **14825 North Outer 40 Road Suite 360**. The attached New Patient Registration packet contains directions and general information about our office policies and procedures, as well as several forms for you to complete and return to the office **on the appointment date** indicated below. Wheelchairs are available inside the main entrance to the building, if you require assistance.

We understand that navigating the benefits and coverage of individual health insurance plans can, sometimes, overwhelm and create a sense of confusion. Dr. Lee is a contracted provider with a variety of insurance plans. If you have questions regarding your insurance coverage, please contact Kathy Kastner at 314-336-2620.

Please bring the following items with you to your first visit:

- ☐ Completed registration packet
- ☐ Photo ID and, if you are covered by private or group health insurance, your insurance card. Although you may have an active legal or worker's compensation case, we need to have your health insurance information on file in the event the claims are denied by worker's compensation or your legal case status changes.
- ☐ Disc and written reports of any imaging studies related to your current medical condition. If you do not bring the disc to your appointment, we may ask you to reschedule.
- ☐ Contact all physicians, and other healthcare practitioners who previously treated you for this condition and ask that they send copies of their records to our office. We do not accept hand-delivered medical records.

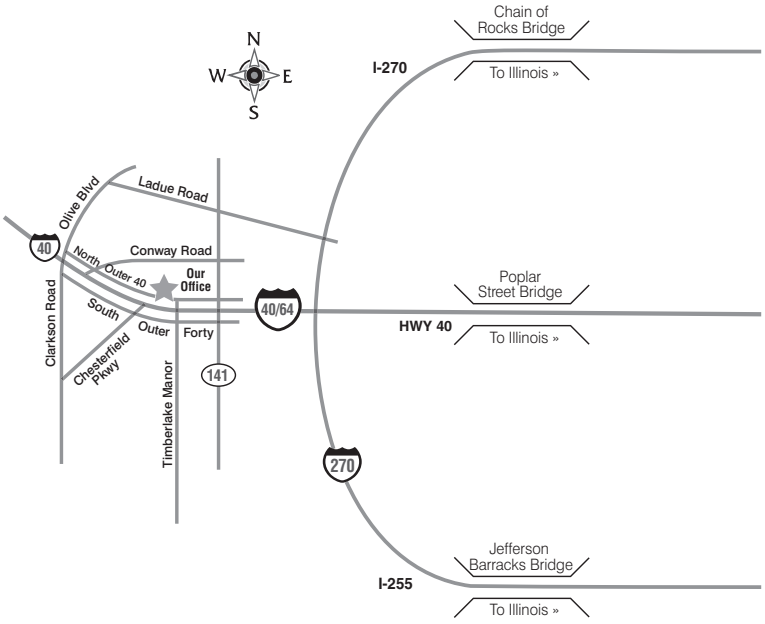
We look forward to working with you to achieve your healthcare goals and encourage you to call the office (314-336-2620) if you have any questions about the information contained in this packet.

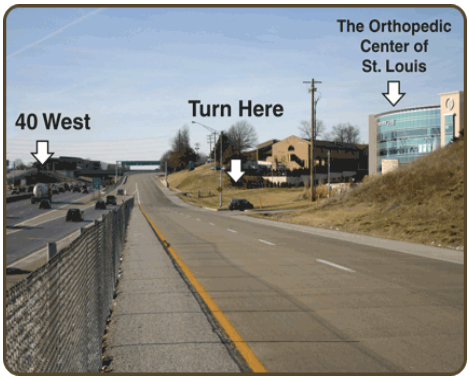
14825 North Outer 40 Rd
Chesterfield MO 63017

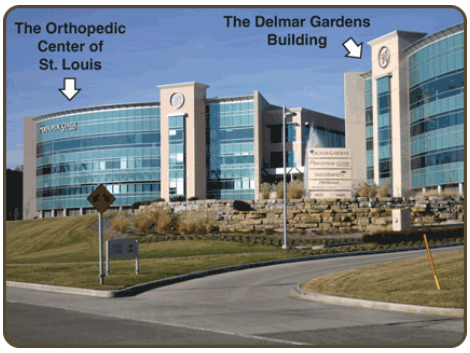
Phone: 314-336-2570
Fax: 314-336-2571

PRS
PAIN AND REHABILITATION SPECIALISTS OF ST. LOUIS

Directions to Pain and Rehabilitation Specialists of St. Louis







Traveling I-64 (Hwy 40) Eastbound

(coming from St. Charles area)

Exit Timberlake Manor Parkway (Exit 21). Turn left at the stoplight and cross over Highway 40. You will immediately come to a second stoplight where you will make a left onto N. Outer Forty Road. Proceed west for 8/10 of a mile. You will pass Bonhomme Presbyterian Church on the right hand side. Prepare to make a right into our entrance.

