Faith Healthcare Inc.

Administrative Office

340 Clifty Street – Suite 1,

Somerset, KY 42501

(P) 606-425-5768 · (F) 606-425-5769

Science Hill Community Care
5775 N Hwy 27 – Suite 6,
Science Hill, KY 42553
(P) 606-685-6131 · (F) 606-685-6179
(F) 855-359-2404

Community Care Clinic
126 Franklin Drive,
Monticello, KY 42633
(P) 606-396-3534 · (F) 606-396-3535
(F) 606-396-3536

Nancy Family Care
9919 West Hwy 80,
Nancy, KY 42544
(P) 606-288-0019 · (F) 606-288-0020
(F) 855-618-2148

Mount Vernon Community Care
325 Richmond Street,
Mount Vernon, KY 40456
(P) 606-331-5720 · (F) 606-208-9348

LC Rheumatology Somerset
26 Oxford Way – Suite A,
Somerset, KY 42503
(P) 606-802-2300 · (F) 866-538-6128

LC Rheumatology London
1675 S Main Street – Suite 4,
London, KY 40741
(P) 606-266-8266 · (F) 606-266-8300

Patient Information **Date** _____

Patient Name _____ **Birthdate**_____

Address _____ **City** _____ **State** _____ **Zip** _____

SS# _____ **Home Phone** _____ **Cell/Alternate** _____

Email address _____

Pharmacy Name/Location _____ **Phone** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

Employer _____ **Phone** _____ **Occupation** _____

Income: Self _____**Weekly/Bi-weekly/ Annually Hourly rate**_____ **Hours worked per week**_____
Spouse _____**Weekly/Bi-weekly/ Annually Hourly rate**_____ **Hours worked per week**_____
Household size _____

Father _____ SS# _____ Birthdate _____ Employer _____
Mother _____ SS# _____ Birthdate _____ Employer _____

Are you a Veteran? ☐ Yes ☐ No **Do you smoke?** ☐ Yes ☐ No **Are you disabled?** ☐ Yes ☐ No

Living Situation: ☐ Own ☐ Rent ☐ Motel/Hotel ☐ Car/Vehicle ☐ Halfway House/Shelter ☐ Homeless Shelter ☐ Permanent Supportive Housing ☐ Street ☐ Transitional ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Domestic Partner

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other ☐ Do not wish to disclose

Pronouns: ☐ he/him/his/his/himself ☐ she/her/her/hers/herself ☐ they/them/their/theirs/themselves

Another Pronoun, please specify:

Sexual Orientation: ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Other ☐ Unsure ☐ Do not wish to disclose

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Student

Migrant Worker? ☐ Yes ☐ No

Education Level Completed: ☐ Less than High School Graduate ☐ High School Graduate
☐ Some College/Associate's Degree ☐ Bachelor's Degree or higher

What language should your information be provided in? _____

How well do you understand English? ☐ Very Well ☐ Moderate ☐ Very Little ☐ None

Advanced Directives: ☐ Yes (please provide a copy) ☐ No

Insurance Information

Is this a Workman's Compensation or auto insurance claim? (If so, please provide this information) ☐ Yes ☐ No

Do you have Medicaid? ☐ Yes ☐ No **Have you applied?** ☐ Yes ☐ No **Policy Number?** _____

Do you have health insurance? ☐ Yes ☐ No

Name of Insurance _____

Person Carrying Insurance _____ Birthdate _____ Relationship _____

I understand that my medical information is confidential. I authorize the exchange of information between Faith Healthcare and any other providers or organizations only as necessary for treatment, payment, or healthcare operations purposes. Patient rights and confidentiality policies are posted in our waiting room and copies are available upon request.

I hereby acknowledge the above statements and authorize treatment by Faith Healthcare. Initials _____

I authorize Faith Healthcare to release my medical records to my insurance carrier, worker's compensation carrier, and/or my attorney. I hereby assign all medical benefits, to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plan, to Faith Healthcare. This assignment and authorization will remain in effect unless revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all medical charges associated with my treatment, whether they are paid by an insurance company or not.

