Barr Center for Innovative Pain & Regenerative Therapies
933 First Colonial Road, Suite 200
Telephone: (757) 578-2260 Fax: (757) 578-2261

Patient Name:	Sex:	DOB:	Age:	SS#:
Home Address:		Primary Phone #:		Secondary Phone #:
Email Address:		Referring Physician:		Primary Care Physician:
Preferred Pharmacy:			Pharmacy Phone:	
Employer Name & Address:			Employer Phone #:	

SPOUSE/GUARANTOR INFORMATION AND EMERGENCY CONTACT

Spouse/Guarantor (if patient is a minor):	Primary Phone #:	Secondary Phone #:
Home Address:		
Patient's Relationship to Guarantor: □ Self □ Spouse □ Dependent Child □ other _____	SS#:	DOB:
Employer's Name & Address:		
In case of Emergency please list a contact:		Phone #:

INSURANCE INFORMATION
(If Workers Comp, please write W/C under Primary Insurance, Please notify the Front Desk if you have Tertiary Coverage)

Primary Insurance Plan Name:	Policy ID#:	Group #:
Secondary Insurance Plan Name:	Policy ID#:	Group #:

The information below will be used to improve the quality of healthcare by granting us the ability to measure and minimize care disparities based on ethnicity, race and preferred language. It gives the practice an accurate estimate of our patient population, and accordingly assesses the need for different services such as interpreter services translated patient forms and cultural competency.

Ethnicity:	Race:		Language:
□ Hispanic or Latino	□ White	□ African American	□ English
□ Not Hispanic or Latino	□ American Indian	□ Alaska Native	□ Spanish
□ Declined	□ Asian	□ Native Hawaiian	
	□ Other Pacific Islander	□ Other	
	□ Declined		

ASSIGNMENT and RELEASE

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services.
- I authorize the physician to release any information required to process this claim.

_____ _____ _____

Patient/Guarantor Signature Witness Date

BARR CENTER FOR INNOVATIVE PAIN & REGENERATIVE THERAPIES

Authorization to Disclose Protected Health Information

Patients Name:		
DOB:	**Daytime Phone:**	**Cell:**

The requested medical information may be disclosed to and used by the following individual(s) or organization:

Name:	**Relationship:**	**Phone #:**	**For the purpose of:** (please circle all that apply)
1.			**Medical Insurance Other**
2.			**Medical Insurance Other**
3.			**Medical Insurance Other**

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time by notifying Barr Institute for Innovative Medicine & Regenerative Therapies in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise **revoked**, this authorization will **expire one year** from the date this form is signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I **do not** need to sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the Privacy Officer at Barr Center for Innovative Pain & Regenerative Therapies in person and/or I may request a read a more detailed version of Barr Center for Innovative Pain & Regenerative Therapies Notice of Privacy.

Patient/Guarantor (Please Print) **Patient/Gaurantor (Signature)**

Witness (Please Print) **Witness (Signature)** **Date**

BARR INSTITUTE FOR INNOVATIVE MEDICINE & REGENERATIVE THERAPIES
CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

1. CONSENT FOR TREATMENT: I voluntarily consent to outpatient care and treatment performed by the physicians and all other healthcare providers at Barr Institute for Innovative Medicine & Regenerative Therapies (The Barr Center). I also consent to routine services, diagnostic procedures, medical treatment, and other services as deemed necessary by the healthcare providers treating me.

2. AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Barr Institute for Innovative Medicine & Regenerative Therapies to utilize confidential health information contained in my medical record as necessary for insurance claims payment, medical management or quality of care review purposes. I further authorize the release and discharge of such confidential information to my insurance company or other health coverage plan as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. I understand this authorization for release of information can be revoked by me in writing at any time but only with respect to the proposed treatment and not with respect to care and treatment that has already been rendered to me.

3. OBLIGATION OF PAYMENT: I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from third party liabilities claims for injuries treated hereunder, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, costs and interest due to Barr Institute for Innovative Medicine & Regenerative Therapies. I understand that if I have insurance, my insurance policy is a contract between me and my insurance company. I am responsible to Barr Institute for Innovative Medicine & Regenerative Therapies for any and all charges not covered by insurance, including but not limited to co-payments, deductibles and fees for non-covered services. Barr Institute for Innovative Medicine & Regenerative Therapies will send all billing information to the person responsible for payment of my bill. It is my sole responsibility, or the responsibility of the Guarantor, to comply in a timely manner with all requirements, supply all information and documents necessary to obtain payment of benefits by any third party or governmental entity as listed above.