Traveling I-64 (Hwy 40) Westbound

(coming from downtown St. Louis)

Exit Timberlake Manor Parkway (Exit 21) and merge into the right hand lane, which becomes N. Outer Forty Road. You will eventually come to a stoplight. Go through the stoplight and proceed west for 8/10 of a mile. You will pass Bonhomme Presbyterian Church on the right hand side. Prepare to make a right into our entrance.

PRS
PAIN AND REHABILITATION SPECIALISTS OF ST. LOUIS

PRACTICE INFORMATION

Because we value open communication and mutual respect, we created this Practice Information Guide to help make your visits here convenient, pleasant, and beneficial.

Office Hours

- Our office is open from 8:00 until 4:30 Monday through Friday.
  The phone number is: **314-336-2570**; we accept telephone calls beginning at 8:00 until 4:00 each day.

After Hours and Emergency Care

- If you experience a life-threatening medical condition after office hours, call 911 or go immediately to the nearest Emergency Department, even if you are out of town.
- If you have an urgent medical concern that cannot wait until the office reopens, you may reach our doctors through our answering service**: 314-771-6080.**
- Reminder: the doctors will not authorize refills of maintenance medications after office hours.

Appointments

- We strive to minimize wait times and to spend as much time as needed to address your medical concerns. For this reason, we see our patients by appointment and strongly discourage walk-in visits.
- We room patients in appointment-time order. Expect the doctor to treat the primary reason for the scheduled office visit. We may ask you to schedule another appointment to address concerns other than the primary reason for your visit.
- If you arrive **LESS than 15 minutes before** your scheduled appointment time, we will do our best to assist you; however, we may ask you to reschedule.

Medication Refills

- We make every effort to process prescription refill requests as quickly as possible.
  Please allow 48-72 hours for our staff to process your refill request.
- To ensure you do not run out of medication, ask your pharmacy to fax the refill request to 314-336-2571 no less than three (3) days before you need it.

Personal Health Information

- Each physician reserves the right to determine the type of medical-care-related forms she will complete and sign.
- The standard fee for completion of forms (for example, FMLA, disability, etc.) is $50.00, payable when you present the form to the office. We must receive payment, either in person or by credit card over the phone, for all requests received by fax or by mail.
- Our practice partners with HealthPort/Ciox to process requests for medical records. We must have a signed, HIPAA-compliant authorization to release copies of your medical records.
  Please allow no less than ten (10) business days from the date we receive the request to process these requests.
  If the request is for your personal use HealthPort may charge you a fee for copying those records. We do not charge for records transferred to another physician or medical facility for the purpose of continued care.

Registration / Insurance

- Please review insurance information with our staff *prior* to receiving care to make certain your doctor is a contracted provider for your plan.
- We expect you present a valid insurance card and photo ID at each visit, even if you have an active workers' compensation claim or active legal case.
- Please tell the staff member at check-in if you have any change in insurance, contact information, address or pharmacy preference

PAIN and REHABILITATION SPECIALISTS

PATIENT REGISTRATION

FIRST NAME	MIDDLE NAME/INITIAL	LAST NAME

Preferred Name	Date of Birth	Social Security Number	Gender: Male Female

Primary Care Doctor	Name	Address	Phone	Fax
Referring Provider	**Name**	**Address**	**Phone**	**Fax**

DEMOGRAPHIC INFORMATION

Home Address	Zip code

Home Phone	Area code	Number	Work Phone	Area code	Number	Extension

Cell Phone	Area code	Number	Preferred Phone	Home Work Cellular

Email Address	Preferred communication	Phone Mail Email

Mailing Address *(if different from home address)-*	Zip code

Whom shall we contact in an emergency?	Relationship to patient?	Phone number

Race	Ethnicity:	Hispanic/Latino	Non Hispanic/Latino	Unreported/Refused

Preferred Language	English Spanish Other	Do you need an interpreter? Yes No What type of interpreter?

