COASTAL VIRGINIA SPINE & PAIN CENTER

4525 South Boulevard
Suite 200
Virginia Beach, VA 23452
Phone: 757-227-3820
Fax: 757-226-9021

Thank you for choosing Coastal Virginia Spine and Pain Center to provide you with health care services. We appreciate your trust in us, and we pledge to do all that we can to accommodate your needs and expectations.

On the day of your appointment please arrive approximately thirty (30) minutes early, so that we can ensure all necessary paperwork is in order.

Your initial visit will require that you be in our office for approximately ninety (90) minutes. Occasionally, due to unforeseen circumstances, this length of time may be longer.

We also would like to familiarize you with some record-keeping items that will facilitate your visit with us. Enclosed, you will find the following forms. **Please complete each of these forms prior to your scheduled appointment.**

- ☐ Patient Registration Form
- ☐ General Consent/Agreement to Outpatient Services
- ☐ Physical Therapy Evaluation
- ☐ Short Musculoskeletal Assessment Form

The following documents are available for your review in our office or on our website www.CovaSpineandPain.com.

- Our Notice of Privacy Practices (HIPAA)
- Notice of Patient Rights and Responsibilities

On the day of your appointment, please bring your insurance card, a state-issued ID (driver's license, Virginia ID card) and your specialist co-pay in order to be seen.

The doctors and staff of Coastal Virginia Spine and Pain Center are dedicated to excellence in patient care, service and satisfaction. If you have any questions please do not hesitate to ask any staff member in our practice.

Sincerely,

Coastal Virginia Spine and Pain Center

COASTAL VIRGINIA SPINE & PAIN CENTER

PATIENT REGISTRATION

PLEASE PRINT

LAST NAME: _____ First:_____ MI: _____ Date of Birth: _____

Sex: ☐ M ☐ F ☐ Gender Neutral Transgender ☐ M ☐ F Social Security #:_____

Address:_____ City_____ State_____ Zip_____

PHONE: HOME:_____ CELL:_____ WORK:_____ E-MAIL: _____

Referring Physician: _____Patient PCP: _____

Preferred Pharmacy: _____ Phone: _____

Employer: _____Phone: _____

Marital Status: _____ If married, Spouse's Full Name:_____

EMERGENCY CONTACT: _____ Relationship to Patient: _____ Phone:_____

INSURANCE INFORMATION

(if Worker's Comp, please write W/C under Primary Insurance)

PRIMARY INSURANCE PLAN: _____

ID#_____ GROUP #:_____

Policy Holder: ☐ **SELF** **OTHER**

If Other: Last Name:_____ First Name_____ MI_____

Relationship to Patient: _____Policy Holder: Date of Birth:_____ Last 4 digits of SSN: _____

Address if different from patient: _____

SECONDARY INSURANCE PLAN: _____

IID#_____ GROUP #:_____

Policy Holder: **SELF** ☐ **OTHER**

If Other: Last Name:_____ First Name_____ MI_____

Relationship to Patient: _____ Policy Holder: Date of Birth:_____ Last 4 digits of SSN: _____

Address if different from patient: _____

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 training for our staff.

RACE: (Please check one) ☐ DECLINED

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other Race

ETHNICITY: (Please check one) ☐ DECLINED

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

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

SIGNED: _____ DATE:_____

GENERAL CONSENT/AGREEMENT
OUTPATIENT SERVICES

1. **CONSENT TO TREATMENT:** I hereby consent to treatment by Coastal Virginia Spine & Pain Center (COVA), their associates, and/or assistants, and accept responsibility for payment of fees for such medical services. I understand that treatment may include injections, manipulations, medication management, medical appliances, and/or other procedures as deemed necessary and appropriate. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.

2. **PAYMENT FOR SERVICES**: I understand that COVA may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to COVA. If I should receive the payments, I understand that I will be responsible for paying COVA. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. I understand and agree that if my plan does not pay the physician or their associates/assistants, I will have to do so. I understand that COVA will hold me responsible in any one of the following situations:

   a. When I choose to have a service that my health plan covers, but I do not obtain the required referral or authorization from my health plan.
   b. When I choose not to use my health plan and agree to pay for services myself. *(Use Do Not Bill Insurance Form)*
   c. When my health plan does not participate with COVA for the services I want, or need, and I agree to pay for my care myself.
   d. When I receive services that are not covered under my health plan.