4. PAST DUE BALANCES AND PROCEDURES FOR COLLECTION: Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service. If I have no insurance, my payment for services is due upon receipt of my services. The undersigned agree(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If payment is not made, I understand Barr Institute for Innovative Medicine & Regenerative Therapies may take action to collect its fees. I agree to pay all costs incurred by Barr Institute for Innovative Medicine & Regenerative Therapies for collecting its fees, including an attorneys fee of thirty-five (35%) of the unpaid bill. The return check fee is $38.00.

5. NOTICE OF DEEMED CONSENT FOR INFECTIOUS DISEASE TESTING: Virginia Code Section 32.1-45.1 provides that when either a person providing health care service or a patient is directly exposed to the body fluids of the other in a way that may transmit human immune- deficiency virus or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

6. NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received, have previously received, or have been offered but decline to receive, the Barr Institute for Innovative Medicine & Regenerative Therapies Notice of Privacy Practices Summary.

I understand that as a condition of my treatment at Barr Institute for Innovative Medicine & Regenerative Therapies, if litigation arises from my injuries which I am being treated for, neither the physician nor office staff will be available to appear in court. Conferences and depositions will be scheduled if required.

Patient Name (Please Print)	Patient/Guarantor (Signature)	Date
Witness (Please Print)	**Witness (Signature)**	**Date**

Payment Authorization of Medicare Benefits

I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to Barr Institute for Innovative Medicine & Regenerative Therapies for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

SIGNATURE of Patient or Authorized Representative:	Date	Witness

Barr Institute for Innovative Medicine & Regenerative Therapies files your insurance as a courtesy to you. If a co-payment is due from you, your insurance company requires us to collect this payment at the time of service. We accept cash, check, Master Card, Visa, and debit cards.

Barr Center
for Innovative Pain &
Regenerative Therapies

OPIOID PRESCRIBING POLICY

The Barr Center for Innovative Pain & Regenerative Therapies (The Barr Center) and its providers are committed to providing the best healthcare possible to our patients. We recognize that, for the most part, people come to see us because they are experiencing pain that interferes with their quality of life. Our goals are to first identify, to the best of our ability, the cause of your pain and then educate you about various treatment options. We expect you to take an active role in your own healthcare.

We can provide or facilitate many different conventional and alternative pain treatments. Typically, we start with non-invasive treatments when possible, such as specific exercises, ergonomic changes, physical therapy, medications, and activity modifications. When that is simply not enough, the full spectrum of intervention “blocks” and other intervention techniques are available here as well as acupuncture and prolotherapy. Occasionally, when we determine that a particular condition is resistant to all of these tools, we may suggest the use of long-term opioids. This decision is often made after we have been through a rather thorough process of evaluation and treatment trials.

The decision to start long-term opioid (narcotic) therapy is not made lightly. We must take many things into account including:

- issues related to any prior history or family history of substance abuse
- prior history of drug seeking of drug diverting behavior. This includes deceiving your doctor in any way; doctor shopping, giving or selling your medications to others or abusing alcohol or “street drugs”.

These issues are considered by most pain management specialists to be reason not to prescribe long-term opioids. This must be evaluated on a case by case basis, and occasionally, input from an addictionologist may be required.

Our policy regarding continuing to write for opioids started by other physicians is simply this: We reserve the right to evaluate the cause of your pain and make treatment recommendations that may or may not include the use of opioids. This means that just because your last doctor prescribed narcotics doesn’t mean we will continue them, even ifyou are running out.

When opioids are considered part of the treatment plan, you will be required to read and sign our narcotic agreement. You will be subjected to periodic drug testing, which under Virginia law requires that a test be done at a minimum of one (1) time every three (3) months for the first year and then very six (6) months thereafter. You may also randomly be called to bring your pills to the office, so we may count them. We routinely communicate with pharmacists, your other physicians, and your insurance company. If we learn that you are going to more than one pharmacy or doctor and getting pain medication of any kind from someone other than your APM doctor, you will be asked to leave the practice. Please keep your opioids in a safe place. All opioids should be stored in their original packaging inside a locked cabinet, lock box or a location where others cannot easily access them.