Marital Status	Single Married Divorced Widowed Domestic Partner

Employment	Full-Time Part Time Not Employed Student	Employer

PRIMARY INSURANCE

Insurance Plan Name		Effective Date	

Subscriber ID		Group Number	
Insured's Name		Date of Birth	
Relationship to Patient Self Spouse Parent Partner		Social Security #	

SECONDARY INSURANCE

Insurance Plan Name		Effective Date	

Subscriber ID		Group Number	
Insured's Name		Date of Birth	
Relationship to Patient Self Spouse Parent Partner		Social Security #	

ASSIGNMENT OF BENEFITS

- I understand I am financially responsible for all charges and services provided to me, including the balance remaining after payment of potential insurance benefits. I authorize payment of medical insurance benefits to PAIN and REHABILITATION SPECIALISTS for professional services rendered.
- I authorize the release of any information necessary to process this claim.
- I certify that all the above information is true and correct to the best of my knowledge. I give my permission to the Provider and/or medical staff to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my medical condition(s).

Signature of Patient / Legal Guardian/Representative	Relationship	Date

EXTENDED INFORMATION

Date of Injury	
How were you injured?	
If you were involved in a Motor Vehicle Accident, in what state did it occur?	

WORKERS' COMPENSATION INFORMATION	
Insurance Company Name	
Claim Number	

Case Adjuster	
Office Phone	
Office Fax	
Email Address	
Mailing Address	
City / State / Zip	

Case Manager	
Office Phone	
Office Fax	
Email Address	
Mailing Address	
City / State / Zip	

ATTORNEY			
Attorney's Name			
Name of Firm			
Mailing Address			
City / State / Zip			
Office Phone		Office Fax	
Email Address			

AUTHORIZATION FOR MEDICAL TREATMENT and RELEASE OF INFORMATION

I authorize my physician and his/her employees, to provide the medical care, tests, procedures, medications, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency and other special services. In consenting to treatment, I have not relied on any statements as to results. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any of antibodies to hepatitis A, B, and C and HIV.

STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to:

a. Any governmental or other entity as required by law for purposes of reporting or for purposes of determining the eligibility in government sponsored benefit programs.
b. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
c. Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.
d. Another health care provider that prescribes medication electronically to provide continuity of care and quality of care issues regarding prescriptions.
e. I also authorize my physician to obtain information from other providers regarding my care and treatment including obtaining my electronic medication and prescription history from whatever source for the purpose of my continuing care and treatment.

Signature of Patient/Legal Guardian/Representative	Relationship	Date

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____
Last First MI Maiden

Date of Birth _____ Social Security Number _____

I Authorize and Request: _____

_____

_____

_____ _____
Office Phone Office Fax

To Release to: **Pain and Rehabilitation Specialists**
14825 N Outer 40 Road, Suite 360
Chesterfield, MO 63017
Office Phone: 314-336-2570
Office Fax: 314-336-2571

Medical Records covering the periods of health care from _____ to _____
Date Date

Please check, and initial, the types of records you <u>do not</u> want released.

☐ HIV Testing/Treatment Records ☐ Substance Use/Abuse History ☐ Psychiatric Evaluation

☐ Other (please specify) _____

The Medical Information is needed for: _____

ATTENTION: Once this information has been released pursuant to the Authorization, it may no longer be protected by Federal, and/or State law/regulations and may no longer be deemed "confidential."

I understand that neither Pain and Rehabilitation Specialists, or any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization, if so requested.

I understand that I may revoke the Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will **expire one (1) year** from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax or bring the letter to the address or fax number at the top of the page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's Death Certificate.

_____ _____ _____
Signature of Patient (if the patient is incompetent, of his guardian or other) ***Relationship*** ***Date***

_____

Printed name of person authorized under State Law to act in the patient's behalf, if the patient is deceased, or his personal representative or if none, of his child, parent or sibling.

PAIN and REHABILITATION SPECIALISTS of ST LOUIS
COMMUNICATION AUTHORIZATION

Patient Name _____
Last First MI Maiden

Date of Birth _____ **Social Security Number-Last 4 Digits** _____

I authorize the providers and staff of Pain and Rehabilitation Specialists of St Louis, LLC to discuss and disclose my Protected Health Information (PHI) to the person(s) named below.

