



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



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

-Weakness in the hands/feet? Yes No -Pain radiating to the thigh/buttocks/legs/feet Yes No

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

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 Problems 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

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
- Other Past Medical History: _____

- 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)

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

NAME: _____

DOB: _____

DATE: _____

FUNCTION ASSESSMENT

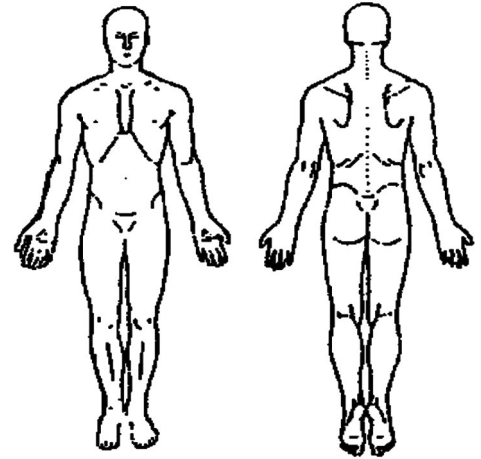
Please rate your pain over this past week. **Only circle one answer per question.** . Please shade in the primary areas of pain you are being seen for today.

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

SHORT MUSCULOSKELETAL FUNCTION ASSESSMENT

NAME: _____ DOB: _____ DATE: _____

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

Please circle only one answer, and answer ALL questions.	None of <u>the Time</u>	A Little of <u>the Time</u>	Some of <u>the Time</u>	Most of <u>the Time</u>	All of <u>the Time</u>
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), neck or 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 feel disabled?	0	1	2	3	4
34. How often do 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 to your injury, condition or pain. *Please circle only one answer and answer ALL questions.*

How much are you bothered by:	Not Bothered <u>At All</u>	A Little <u>Bothered</u>	Moderately <u>Bothered</u>	Very <u>Bothered</u>	Extremely <u>Bothered</u>
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
43. 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