3. **ADVANCED DIRECTIVES**: COVA does not honor Advanced Directives. Unexpected complications due to procedures and/or treatment are not natural causes, and therefore will be treated. This means that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative, or other stabilizing measures, and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment, or withdrawal of treatment measures already begun, will be ordered in accordance with your wishes, Advanced Directive, or Health Care Power of Attorney. The admitting facility is not affiliated, or in partnership with COVA.

4. **ELECTRONIC PRESCRIBING**: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to COVA for the purpose of continued treatment.

5. **RELEASE OF INFORMATION**: I authorize COVA to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.

   If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim, or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, physical therapy notes, and consultations.

   Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include, but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access by information; aggregating and comparing my information for quality

improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to blood borne diseases, such as HIV and AIDS.

6. **DISCLOSURE TO FAMILY AND FRIENDS**: I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

NAME	RELATIONSHIP	CONTACT NUMBER

7. **COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT**: I agree that when I provide my landline or cell phone number(s) below, I am giving express consent for COVA and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent, I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of COVA. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

   You may be contacted via voicemail or text to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health information. I consent to receiving healthcare communications at the phone number provided. This request to receive text messages applies to future communications unless I request a change in writing.

   Home Phone: _____ Cell Phone: _____

   OR

   ____ (initials) _____ I decline to receive communications via text

8. **NOTICE OF PRIVACY PRACTICES**: I acknowledge that I have received/reviewed COVA's Notice of Privacy Practices. I understand that I may contact the Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

9. **AUTHORIZATION FOR RELEASE OF PRESCRIPTIONS**: I hereby authorize COVA Spine and Pain Center to release my prescriptions to the following in the event that I am unable to pick up my prescriptions.

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

I agree to the items as outlined in the Agreement,

Name (Print): _____

Signature: _____ Date: _____

Relationship to Patient (Self/Parent/Personal Representative):_____

PHYSICAL THERAPY MEDICAL HISTORY QUESTIONNAIRE

DATE: _____

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

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

What is your PRIMARY Reason/Diagnosis for coming to physical therapy? ☐ Left ☐ Right

☐ Headache ☐ Face/Jaw Pain ☐ Neck Pain ☐ Shoulder Pain ☐ Arm Pain ☐ Thoracic Pain ☐ Rib/Chest Pain

☐ Abdominal Pain ☐ Low Back Pain ☐ Hip Pain ☐ Leg Pain ☐ Foot/Ankle Pain ☐ Other: _____

Please describe the event and any initial treatment. DATE OF INJURY/ONSET OF PAIN: _____

☐ Accident/Injury ☐ Work Related ☐ Motor Vehicle Accident ☐ Surgery ☐ After Illness ☐ Came on gradually ☐ Unknown

PAIN CHARACTERISTICS:

Describe your pain: ☐ Aching ☐ Deep Ache ☐ 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 Describe: _____

Your pain is ☐ Getting Better ☐ Getting Worse ☐ Staying the Same ☐ Progresses as the day progresses _____

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? _____

Do you have any of the following with your pain?

-Tingling/numbness in the hands/feet? ☐ Yes ☐ No

-Weakness in the hands/feet? ☐ Yes ☐ No

-Dragging of the foot while walking? ☐ Yes ☐ No ☐ Left ☐ Right

-Pain radiating to the arm/forearm/hands? ☐ Yes ☐ No

-Pain radiating to the thigh/buttocks/legs/feet ☐ Yes ☐ No

-Difficulty holding bladder or bowel movement ☐ Yes ☐ No

Which of the following affects your pain? *PLEASE Mark "B" for Better and "W" for Worse*

B W Massage/Rubbing	B W Coughing	B W Strong emotions	B W Standing	B W Alcohol
B W Sudden Movements	B W Anxiety	B W Getting Out of Bed	B W Running	B W Coffee/Tea/Caffeine
B W Noise	B W Heat	B W Sitting	B W Bright Light	B W Eating
B W Cold Weather	B W Lying Down	B W Walking	B W Bending	B W Sleep/Rest
B W Vibration	B W Ice	B W Physical Therapy	B W Straining	B W Distraction (TV/Reading)
B W Wet Climate	B W Fatigue	B W Reaching	B W Lifting	B W Work/Hobbies
B W Medication	☐ Other _____			

EFFECTIVE: 1/02/2019
REVISED: 1/17/2024

SLEEP PATTERNS:

Do you have trouble falling asleep? ☐ Never ☐ 1-2 times/week ☐ 3-5 times/week ☐ 6-7 times/week