Name	Relationship	Phone Number

I authorize the providers and staff of Pain and Rehabilitation Specialists to leave messages:

☐ _____ On my **home** answering machine / voice mail. _____
Initials Phone Number

☐ _____ On my **cell phone** voice mail. _____
InitialsPhone Number

HIPAA: NOTICE OF PRIVACY PRACTICES

I have received, and/or been provided the opportunity to receive, a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used or shared.

I acknowledge that the Pain and Rehabilitation Specialists physicians, medical assistants and other staff may use and share my confidential health information with others in order to 1) treat me, 2) to arrange for payment of my bill, and 3) for issues that concern Pain and Rehabilitation Specialists operations and responsibilities.

This authorization remains in force until revoked in writing. The purpose of this disclosure/use is for continued medical care.

_____ _____ _____
Signature of Patient, Guardian, Personal Representative Relationship Date

_____
Print name of person authorized under state law to act in the patient's behalf, if the patient is deceased, or his personal representative, or if none, of his child, parent or sibling.

PATIENT FINANCIAL AGREEMENT

We strive to maintain a strong physician-patient relationship. Sharing our Financial Policy in advance allows for a good flow of communication and enables us to achieve our goal. If you have any questions, do not hesitate to ask a member of our staff.

Health Insurance

- Deductibles, copayment and co-insurance payments are your responsibility.
- We file claims with our contracted insurance plans only. Since the insurance contract is an agreement between you and your insurance company. It is your responsibility to understand your insurance plan benefits with regard to a covered service, if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure. If you have more than one insurance policy, it is your responsibility to inform the office which policy is **Primary** (first) coverage and which policy is **secondary** or **Tertiary**. With each policy, we require the name, birth date, address, phone number, and social security number of the individual who carries the policy.

We expect our patients to pay at time of service any copayment, co-insurance, or deductible required by the insurance company. Because this is an insurance requirement, we cannot bill the patient for these amounts.

Patient/Responsible Party Initial _____

I agree to provide a copy of my insurance card(s) at each visit with the name, address, phone number, date of birth and social security number of the individual who carries the insurance.

Patient/Responsible Party Initial _____

I agree to provide a valid authorization/referral. I understand that if I do not have a valid referral, the staff may ask me to reschedule or pay for the visit in full at check in.

Patient/Responsible Party Initial _____

General Financial Information

Returned Checks: We charge a $30.00 fee for any check returned by the bank. We expect payment by cash, credit card, or money order within 14 days of the notice that your check was returned.

Patient/Responsible Party Initial _____

Past Due Balances: We offer monthly payment plans tailored to each individual's circumstances. If your account becomes delinquent, we reserve the right to take all steps necessary to collect this debt, including referral of your account to a collection agency and/or collection attorney. If such action becomes necessary you assume responsibility for any and all related fees.

Patient/Responsible Party Initial _____

Workers' Compensation: If your employer has pre-approved treatment, we will file claims and you should not expect to have any financial liability. If your employer has not approved treatment and **you choose to receive care by our** physician, you assume full financial responsibility for costs associated with that treatment.

Patient/Responsible Party Initial _____

Personal Injury: If you are receiving treatment as part of a personal injury claim or lawsuit, we require verification from your attorney **prior to your initial visit**. In addition to this verification, we require that you allow us to bill your personal health insurance, if available. We will require you to sign a Notice of Doctor's Lien. In the absence of insurance, other financial arrangements may be available. **Payment of all charges remains the patient's responsibility. We cannot bill your attorney for charges incurred due to your personal injury.**

Patient/Responsible Party Initial _____

Completion of Forms: We charge a fee of **$50.00** to complete any forms not related to health insurance claims (disability, FMLA, injury, for example). Payment is due each time you deliver a form for completion. For forms received by fax or mail, we must receive your payment prior to returning the form to the requestor. We cannot bill you for this service.