Patient Signature or guardian (if minor) _____ Date _____

Name and relationship (if not patient) _____ Date _____

Health and Psychiatric History

Name _____ **Birthdate** _____ Age _____

Are you here for a routine exam? ☐ Yes ☐ No

MEDICAL HISTORY – Please check if you have had any of the following:

___ Anemia
___ Eye Problems
___ Severe Headaches
___ Diabetes
___ High Blood Pressure
___ Heart Disease
___ Asthma
___ Lung Disease
___ Cancer
___ Seizure
___ Thyroid Problem
___ Breast Lump
___ Allergies

___ Swollen Legs/Ankles
___ Varicose Veins
___ Blood Clots
___ Bleeding Problems
___ Stomach Problems
___ Bowel Problems
___ Kidney Problems
___ Liver Problems
___ Gallbladder Problems
___ Urinary Tract Infections
___ Sexually Transmitted Disease
___ Pelvic Infections
___ Arthritis

___ Osteoporosis
___ Broken Bones
___ Serious Injury/MVA
___ eating disorder
___Personality Disorder
___ Severe Depression
___ Bipolar Disorder
___ Anxiety

___ Hallucinations __ visual __ auditory
___Attention Deficit Hyperactive Disorder
___ Schizophrenia
___ Mood Disorders
___Oppositional Defiant Disorder (ODD)
___Major Depressive Disorder (MDD)
yes / no Previous suicidal attempts
___ Post Traumatic Stress Disorder (PTSD)

WOMEN

Date of last menstrual period
_____/ _____/ _____

# of Pregnancies _____

# of Births _____

Please describe/explain any of the above problems	**List any PSYCHIATRIC CARE, HOSPITALIZATIONS or SURGERIES you have had. Please list the facility and the year.**

Are you disabled? YES / NO If yes please list the reason(s) why.

_____

Do you have any legal issues? _____

FAMILY HISTORY (Father, Mother, Brother, Sister, Grandmother, Grandfather)

	Relationship		**Relationship**
___ Diabetes	_____	___ Breast Cancer	_____
___ Stroke	_____	___ Colon Cancer	_____
___ Heart Disease	_____	___ Ovarian Cancer	_____
___ High Blood Pressure	_____	___ Other Cancer	_____
___ High Cholesterol	_____	___ Osteoporosis	_____
___ Anemia	_____	___ Depression	_____
___ Chronic Lung Disease	_____	___ Anxiety	_____
___ Bleeding Problems	_____	___ Drug/Alcohol Problems	_____

FAMILY HEALTH – List the present age/health status of the following family members. If deceased, then list age and cause of death.

FATHER _____ MOTHER _____ SIBLINGS _____

SOCIAL HISTORY and PSYCHOSOCIAL HISTORY

Habits

___ **Smoking** If yes, how many packs a day? _____ How many years? _____

___ **Smokeless Tobacco use** If yes, what type? _____ How many years? _____

___ **Alcohol** If yes, how many drinks a day? _____ Drinks per week? _____

___ **Street drug use** If yes please circle what type. **Opiates, Alcohol, Methamphetamine, Cocaine, Heroin, Kratom, Delta 8/CBD, Fentanyl, other**

___ **Caffeine oz per day _____**

___ **Seat belt use**

___ **Regular exercise**

Personal Profile

Marital Status ___ Married ___ Single ___ Divorced ___ Widowed

Number of living children _____ How many live with you and who are they _____

School completed: ___ High School ___ College ___ Graduate Degree

Current/Most recent job: _____

Other

Are you or have you been **sexually/physically** mistreated? _____

Do you want to talk to someone about this? _____

Review of Symptoms – Check all symptoms that you are currently experiencing

Constitutional

___ Fever
___ Chills
___ Sweats/Night Sweats
___ Fainting
___ Weight Change
___ Fatigue
___ Seizures
___ Dizziness
___ Sleeping difficulties