Discarding unused opiates can be done in several ways.

1. You can get a Drug Disposal Bag from the Health Department
2. You return unwanted prescription drugs for destruction at one of the authorized pharmacies listed at http://www.dhp.virginia.gov/pharmacy/destructionsites.asp .
3. You may mix them in used cat litter or other undesirable material and then throw into the trash separate from there container.

Remove labels before discarding the empty bottles/containers.

We start patients on opioids with the best intention of helping to ease pain, in order to improve function. If you develop sedation or dizziness, you should not drive a car or operate machinery as you may jeopardize the safety of yourself or others. Please notify us immediately if you experience side effects, or if you have concerns about your medication. Constipation is a common side effect of consistent narcotic use, and can be addressed with either over the counter or prescription medications. If you abruptly discontinue your pain prescription, you may experience nausea, vomiting, sweating, anxiety and increased pain. These symptoms are typical of withdrawal.

Occasionally, we discover during treatment that the use of opioids is not in your best interest. When this is the case, we will assist you in tapering off the medication, and help you look at other treatment options.

Once opioids are prescribed, you will need to be seen at least every three (3) months to receive your prescriptions; your doctor will decide this interval. Opioid prescriptions, once written, will not be replaced if lost. Most of our patients get at least a one-month supply of medication. Given that, if you phone in for early refills, we will not oblige. Please do not wait until late afternoon, Friday afternoon or weekends to notify us that you need a refill, as we will not be able to help you until we have access to your chart; this may take one or two (1-2) days.

You will be discharged from the practice if you break any of the following rule or at the discretion of the physician:

- Use more than we prescribe (run out early)
- Get pain medication from any other physician or person
- Act rudely on the phone to staff
- Use the medication in a way that was not prescribed
- Exhibit deceitful behavior or provide false information
- Attempt to get medication by using excuses such as the medication was lost or stolen, you are going out of town, etc.
- Make repeated calls to the office to obtain medication
- Call after hours (Monday –Friday, 8:30am-5:00pm) or on weekends or holidays to obtain medication
- Use multiple pharmacies
- Fail a urine drug screen (Indication of use of illegal, illicit or non-prescribed drugs, misuse of prescribed drugs, undetectable amounts of prescribed drugs in system)

If, at any time during our therapeutic relationship, we believe that you would benefit from seeing a behavioral psychologist, we expect you to go. These services could include education in pain coping skills, biofeedback, and help with adjustment issues.

These skills help to empower you and are often an essential ingredient to the success of an overall treatment plan.

We also work closely with local addictionologists who medical doctors are specializing in the disease of addiction. If we believe this has become an issue for you, we will expect you to seek appropriate help in this regard. If you do not comply you will no longer receive opioid prescriptions from this practice.

This authorizes Barr Center for Innovative Pain & Regenerative Therapies to request and receive from the Virginia Prescription Monitoring Program, information relating to Schedule II-V controlled substances dispensed to the patient named below. I understand that this authorization permits the Virginia Prescription Monitoring Program to disclose confidential health care records to the prescribers named above. A copy of the authorization shall be included with my original records. There is a potential for any information disclosed pursuant to the authorization to be subject to re-disclosure as permitted or required by law. I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified. This applies to the Virginia Prescription Monitoring Program website only.

Patient Signature_____ Date_____

Witness Signature_____ Date_____

Barr Center
for Innovative Pain & Regenerative Therapies

AUTHORIZATION FOR RELEASE

OF

PRESCRIPTION MEDICATIONS

I,_____hereby authorize The Barr Center to release my prescriptions to_____', in the event that I am unable to pick up my prescriptions.