Patient/Responsible Party Initial _____

By signing initialing and signing this form, I agree to all of the terms and conditions herein and the agreement will be in full force and effect. I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Signature of Patient / Guardian / Legal Representative	Relationship to Patient	Date

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PAIN AND REHABILITATION SPECIALISTS OF ST. LOUIS

DR. THOMAS LEE: HEALTH HISTORY

Date of Visit _____

Name _____ DOB _____ Gender ☐ M ☐ F

Email address _____ Height _____ Weight _____

Hand Preference ☐ Right ☐ Left Are you pregnant? ☐ No ☐ Yes ☐ Unknown

Primary Care Provider _____ Phone _____

Preferred Pharmacy _____ Phone _____

CHIEF COMPLAINT

Please describe your current injury/complaint. _____

_____

How long have you experienced this condition? _____

What makes your symptoms better (ie, rest, medication)? _____

What makes your symptoms worse (ie, walking, bending)? _____

Which of your symptoms caused you the most concern? _____

Date of onset/injury _____ Were you in an auto accident? _____

Is this a work-related injury? ☐ YES ☐ NO Who is your case manager/case adjuster? _____

Have you had any x-rays or test performed for this condition? ☐ **YES** ☐ **NO**

Type of test/scan _____

Date _____ Where was it done? _____

Type of test/scan _____

Date _____ Where was it done? _____

Type of test/scan _____

Date _____ Where was it done? _____

Have you had any prior treatment for this condition? ☐ **YES** ☐ **NO**

Describe _____

PAST MEDICAL HISTORY: *Please check if you have now, or have had in the past, any of these medical conditions.*

☐ **NO PAST MEDICAL PROBLEMS**	☐ Psychiatric history	☐ Ulcerative Colitis
☐ Heart Attack	☐ Anxiety	☐ Irritable Bowel
☐ Angina or Chest Pain	☐ Depression	☐ Diverticulitis
☐ Congestive Heart Failure	☐ Schizophrenia	☐ Osteoarthritis
☐ Mitral Valve Prolapse	☐ Headache	☐ Hepatitis _____
☐ High Blood Pressure	☐ Lung Disease	☐ Liver Problems
☐ High Cholesterol/Triglycerides	☐ Emphysema (COPD)	☐ Diabetes-Insulin?
☐ Heart Disease	☐ Pneumonia	☐ Diabetes – Non Insulin
☐ Arrhythmia	☐ Chronic Bronchitis	☐ Thyroid Disease
☐ Anemia	☐ Blood Clot in Lung	☐ Kidney Stones / Disease
☐ Bleeding Ulcer	☐ Tuberculosis	☐ Urologic Problems
☐ Blood Clot/DVT	☐ Hiatal Hernia	☐ Stress Incontinence
☐ Legs ☐ Lungs ☐ Other	☐ Reflux	☐ Enlarged Prostate
☐ Peripheral Vascular Disease	☐ Stomach or Intestinal Ulcer	☐ Frequent Urinary Inf (UTI)
☐ Peripheral Neuropathy	☐ Crohn's Disease	☐ HiV+
☐ Cancer _____	☐ Peptic Ulcer Disease	☐ Intestinal Bleeding
☐ Fracture(s) _____	☐ Crohn's Disease	☐ Seizure Disorder
☐ Sleep Apnea	☐ Problems with Anesthesia	☐ Other _____
☐ Asthma	☐ Fibromyalgia	☐ Other _____

SURGICAL HISTORY: *Please check if you have had any of these surgeries.*

☐ **NO PREVIOUS SURGERY**	☐ Breast Surgery	☐ Prostate Surgery
☐ Abdominal Surgery	Type _____	☐ Other (explain)
Type: _____	☐ Carotid Surgery	_____
☐ Aneurysm	☐ Colon Surgery	_____
☐ Angioplasty/Stents	☐ Coronary Bypass (CABG)	_____
☐ Artery Bypass of Arm or Leg	☐ Heart Valve Replacement	_____
☐ Bone/Joint Surgery	☐ Hysterectomy	_____
Type _____	☐ Pacemaker/Defibrillator	_____

☐ Back/Neck Surgery

☐ Cervical (neck)	Level(s)	_____	When?	
☐ Thoracic	Level(s)	_____	When?	_____
☐ Lumbar (low back)	Level(s)	_____	When?	_____

☐ Implanted Devices *(If YES, check all that apply.)*

☐ Screws, Pins, Plates	☐ Pacemaker	☐ IUD	☐ Venous Access
☐ Aneurysm Clip(s)	☐ AICD	☐ Breast Implant	☐ Spinal Cord Stimulator
☐ Intrathecal Pump			

CURRENT MEDICATION: *Please include herbal and over-the-counter medications. List all medications with dosage.*

☐ **NOT CURRENTLY TAKING ANY MEDICATIONS-PRESCRIPTION OR OVER-THE-COUNTER, OR HERBAL SUPPLEMENTS**

DRUG	DOSAGE		DRUG	DOSAGE

MEDICATION ALLERGIES

☐ **NO KNOWN MEDICATION ALLERGIES**

Are you allergic to Contrast Dye?	☐ NO	☐ YES	Reaction?
Are you allergic to Latex?	☐ NO	☐ YES	Reaction?
Are you allergic to Tape?	☐ NO	☐ YES	Reaction?
Are you allergic to any Food Items?	☐ NO	☐ YES	Reaction?
Other			Reaction?
Other			Reaction?
Other			Reaction?