How long does it take for you to fall asleep? _____

Do you wake up in the middle of the night because of pain? ☐ Never ☐ 1-2 times/week ☐ 3-5 times/week ☐ 6-7 times/week

How long does it take for you to return to sleep? _____

Need for medication to sleep? ☐ Never ☐ 1-2 times/week ☐ 3-5 times/week ☐ 6-7 times/week

What sleep medication do you take? (Include over-the-counter medications):

How many hours of sleep do you average per night? _____ Hours. Do you feel rested when you wake? ☐ Yes ☐ No

How many hours of sleep do you need to feel rested? ____ Do you take or need to take daytime naps? ☐ Yes ☐ No

Primary sleeping position: ☐ Back ☐ Left Side ☐ Right Side ☐ Stomach Number of pillows used: _____

Do you have any pets that sleep with you at night? ☐ Yes ☐ No _____

MEDICATION HISTORY ☐ **No Medication is used**

Please list all current medication (including Over-The-Counter medications) ***Please feel free to attach additional sheets if necessary.***

Medication	Indication	Dose	Prescribing Physician

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

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 ☐ Thyroid 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

What assistive do you have to or need to use for walking or for support?

☐ None ☐ Cane/walking stick ☐ Crutches ☐ Walker ☐ Brace ☐ Wheelchair ☐ Motorized scooter

Do you have stairs at home? ☐ Yes ☐ No How many in to the house: ____ In the house: ____

Do you have trouble navigating stairs? ☐ Yes ☐ No If Yes, describe: _____

Have you fallen in the recent past? ☐ Yes ☐ No If Yes, how many times. _____

Have you attended a Balance Clinic? ☐ Yes ☐ No If Yes, When _____ Where _____

GENERAL HEALTH: CURRENT: ☐ Excellent ☐ Good ☐ Fair ☐ Poor **PREVIOUS** ☐ Excellent ☐ Good ☐ Fair ☐ **Poor**

EFFECTIVE: 1/02/2019
REVISED: 1/17/2024

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
☐ Diabetes
☐ DVT (Blood Clot)
☐ Gastrointestinal Issues
☐ Glaucoma
☐ Head Injury or Concussion
☐ Heart Disease (Coronary Artery Disease)
☐ Heart Failure
☐ Hernia
☐ High Cholesterol
☐ HIV/Aids Disease
☐ Hypertension (High Blood Pressure)
☐ Hypermobility Syndrome
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ 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
☐ Chiropractic
☐ Dental
☐ TENS/Electrical Stimulation Unit (Home Use)
☐ Psychological support ☐ Yes ☐ No Name: _____
Pain ☐ Yes ☐ No If yes, Where: _____ When? _____
☐ Work Hardening
☐ Acupuncture
☐ Injections: _____
☐ Radiofrequency Ablations
☐ Other: _____

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: _____

How does your pain limit your daily function? _____

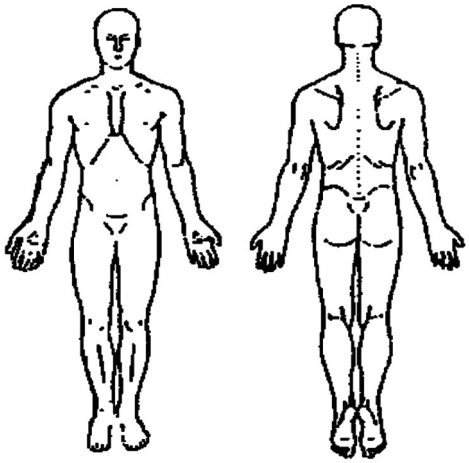
What specific activities are you limited in or not able to do that you hope to improve? _____

What are your goals/expectations for physical therapy for your primary problem?

☐ Decrease pain ☐ Increase Function ☐ Learn Management Skills ☐ Ability to Return to Full Pre-Injury/Pain Status
☐ Other: _____

SHORT MUSCULOSKELETAL FUNCTION ASSESSMENT

NAME: _____ **DOB:** _____ **DATE:**_____



Please rate your pain over this past week. **Only circle one answer per question. . Please shade in the primary areas of pain your are being seen for today.**

Worst pain this past week:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (Lots of Pain)
Least pain this past week:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (Lots of Pain)
Average pain this past week:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (Lots of Pain)
Current pain:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (Lots of Pain)

These questions are about **how much difficulty you may be having this week** with your daily activities because of your injury, condition or pain.

