Med Cannabis Care
New Patient Evaluation Form

Name:_____ D.O.B._____ Today's Date:_____

Chief Complaint and History of Present Illness

Please circle your qualifying condition:

□ Cancer □ Epilepsy □ Glaucoma □ HIV □ AIDS □ PTSD □ ALS

□ Crohn's □ Parkinson's Disease □ Multiple Sclerosis

□ other debilitating medical conditions of the same kind or class or as comparable to those listed above (this may include Generalized Anxiety Disorders, Fibromyalgia, Irritable Bowel Syndrome, Nerve Pain and Neuropathies, Migraines, Painful Muscle Spasm, Tremors, Muscular Dystrophy, Diabetic neuropathies and many other related ailments)

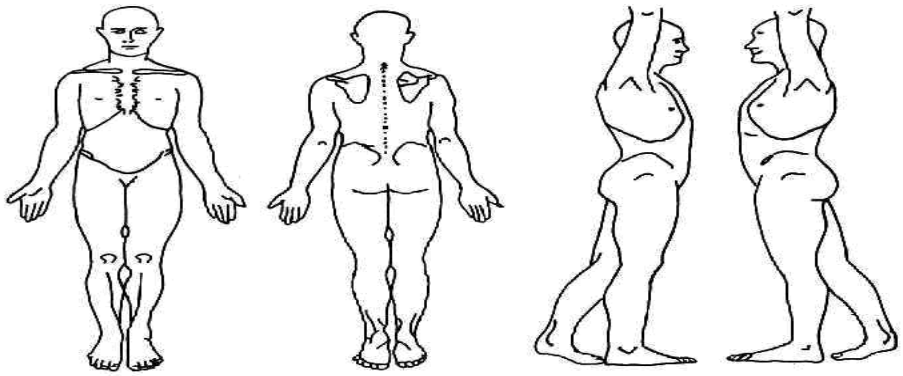
Please list your **DAILY SEVERE AREAS OF PAIN** only:

LOCATION: _____

Start date: _____ Due to: _____

□ gradual □ sudden □ constant □ comes/goes □ better □ worse □ same

Mark your **MOST SEVERE** areas of pain? Mark and draw below (draw 'X' on most severe areas of pain and use arrows for radiating pain)



Describe your pain: □ ache □ burn □ cramp □ dull □ sharp □ stabbing □ tearing □ throb □ numbness □ pins/needles

Rate your pain level **NOW**:	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10
WORST pain level in past week:	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10
LOWEST pain level in past week:	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10

Associated symptoms:

- □ numbness
- □ weakness
- □ fevers
- □ chills
- □ weight loss
- □ loss of bladder control
- □ loss of bowel control
- □ can't empty bladder
- □ imbalance
- □ stiffness
- □ swelling
- □ redness/warmth
- □ sleep problems
- □ Other_____

Please list recent imaging:

X-rays:	□ neck	□ low back	□ other		Dates: _____
MRI:	□ neck	□ low back	□ head	□ other	Dates: _____
CT scans:	□ neck	□ low back	□ head	□ other	Dates: _____

EMG/Nerve Study: □ yes Dates: _____

Other: _____ Dates: _____

Past treatments:

□ Rest
□ Ice
□ Heat
□ Exercise program
□ Physical therapy
□ TENS
□ Bracing
□ Chiropractic
□ Joint injections
□ Trigger point injections
□ Facet joint injections
□ RFA/Rhizotomy
□ Epidurals
□ Nerve blocks: _____
□ Spinal cord stimulator
□ Pain pump
□ Other: _____

Past medications: (indicate the PAIN medications you have tried in the **PAST** and **NOT** currently taking):

Anti-inflammatories:

□ ibuprofen (Motrin/Advil)
□ naproxen (Aleve)
□ meloxicam (Mobic)
□ diclofenac (Voltaren/ Pennsaid/Flector)
□ Indomethacin (Indocin)
□ piroxicam
□ Relafen
□ Toradol
□ Celebrex
□ sulindac
□ etodolac (Lodine)
□ aspirin (BC/Goody's/Bayer/Excedrin)

Muscle Relaxers:

□ Baclofen
□ Flexeril
□ Robaxin
□ Soma
□ Skelaxin
□ Zanaflex
□ Valium
□ Norflex

Opioids:

□ tramadol (Ultram/Ultracet)
□ hydrocodone (Lortab/Vicodin /Lorcet/Norco)
□ oxycodone (OxyContin/Endocet /Percocet/Tylox)
□ Dilaudid
□ morphine (Kadian, MS Contin)
□ Opana
□ Methadone
□ fentanyl (Duragesic/Actiq)
□ Nucynta
□ Exalgo
□ Butrans
□ Suboxone (buprenorphine)
□ Tylenol/codeine (Tylenol #3/#4)

Nerve Medicines:

□ gabapentin/Neurontin
□ Lyrica
□ Cymbalta
□ amitriptyline (Elavil)
□ nortriptyline (Pamelor)
□ Savella
□ Topamax
□ Tegretol
□ Trazodone

Other:

□ Lidoderm
□ capsaicin
□ menthol

Past evaluations:

Have you seen a **PAIN MANAGEMENT SPCECIALIST** in the past? □ Yes □ No, if yes then who? _____