Eyes

___ Change in Vision
___ Burning/itching eyes
___ Blurred/double vision
___ Redness/Eye pain

Ears, Nose, Mouth, Throat

___ Ear pain
___ Ringing in ears
___ Dry mouth
___ Colds
___ Sore throat
___ Hoarseness
___ Difficult swallowing

Respiratory

___ Shortness of breath
___ Chronic cough
___ Bloody sputum
___ Wheezing

Cardiovascular

___ Chest Pain
___ Palpitations/heart fluttering

Gastrointestinal

___ Abdominal Pain
___ Heartburn, indigestion
___ Nausea/Vomiting
___ Change in Appetite
___ Change in bowel habits
___ Constipation of diarrhea
___ Dark/Bloody stools
___ Rectal bleeding

Urinary

___ Painful urination
___ Frequent urination
___ Urinary urgency/incontinence
___ Blood in urine
___ Getting up at night to urinate

Musculoskeletal

___ Backache, back pain
___ Weakness
___ Joint pain/stiffness
___ Muscle cramps
___ Swelling of hands, feet, ankles
___ Leg pain, redness

Skin

___ Change in moles, freckles
___ Rash
___ Change in hair growth, loss
___ Nodule

Hematologic/Lymphatic

___ Swollen lymph glands
___ Easy bruising
___ Easy bleeding

Endocrine

___ Excessive thirst/urination
___ Cold/Heat intolerance

Breast

___ Breast Lumps
___ Breast Pain
___ Breast Nipple Discharge

Neurological/Emotional

___ Memory Change
___ Numbness/tingling
___ Depression
___ Anxiety
___ Mood swings

Women

___ Bleeding/pain with intercourse
___ Vaginal discharge/odor
___ Pelvic pain
___ Vulvar/vaginal itching/burning
___ Excessive menstrual bleeding
___ Menstrual cramps
___ Problems with sexual function

Men

___ Pain/lump in testicles
___ Difficulty with erections
___ Problems with sexual function

Faith Healthcare, Inc.

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: YOU HAVE THE RIGHT, AS A PATIENT, TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED SURGICAL, MEDICAL OR DIAGNOSTIC PROCEDURE TO BE USED SO THAT YOU MAY MAKE THE DECISION WHETHER OR NOT TO UNDERGO ANY SUGGESTED TREATMENT OR PROCEDURE AFTER PLAN HAS BEEN RECOMMENDED. THIS CONSENT FORM IS SIMPLY AN EFFORT TO OBTAIN YOUR PERMISSION TO PERFORM THE EVALUATION NECESSARY TO IDENTIFY APPROPRIATE TREATMENT AND/OR PROCEDURE FOR ANY IDENTIFIED CONDITIONS(S).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating:

- This consent in continuing in nature even after a specific diagnosis has been made and treatment recommended
- You consent to treatment at this office or any other satellite office under common ownership
- This consent will remain fully effective until it is revoked in writing
- You have the right at any time to discontinue services

You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider. We encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary to perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Date

Faith Healthcare, Inc.

Telehealth Consent Form

Patient Name: _____ Birthdate: _____

- This form is for your consent for participation in telehealth sessions, visits, etc. with your provider as needed.
- All existing laws and regulations regarding your access to treatment information apply during all telehealth visits. The visit will not be recorded or stored for any purpose. Appropriate and reasonable efforts have been made to eliminate confidentiality and/or privacy risks associated with the modality of telehealth. All existing confidentiality protections under federal law apply to information disclosed during a telehealth visit.
- The system that will be used during telehealth visits is compliant with HIPAA, however it is your responsibility as the patient to be in a confidential and secure environment (both digitally and physically) to ensure that your health information is protected.
- Patients who participate in telehealth visits are prohibited from recording, taking screenshots, or allowing non-approved individuals to participate in the telehealth visit. Your provider has the right to discontinue or refuse telehealth visits if they feel the surrounding environment is not appropriate or private enough for the patient or provider.
- During your telehealth visit, the provider will introduce themselves and anyone else present in the provider's room at the time.
- There are limitations with telehealth visits, such as being unable to conduct physical examinations, which may limit your provider's ability to diagnose and treat certain conditions. Telehealth visits may require follow-up visits in person based on the diagnosis made. Not all visit types will be acceptable, nor desirable, to be performed via telehealth.
- Potential risks associated with telehealth visits include interruption of the audio/video link or disconnection from the internet on either the patient's or provider's end.