_____ _____

Printed Name of Patient or Personal Representative Date

_____

Signature of Patient

Revised: 12/2018

Barr Center
for Innovative Pain & Regenerative Therapies

Medical History Questionnaire

DATE: _____

Name: _____ Age: _____ ☐ Right-Handed ☐ Left Handed

Referring Physician: _____ Primary Care Physician (PCP): _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____ City: _____

Reason for Visit: _____

Was there an initiating event for your pain? ☐ Yes ☐ No. If yes, please describe the event and any initial treatment

PAIN CHARACTERISTICS:

Describe your pain: ☐ Aching ☐ Burning ☐ Stabbing ☐ Sharp ☐ Shooting ☐ Numbness ☐ Pulsating ☐ Tingling ☐ Weakness ☐ Other: _____

Does the pain shoot or refer to another part of the body? ☐ Yes ☐ No

If yes, where? _____

Your pain is: ☐ constant ☐ Intermittent ☐ occasional _____

How many hours per day do you have pain? _____ Hours/day _____

How long have you been in pain? _____

Do you occasionally need to stop all activities because of pain? ☐ Yes ☐ No

If yes, number of times? ☐ Daily _____ ☐ Weekly _____ ☐ Monthly _____ ☐ Yearly _____

Have you ever previously experienced this type of pain? ☐ Yes ☐ No

If yes, what was done for you? _____

Pain Analogue Scale:

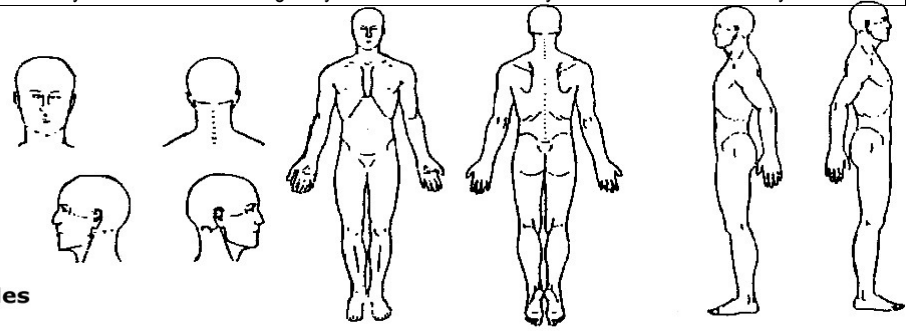
No Pain	*Minimal*		*Moderate*		*Intense*		*Emergency*
0	*1*	*2* *3*	*4*	*5* *6*	*7*	*8* *9*	*10*

Pain Diagram:

Please rate your pain: Today: ____ /10 Average day: ____ /10 Good Day: ____ /10 Bad Day ____ /10

- Please mark the areas of your pain. You may use the key to indicate different kinds of pain sensations.
- Please number each painful area in order of the most troublesome, i.e., 1-10 on the diagram.

Key:
- → - shooting
- /// - stabbing
- xxx - aching
- 000 - throbbing
- ●●● - pins & needles
- ••• - burning



Alleviating Factors: What makes your pain better? (please check all that apply)

☐ Medication ☐ Heat ☐ TENS ☐ Massage ☐ Traction ☐ Rest ☐ Movement ☐ Activity ☐ Exercise ☐ Stretching ☐ Sleep ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Nothing

☐ Other: _____

Exacerbating Factors: What makes your pain worse? (please check all that apply)

☐ Movement ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Driving ☐ Sleep ☐ Lack of sleep ☐ Stretching ☐ Exercise ☐ Bending ☐ Lifting ☐ Coughing ☐ Sneezing ☐ Tension ☐ Reaching over head ☐ Getting in/out of a chair ☐ Nothing

☐ Other _____

*****Please complete the following section ONLY IF you were involved in a motor vehicle accident.*****

Date of Accident: You were the: □ Driver □ Passenger in the □ front □ rear

You were: □ Rear-ended by another vehicle □ Rear-ended another vehicle □ Involved in a head on collision

□ T-boned by another vehicle □ Driver's Side □ Passenger's side □You T-boned another vehicle

□ Side-swiped driver's side □ Side-swiped on the passenger's side

You were the □ restrained □ unrestrained □ Driver □ Passenger in the □ front seat □ rear seat

Was there an air bag? □ Yes □ No Did it deploy? □ Yes □ No

Was anyone else injured in the accident? □ Yes □ No

Is there a Lawyer involved in your case? □ Yes □ No If yes, Name: _____

MEDICATION HISTORY

Please list all current medication (including over the counter medications) ***Please feel free to attach additional sheets if necessary.***