List the pain medications they were recently prescribing you **IF you are not currently taking them:**

Medication	Dose	Number of pills/day

Were you discharged from the practice? □ Yes □ No. If yes, why? _____

List **ANY OTHER** specialists you have seen about your pain: _____

Medications

Please list all medications that you are currently taking, **INCLUDE OVER THE COUNTER**

Medication Name	Dosage	Frequency	Who Prescribed Medication

Allergies

List Allergies	Reaction you had

Past Medical History

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Abuse-sexual or domestic
- ☐ Acid reflux
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arrhythmia
- ☐ Atrial fibrillation
- ☐ Bipolar disorder
- ☐ Blood clots
- ☐ Brain injury
- ☐ Cancer (type: _____, remission?: ☐ yes ☐ no)
- ☐ COPD (home oxygen?: ☐yes ☐ no)
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Fractures: _____
- ☐ Gastrointestinal disease
- ☐ Gout
- ☐ Heart disease
- ☐ Hypertension
- ☐ Kidney stones
- ☐ Lupus
- ☐ Migraines
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Sleep apnea (CPAP?: ☐ yes ☐ no)
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Ulcers
- ☐ Other: _____

Past Surgical History

Provide a complete list of **ALL** surgeries. (Use back of page if necessary)

☐ Spine surgery (cervical/thoracic or lumbar?, number of times, levels involved and dates):_____

_____

☐ ALL OTHER:_____

_____

_____

Family History

Please list any major illness in your family:

- ☐ Autoimmune disease
- ☐ Back/spine problems
- ☐ Bleeding disorder
- ☐ Stroke
- ☐ Chronic pain
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hypertension
- ☐ Cancer, type?: _____
- ☐ Mental disorder
- ☐ Neuropathy
- ☐ Substance abuse
- ☐ Lupus
- ☐ Tobacco dependence
- ☐ Other: _____

Social History

Tobacco Use: ☐ Never ☐ Quit ☐ Current: ☐ daily ☐ some days of week for _____ # of years

Marital Status (circle one): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic partner

Occupation: ☐ employed, type of work:_____ ☐ unemployed ☐ retired ☐ student ☐ disabled

Education: ☐ high school grad, if no highest grade:____ ☐ trade school ☐ college ☐ graduate/professional school

Alcohol Use: ☐ Never ☐ # of Beer(s)/week_____ ☐ # of Liquor drinks/week_____ ☐ # of Wines/week_____

☐ Recovering Alcoholic: # of years sober_____

Illicit Drug Usage: ☐ Never ☐ Past History ☐ Current. Please list drugs used _____

Drug/Alcohol Abuse Treatment in Past: ☐ Yes ☐ No. If yes, ☐ In-Patient ☐ Out-Patient ☐ Both

Exercise (circle one): ☐ Not Exercising ☐ Occasional ☐ Moderate ☐ Heavy

Difficulty Walking/Climbing: ☐ Yes ☐ No

Able to Care for Self: ☐ Yes ☐ No, Caregiver: ☐ Yes ☐ No

Review of Systems

Symptoms you are CURRENTLY having only:

Constitutional	ENT	CV	Resp	GI
☐ Lethargy/sedation ☐ Fevers ☐ Weight loss	☐ Hearing loss ☐ Snoring	☐ Fainting ☐ Palpitations	☐ Short of breath ☐ Sleep apnea	☐ Nausea/vomiting ☐ Constipation
GU	**Neuro**	**Psych**	**Heme/Lymph**	**Skin/Allergy**
☐ loss of urine control ☐ Urinary retention	☐ Seizures ☐ Dizziness	☐ Depression ☐ Anxiety ☐ Insomnia	☐ Swollen glands ☐ Easy bruising	☐ rashes ☐ itching ☐ allergic reaction

By signing below I certify that the above information is true to the best of my knowledge and I consent for the provider to evaluate, and treat me for the condition or conditions present above.

_____ _____

Signature of Patient, Guardian or Patient Representative Date

Med Cannabis Care

Max Shokat, DO
Fax 855-313-1262

CONSENT TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and consent that _____ to release healthcare information of the patient named above to:

Med Cannabis Care

Address: 621 SW Baya Dr, Suite 102

City: Lake City State: FL Zip Code: 32025

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I consent the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I consent the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS CONSENT EXPIRES 180 DAYS AFTER IT IS SIGNED.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may us or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Rev. 11/23/09

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy note; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____ Signature:_____ Date: _____

Med Cannabis Care

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Southern Interventional Pain Center for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- The services provided at Med Cannabis Care ARE NOT covered by insurance.
- Patients are responsible for payment prior to services being performed.
- All payments are due at time of service.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned checks - $30.00
    - Collection fee - any fee incurred by Med Cannabis Care for the purposes of collecting a debt through the use of an outside debt collection agency
    - Charge for missed appointments - if a patient cancels or 'no shows' less than 48 hours of their appointment time then a $50 admin fee will be charged and must be paid prior to rescheduling an appointment.
    - **PLEASE NOTE** – repeated tardiness to an appointment (greater than 15 minutes late) will be considered a missed appointment

By my signature below, I acknowledge that I have received and understand the patient financial responsibilities of Med Cannabis Care.

Patient Name _____

Patient/Guardian Signature _____ Date_____