FAMILY HISTORY:

*Please check below if any immediate relatives have had any of these conditions: **F**–father, **M**–mother, **S**-sibling.*

☐	**NO FAMILY HISTORY TO REPORT**	☐	Cancer	☐	Stroke
☐	Heart Disease	☐	Liver Disease	☐	Diabetes
☐	Lung Disease	☐	Arthritis	☐	Psychiatric Disease
☐	Osteoporosis	☐	High Blood Pressure	☐	Other (Explain)
☐	Anesthesia Difficulties	☐	Kidney Disease		_____
☐	Bleeding Disorders	☐	Rheumatoid Arthritis		_____
☐	Other Inherited Disease (type)				

Patient Name _____ DOB _____ Date of Visit _____

SOCIAL HISTORY:

Occupation									
Work Demands	☐	Sedentary	☐	Moderately Active	☐	Heavy Labor			
Work Status	☐	Working	☐	Retired	☐	Disabled	☐	Other	
Education Level	☐	Grade School	☐	High School	☐	Technical School	☐	Associated Degree	
	☐	Bachelor's Degree	☐	Master's Degree	☐	Doctorate			
Marital Status	☐	Single	☐	Married	☐	Partner	☐	Divorced	☐ Widow/Widower
Smoking	☐	Never Smoked	☐	Former Smoker	☐	Current Smoker? How may packs /day? _____			
Do you dip or chew tobacco?	☐	No	☐	Yes	How much per day? _____				
Do you drink alcoholic beverages?	☐	No	☐	Yes	How many drinks per week? _____				
Do you use recreational drugs?	☐	No	☐	Yes	What and how often? _____				
Have you injected illegal drugs?	☐	No	☐	Yes	What and how often? _____				
Do exercise regularly?	☐	No	☐	Yes	Describe _____				
What sports/activities do you participate in?									

REVIEW OF SYSTEMS: *Please check if you have now, or recently experienced any of these medical conditions.*

☐	**Good General Health**	☐	Wheezing	☐	Dry Skin / Itching
☐	Recent Weight Gain / Loss	☐	Spitting up Blood	☐	Chronic Skin Ulcers
☐	Fever/Chills/Night Sweats	☐	Change in Bowel Habits	☐	Varicose Veins
☐	Fatigue	☐	Loss of Appetite	☐	Numbness / Tingling
☐	Eye Disease/Injury	☐	Nausea / Vomiting	☐	Blackouts
☐	Wear Glasses / Contacts	☐	Diarrhea	☐	Tremors
☐	Blurred / Double Vision	☐	Constipation	☐	Paralysis
☐	Hearing Loss / Ringing	☐	Indigestion	☐	Depression
☐	Chronic Sinus Problem	☐	Burning / Painful Urination	☐	Memory Loss or Confusion
☐	Nose Bleed	☐	Frequent Urination	☐	Nervousness
☐	Difficulty Swallowing	☐	Blood in Urine	☐	Insomnia
☐	Shortness of Breath	☐	Joint Pain	☐	Slow Healing after Cuts
☐	Chest Pain	☐	Back Pain	☐	Bruising Tendency
☐	Palpitations	☐	Difficulty Walking	☐	Transfusions
☐	Faintness	☐	Muscle Weakness	☐	Excessive Thirst
☐	Breathing Problems	☐	Leg Cramps	☐	Excessive Sweating
☐	Chronic / Frequent Coughs	☐	Rashes	☐	Other _____

I understand the need to inform Dr. Lee of any changes in my medical condition. To the best of my knowledge, the information provided on this form is correct and accurate.