Please circle only one answer and answer ALL questions.	Not At All Difficult	A Little Difficult	Moderately Difficult	Very Difficult	Unable To Do
01. How difficult is it for you to get in or out of a low chair?	0	1	2	3	4
02. How difficult is it for you to open medicine bottles or jars	0	1	2	3	4
03. How difficult is it for you to shop for groceries or other things?	0	1	2	3	4
04. How difficult is it for you to climb stairs?	0	1	2	3	4
05. How difficult is it for you make a tight fist?	0	1	2	3	4
06. How difficult is it for you get in or out of the bathtub or shower?	0	1	2	3	4
07. How difficult is it for you to get comfortable to sleep?	0	1	2	3	4
08. How difficult is it for you to bend or kneel down?	0	1	2	3	4
09. How difficult is it for you to use buttons, snaps, hooks or zippers?	0	1	2	3	4
10. How difficult is it for you to cut your own fingernails?	0	1	2	3	4
11. How difficult is it for you to dress yourself?	0	1	2	3	4
12. How difficult is it for you to walk?	0	1	2	3	4
13. How difficult is it for you to move after sitting or lying down?	0	1	2	3	4
14. How difficult is it for you to go out by yourself?	0	1	2	3	4
15. How difficult is it for you to drive?	0	1	2	3	4
16. How difficult is it for you to clean yourself after going to the bathroom?	0	1	2	3	4
17. How difficult is it for you to turn knobs or levers (i.e. opening doors, roll down car windows)?	0	1	2	3	4
18. How difficult is it for you to write or type?	0	1	2	3	4
19. How difficult is it for you to pivot?	0	1	2	3	4
20. How hard is it for you to do your usual physical recreational activities (i.e. biking, jogging, walking)?	0	1	2	3	4
21. How hard is it for you to do your usual leisure activities (i.e. crafts, gardening, playing cards, going out with friends)?	0	1	2	3	4
22. How much difficulty are you having with sexual activity?	0	1	2	3	4
23. How difficult is it for you to do light housework or yard work (i.e. dusting, washing dishes, watering plants)?	0	1	2	3	4
24. How difficult is it for you to do heavy housework or yard work (i.e. vacuuming/ washing floors, mowing lawns)?	0	1	2	3	4
25. How difficult is it for you to do your usual work (i.e. paid job, housework, volunteer activities)?	0	1	2	3	4

EFFECTIVE: 1/02/2019
REVISED: 1/17/2024

SHORT MUSCULOSKELETAL FUNCTION ASSESSMENT

NAME: _____ **DOB:** _____ **DATE:**_____

These next questions ask how often you are experiencing problems **this week** because of you injury, condition or pain.

Please circle only one answer, and answer ALL questions.	None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time
26. How often do you walk with a limp?	0	1	2	3	4
27. How often do you avoid using your painful limb(s), neckor back?	0	1	2	3	4
28. How often do you have your leg lock or give way?	0	1	2	3	4
29. How often do you have problems with concentration?	0	1	2	3	4
30. How often do you find too much in one day affects what you do the next day?	0	1	2	3	4
31. How often do you act irritable toward those around you, (i.e. snap at people, give sharp answers or criticize easily)?	0	1	2	3	4
32. How often are you tired?	0	1	2	3	4
33. How often do you do you feel disabled?	0	1	2	3	4
34. How often to you feel angry or frustrated that you have this injury, condition or pain?	0	1	2	3	4

These next questions are about **how much you are bothered** by problems you are having **this week** due your injury, condition or pain. *Please circle only one answer and answer ALL questions*.

How much are you bothered by:	Not Bothered At All	A Little Bothered	Moderately Bothered	Very Bothered	Extremely Bothered
35. Problems using your hands?	0	1	2	3	4
36. Problems using your neck or back?	0	1	2	3	4
37. Problems doing work around your home?	0	1	2	3	4
38. Problems with bathing, dressing, toileting or other personal care?	0	1	2	3	4
39. Problems with sleep and rest?	0	1	2	3	4
40. Problems with leisure or recreational activities?	0	1	2	3	4
41. Problems with your friends, family or other important people in your life?	0	1	2	3	4
42. Problems with thinking, concentrating or remembering?	0	1	2	3	4
434. Problems adjusting or coping with your injury or condition?	0	1	2	3	4
44. Problems doing your usual work?	0	1	2	3	4
45. Problems with feeling dependent on others?	0	1	2	3	4
46. Problems with stiffness and pain?	0	1	2	3	4

For Office Use Only **DYSFUNCTION INEX: _____% BOTHER INDEX: _____% PAIN SCORE: _____/10**

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