Medication	Indication	Dose	Prescribing Physician

ALLERGIES

□ **NO KNOWN DRUG ALLERGIES** □ Iodine □ Contrast Dye (IVP) □ Latex

Please list drug allergies, type or reaction and onset date, if known: _____

Any severe allergic Reactions (Anaphylaxis) to anything? □ Yes □ No If yes, to what, type of reaction and onset date:

_____

REVIEW OF SYSTEMS

CONSTITUTIONAL	□ Fever □ Weight Loss □ Weight Gain □ Weakness □ Fatigue □ Difficulty Sleeping □ Chills □ Night Sweats
EYES	□ Visual Problems □ Glaucoma
HENT	□ Headaches □ Sinus Problmes □ Hearing Problems □ Sleep Apnea
CARDIOVASCULAR	□ Heart Trouble □ Swelling of feet □ Hypertension □ Lower Extremity Swelling
RESPIRATORY	□ Cough □ Shortness of Breath
GASTROINTESTINAL	□ Liver Disease □ Hepatitis □ Gall Bladder Problems □ Reflux □ Bowel Problems □ Consitpation □ Diarrhea
GENITOURINARY	□ Kidney Stone □ Kidney Disease □ Bladder Problems □ Blood in Urine □ Reduced Libido (desire for sex)
INTEGUMENT	□ Dry Skin □ Rashes
NEUROLOGICAL	□ Seizures □ Stroke □ Peripheral neuropathy □ Numbness □ Memory or concentration difficulties □ Loss of Balance □ Falls □ Head Injuries
MUSCULOSKELETAL	□ Neck Pain □ Shoulder Pain □ Elbow Pain □ Wrist/Hand Pain □ Carpal Tunnel Syndrome □ Low Back Pain □ Hip Pain □ Knee Pain □ Foot/Ankle Pain □ Gout
ENDOCRINE	□ Thyrod Problem □ Diabetes □ Excessive Thirst
PSYCHIATRIC	□ Depression □ Anxiety □ Anger □ Guilt
HEME-LYMPH	□ Easy Bruising □ HIV Exposure □ Bleeding Problems
ALLERGIC-IMMUNOLOGIC	□ Seasonal Allergy Allergies □ Anaphylactic (Severe) Medication Allergies □ Anaphylactic (severe) Reaction to Bee Stings

PAST MEDICAL HISTORY

- ☐ **No significant Past Medical History**
- ☐ Alzheimer's disease/Dementia
- ☐ Anxiety
- ☐ Asthma/COPD
- ☐ Atrial fibrillation
- ☐ CANCER-Type: _____
- ☐ Cardiac pacemaker
- ☐ Chronic Regional Pain Syndrome (CRPS)
- ☐ Depression
- ☐ DVT (blood clot)
- ☐ Ehler's Danlos Syndrome
- ☐ Gastric ulcer
- ☐ Glaucoma
- ☐ Head Injury or Concussion
- ☐ Heart Disease (Coronary Artery Disease)
- ☐ Heart Failure
- ☐ Hernia
- ☐ High Cholesterol
- ☐ HIV/Aids Disease
- ☐ Hypertension (High Blood Pressure)
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Marfan Syndrome
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid arthritis
- ☐ Seizure disorder
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Stroke (CVA)
- ☐ Other Past Medical History:

SURGICAL HISTORY

☐ **No Pertinent Past Surgical History**

Please list all surgeries: _____

PREVIOUS TREATMENT

- ☐ Physical Therapy
- ☐ TENS
- ☐ Chiropractic
- ☐ Psychological support ☐ Yes ☐ No Name: _____
- ☐ Work Hardening
- ☐ Injections: _____
- ☐ Acupuncture
- ☐ Other: _____

Pain Clinics ☐ Yes ☐ No If yes, Where: _____ When? _____

FAMILY MEDICAL HISTORY

☐ **No Significant Family History** ☐ **Family History Unknown**

Condition:	Relative	Age	Condition	Relative	Age
☐ Cancer: TYPE: _____			☐ High blood pressure (Hypertension)		
☐ Diabetes			☐ Stroke		
☐ Heart disease (coronary artery disease)					

☐ **Other Family Medical Problems:** _____

SOCIAL HISTORY

- ☐ Able to care for self
- ☐ Able to drive
- ☐ Climbs stairs daily
- ☐ Regular exercise