_____ _____

Signature of Patient / Legal Guardian Date

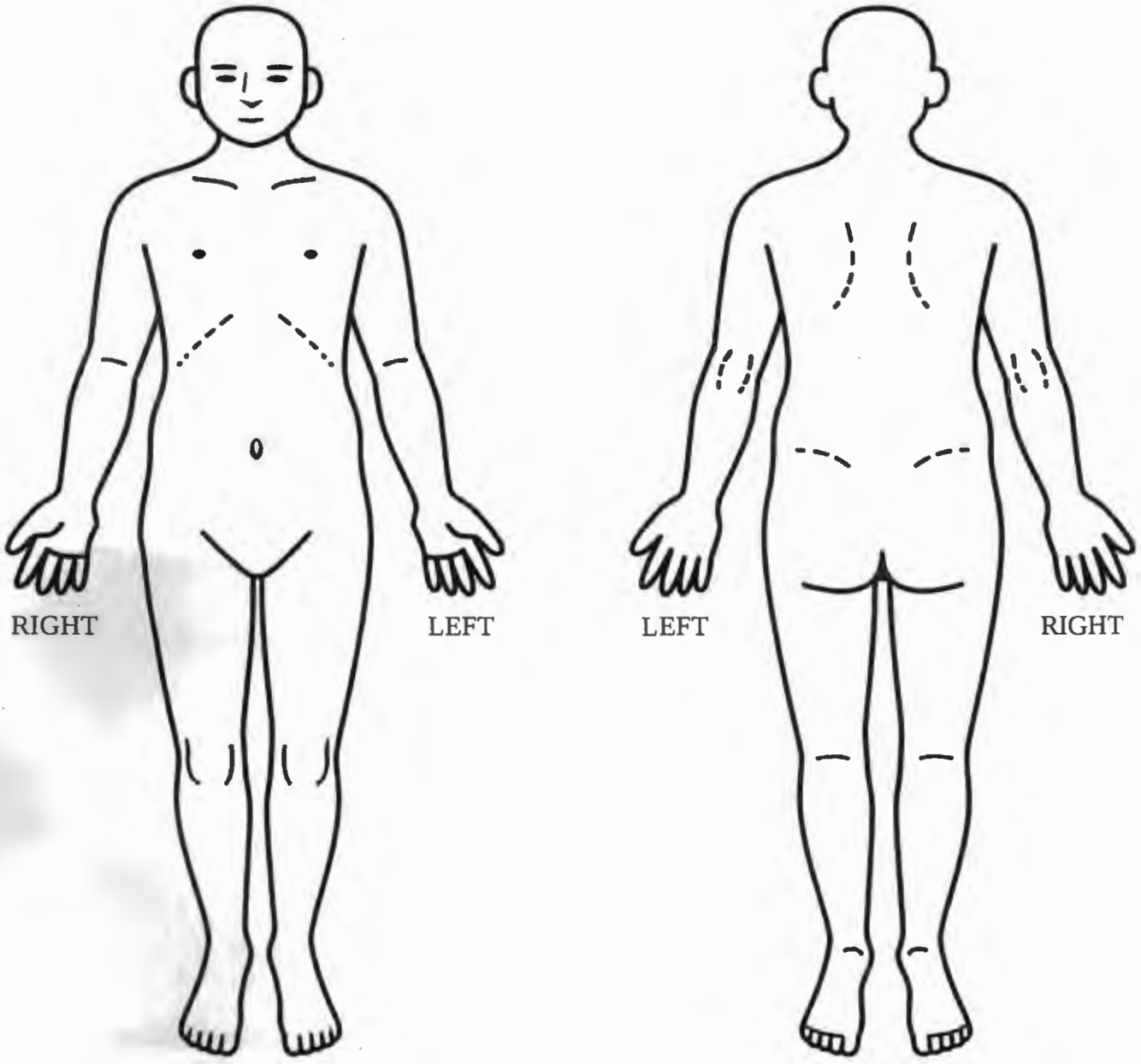
Patient Name _____ DOB _____ Date of Visit _____

Patient Name:_____ Date:_____

BODY PAIN INDICATOR CHART

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Mark the areas of the body where you feel painful sensations using the appropriate symbols to indicate the type of symptoms.

Aching	Burning	Stabbing	Numbness	Pins & Needles
+++++	xxxxx	/////	=====	ooooo



Medical History

Today's Date

Patient Name:

Patient Medication List

Please list ALL medications (including prescription, over –the-counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

Medication	Dosage	Frequency	Route of Administration