Signature: _____ Date: _____

Faith Healthcare, Inc.

Controlled Medication Agreement

This contract is binding between myself and my primary care provider at Faith Healthcare, Inc. regarding this policy for being prescribed any controlled substance(s) for the treatment of pain, anxiety, seizures, obesity, or other diagnosis of medical conditions that necessitate said substance(s).

I understand and voluntarily agree that:

- I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.
- I will participate in all other types of treatment I am asked to do.
- I will keep the medication safe, secure, and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.
- I will take my medication as instructed and not change the way I take it without first talking to my prescriber/primary care provider.
- I will not call between appointments, at night, or at the weekends to request a refill. I understand that prescriptions will be filled only during scheduled office visits with the treatment team of Faith Healthcare.
- I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the office staff immediately.
- I will treat the office staff respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients, my treatment will be stopped.
- I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.
- I will sign a release form to let the prescriber/primary care provider speak to all other doctors or providers that I see.
- I will inform the staff and primary care provider at Faith Healthcare of all other medications that I take and make it known right away if I have a prescription for a new medication.
- I will only use one pharmacy to get my medication(s).
- I will not get any opioid pain medications that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium, etc.) or stimulants (Ritalin, amphetamines, etc.) without telling a member of the treatment team at Faith Healthcare before I fill that prescription. I understand that the only exception to this is if I need pain medication for an emergency at night or on the weekends.
- I will not use illegal drugs including, but not limited to, heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.
- I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that this will occur at a minimum of once a month, if I am prescribed any controlled substance while under the care of Faith Healthcare. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.
- I will keep up to date with any bills from the office and tell a member of the treatment team immediately if I lose my insurance or cannot pay for treatment anymore.
- I agree to consult with any pain clinic physicians or psychiatrists if so, requested by the treatment team of Faith Healthcare.
- I agree to have KASPER reviewed and discussed at any time deemed necessary by my primary care provider at Faith Healthcare for medication care/treatment and continuation of care.

I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Patient Signature _____ Date _____

Faith Healthcare, Inc.

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the USE & DISCLOSURE of all medical records (including but not limited to records of any substance abuse, psychiatric/mental health information of HIV/AIDS information) of:

Patient Name (Print) _____ Phone _____

Patient Date of Birth _____ Social Security Number _____

Please list any physicians or organizations authorized to release the information and any contact information:

_____ _____

_____ _____

For the following dates of treatment (include specific description of information requested): _____ ALL RECORDS

For the purpose of:

_____ Further Medical Care
_____ Legal Reasons
_____ Self
_____ Other (please specify)

I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed to a third party and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment, or healthcare operations. I may inspect or copy any information used/disclosed under this authorization.

This authorization and request are fully understood and are made voluntarily on my part. I release the above-named facility of Faith Healthcare of any legal liability that may arise from the release of the information requested.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has been taken. This authorization will automatically expire one year from the date on which it is signed. Cancellation of this authorization before expiration must be made in writing and sent to the Health Information Management.

Patient Signature _____ Date _____

Guardian/Legal Rep. Signature _____ Date _____

Witness _____ Date _____

CURRENT MEDICATIONS LIST

Name _____ Date Last Updated: _____

Emergency Contact Name & Phone Number: _____

Prescription Medications:

Name of Medication	Strength & Frequency	Condition Medication Taken For	Physician Who Prescribed Medication	Notes

Drug Allergies

Pharmacy/Prescription Drug Plan

Faith Healthcare, Inc.