Alcohol:

- ☐ Denies use ☐ Occasional use
- ☐ more than 15 drinks/week

Marital status:

- ☐ Single ☐ Married
- ☐ Divorced/separated ☐ Widow/Widower

Smoking: ☐ Denies

☐ Admits to smoking (____ packs/day) ☐ Former Smoker: Date Quit: _____

Substance Abuse : ☐ Denies

- ☐ In past (including alcohol)
- ☐ Use of illegal drugs in the last year

Work status:

- ☐ Student
- ☐ Does not work outside the home: ☐ Disabled ☐ Retired
- ☐ Works outside the home

Occupation: _____

Other important social issues: _____

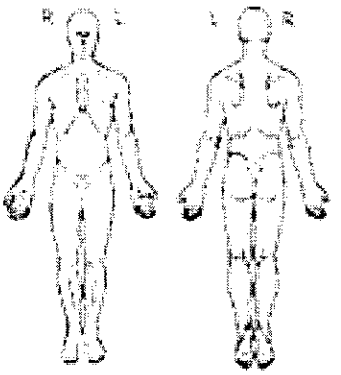
Barr Center
For Innovative Family Regenerative Therapies

FOLLOW-UP QUESTIONNAIRE

HT:_____WT:_____
BP:____/____ HR:____

Patient Name: _____ DOB:_____ Date:_____

What is your chief complaint today? _____
Have you had any diagnostic testing since last visit? YES/NO If yes, where_____
Do you have a new problem to address today? __Y __N If so, what is it? _____
Since your last visit are you: Better Worse Same _____
On a scale of 0-100%, how much better are you now? (If no better put 0%)____%
What is the quality of the pain?__Sharp_Dull_Stabbing _Throbbing _ Aching _Burning
The pain is now:__Constant__Intermittent (comes ang goes) _____
Does your pain wake you from your sleep?__Y__N _____
Does your pain radiate anywhere? If yes, where?
_____
Do you have? __Numbness__Tingling__Weakness_Loss of bowel or bladder function____None
What makes your symptoms/ pain worse? _____
What makes your symptoms/ pain better? _____



On a scale of 0-10 (10 being the worst), how severe is your pain now? 0 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS:

CONSTITUTIONAL	⌋ Fever · WeightLoss · WeightGain · Weakness · Fatigue · DifficultySleeping · Chills · NightSweats
EYES	⌋ Visual Problems · Glaucoma
HENT	⌋ Headaches · Sinus Problems · Hearing Problems · Sleep Apnea
CARDIOVASCULAR	⌋ Heart Trouble · Swelling of feet · Hypertension · Lower Extremity Swelling
RESPIRATORY	⌋ Cough · Shortness of Breath
GASTROINTESTINA	⌋ LiverDisease · Hepatitis · GallBladderProblems · Reflux · BowelProblems · Constipation · Diarrhea
GENITOURINARY	⌋ KidneyStone · KidneyDisease · BladderProblems · BloodinUrine · ReducedLibido(desireforsex)
INTEGUMENT	⌋ Dry Skin · Rashes
NEUROLOGICAL	⌋ Seizures · Stroke · Peripheralneuropathy · Numbness · Memoryorconcentrationdifficulties ⌋ Loss of Balance · Falls · Head Injuries
MUSCULOSKELETAL	⌋ NeckPain ShoulderPain ElbowPain Wrist/HandPain Carpal Tunnel Syndrome ⌋ Low Back Pain Hip Pain Knee Pain Foot/Ankle Pain Gout
ENDOCRINE	⌋ Thyroid Problem ϒDiabetes Type I or TypeII (please circle) ϒ Excessive Thirst
PSYCHIATRIC	⌋ Depression ϒAnxiety ϒAnger ϒGuilt
HEME-LYMPH	⌋ Easy Bruising ϒ HIV Exposure ϒ Bleeding Problems
ALLERGIC-IMMUNOLOGIC	⌋ Seasonal Allergy Allergies ϒ Anaphylactic (Severe) Medication Allergies ϒ Anaphylactic (severe) Reaction to Bee Stings

Patient Signature:_____**Date:** _____
MD/NP Signature:_____**Date:** _____