NO SHOW POLICY

Thank you for trusting your medical care to Faith Healthcare. When you schedule an appointment with Faith Healthcare, we set aside enough time to provide you with the highest quality care. If you need to cancel or reschedule an appointment, contact our office as soon as possible, and no later than 24 hours before your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- If you have three (3) No Show or cancellation/reschedule with no 24-hour notice, your provider reserves the right to decline future appointments and care.
- As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office manager to discuss future appointments. Should you need to cancel/reschedule after regular business hours Monday through Friday, or on a weekend, you may leave a message. Messages left are acceptable.

_____ _____

Patient Signature Date

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 IN ITS ENTIRETY.

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 of your protected health information. PHI is information about you, including demographic information that may identify you and relates to your past, present, or future physical or mental health condition(s) and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

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 PHI 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 to a home health agency that provides care for you or to a physician to whom you have been referred to ensure the physician has the necessary information to diagnose or treat you.

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

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review, training of medical students, licensing, and conducting or arranging other business activities. We may disclose your PHI 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 provider. We may also call you by name in the waiting room when your provider is ready for your visit. We may use or disclose your PHI to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable disease(s), health oversight, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, workers' compensation, or inmate required uses & disclosures.

Under the law, we must make disclosures to you when required by the Department of Health & Human Services to determine our compliance with 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 provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

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 notes, 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 PHI not be disclosed to anyone who may be involved in your care or for the notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your PHI, it 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 electronically.

You may have the right to have your provider 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.

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

You have the right to use any pharmacy of your choice for medications prescribed by Faith Healthcare.

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. Our HIPAA Compliance Officer can be contacted at **(606) 425-5768. We will not retaliate against you for filing a complaint.** This notice was published and becomes effective on **November 1, 2019.**

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 PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at **(606) 425-5768.**

Print Name _____

Signature _____ Date _____

Please list the person(s) that are granted access to your medical records.

Name	**Phone**	**Relationship**
_____	_____	_____
_____	_____	_____

Request for Release of Medical Records

Below is a request for medical records in case we need to obtain any medical records from you in the future.

PLEASE FILL IN YOUR NAME, SIGNATURE, and DATE OF BIRTH ONLY.

Patient Name: _____

Patient Signature: _____

Date of Birth: ____/____/_____

To: _____

I hereby authorize you to release my medical records to:

LC Rheumatology Somerset
26 Oxford Way – Suite A,
Somerset, KY 42503
(P) 606-802-2300 · (F) 866-538-6128

LC Rheumatology London
1675 S Main Street – Suite 4,
London, KY 40741
(P) 606-266-8266 · (F) 606-266-8300

What brings you to the rheumatologist?

_____

_____

_____

_____

Where are your symptoms located? _____

_____

Mark quality of symptoms: Achy__ Stiff__ Throbbing__ Burning__ tingling__ Sharp__ Dull__

When did your symptoms start? _____

What diagnosis have you been given, if any? _____

_____

Which providers have you seen for this condition? _____

_____

What has helped your symptoms? _____

_____

What has *not* helped your symptoms? _____

_____

MEDICAL HISTORY: at any time have you or a blood relative had any of the following?

	Yourself	Relative	Relationship
Rheumatoid Arthritis	___	___	_____
Psoriasis/Psoriatic Arthritis	___	___	_____
Lupus or "SLE"	___	___	_____
Fibromyalgia	___	___	_____
Ankylosing Spondylitis	___	___	_____
Sjogren's Syndrome	___	___	_____
Osteoporosis	___	___	_____
Osteoarthritis	___	___	_____
Gout	___	___	_____

Select which best describes your abilities OVER THE PAST WEEK:

Are you able to:	*Without difficulty*	*Some difficulty*	*Much difficulty*	*Unable to do*
Stand up from a straight chair?				
Get on/off toilet?				
Reach & get down a 5-pound object (sugar) from just above your head?				
Open car doors?				
Do outside work (yard work)?				
Wait in line for 15 minutes?				
Lift heavy objects?				
Move heavy objects?				
Go up two or more flights of stairs?				