HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to the is restriction, but if we do, we shall honor that agreement

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or healthcare operations.
Initial: _____

The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this notice.
Initial: _____

The practice reserves the right to change the Notice of Privacy Practices.
Initial: _____

The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
Initial: _____

THIS CONSENT WAS SIGNED BY:

NAME (PRINT): _____ DATE: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT (IF NOT SELF): _____

WITNESS INFORMATION (OFFICE USE ONLY):

NAME (PRINT - REPRESENTATIVE): _____

SIGNATURE: _____ DATE: _____

Anesu
RESTORATIVE CARE

TM-FLOW MEDICAL QUESTIONNAIRE

NAME: ***OFFICE USE ONLY***

DATE OF BIRTH: ***HEART RATE:***

WEIGHT: ***PULSE OX %:***

HEIGHT: ***B/P:***

Please Circle Yes or No for the following Questions

Are you undergoing external defibrillation?	YES NO
Do you have an implantable pacemaker/cardiac device/insulin pump?	YES NO
Do you have a bilateral mastectomy?	YES NO
Are you missing two or more limbs?	YES NO
Do you have any arterial catheters in the arm/leg or a fistula/shunt?	YES NO
Do you have a history of seizures?	YES NO

Are you a diabetic? YES NO If yes, what is your A1C? _____

PLEASE CIRCLE ALL THAT APPLY

SYMPTOMS/CONDITIONS

Weakness	Legs/Feet Fall Asleep While Walking	Impaired Reflex Tests
Headaches	Erectile Dysfunction	Alcoholism
Dizziness	Tingling in Toes	Cramping in Legs
Chronic Pain	Numbness	Upper Limb Symptoms
Exercise Intolerance		Restless Leg Syndrome

PLEASE CIRCLE ALL THAT APPLY

DISEASES:

Parkinson's Disease	Renal Failure
Heart Failure	AIDS
Atherosclerosis	Cushing's Syndrome
LV Hypertrophy	Hepatitis (A/B/C)
Arrhythmia	Digestive Disorders
Hypertension	Liver Failure
Guillain-Barre Syndrome	Cancer
Raynaud's Syndrome	Hyp(er/o)thyroidism
Alzheimer's Disease	Nephropathy
A.L.S	Depression
Diabetes	Neuropathy
Glaucoma	Retinopathy

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MEDICAL HISTORY

(PLEASE CIRCLE ALL THAT APPLY)

CARDIOVASCULAR

Aneurysm

Lymphedema Thrombosis

Deep Vein Thrombosis

Hypertension

Heart Attack

Heart Failure

EARS

Hearing Aids

NOSE/SINUSES

Allergic Rhinitis

Sinus Infection

MOUTH/TEETH

Dentures

EYES

Blindness

Cataracts

Glaucoma

Glasses/Contacts

GASTROINTESTINAL

Cirrhosis

Gastroparesis

GERD

Gallbladder disease

Heartburn

Hemorrhoids

Hepatitis

Hiatal Hernia

Irritable Bowel Syndrome

Jaundice

Ulcer

GENITOURINARY

Hernia

Incontinence

Nephrolithiasis

Other Kidney Diseases

STDs

UTIS

RESPIRATORY

Asthma

Bronchitis

COPD

Emphysema

Pleuritis

Pneumonia

HEAD

Trauma

MUSCULOSKELETAL

Arthritis

Back Pain

Gout

Autoimmune system

SKIN

Dermatitis

Mole(s)

Psoriasis

Other Skin Conditions

ENDOCRINE

Goiter

Hyperlipidemia

Hypothyroidism

Thyroiditis

Diabetes (Type I/II)

Diabetic neuropathy

INFECTIOUS

HIV

STDs

Tuberculosis (dz)

HEME/ONC

Anemia

Cancer

Neuropathy After Cancer Treatment

PSYCHIATRIC

Bipolar Disorder

Depression

Hallucinations

Sciatica

Suicidal ideation

NEUROLOGICAL

Epilepsy

Seizures

Severe Headaches

Neurological neuropathy

TIA

Stroke

SURGICAL HISTORY

Procedure	Surgery Year	Complications

FAMILY HISTORY OF NEUROPATHY?: YES NO

NAME (PRINT):_____ DATE:_____

SIGNATURE:_____

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MEDICATIONS, VITAMINS, AND SUPPLEMENTS LIST

NAME	DOSAGE/MG

NAME: _____ **DATE**:_____

SIGNATURE_____

Do I need a test for Peripheral Arterial Disease (PAD)?

Patients with peripheral arterial disease (PAD) may have similar symptoms as those that have neuropathy. PAD is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It could result in leg discomfort while walking, poor healing leg sores/ulcers,m difficult to control blood pressure or symptoms of stroke. People with PAD are at significantly increased risk of stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

CHECK YES OR NO TO ALL THAT APPLY:

YES **NO** Foot/Calf/Buttock/Hip/Thigh discomfort when walking relieved by rest?

YES **NO** Any pain at rest in lower legs/feet?

YES **NO** Toes/Feet pale, discolored, or bluish?

YES **NO** Skin wounds or ulcers on feet/toes that are too slow to heal?

YES **NO** Diagnosed with diminished or absent pedal (foot) pulses?

YES **NO** Suffered severe injury to legs/feet?

YES **NO** Have infection of the leg/feet that may be gangrenous (black skin tissue)?

Name:_____ Date: _____

Signature: _____

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____MI_____

DATE OF BIRTH: M_____ D____ Y_____SSN:_____

EMAIL ADDRESS:_____

PATIENT ADDRESS

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMERGENCY CONTACT INFORMATION:

LAST NAME:_____ FIRST NAME:_____MI_____

PHONE NUMBER: _____ (HOME OR CELL)

RELATIONSHIP TO PATIENT: _____

PROVIDER INFORMATION

PHARMACY ADDRESS:_____

PHARMACY PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____PHONE:_____

CARDIOLOGIST: _____PHONE: _____

NEUROLOGIST: _____ PHONE: _____

SOCIAL HISTORY

DO YOU SMOKE? YES NO QUANTITY/PER DAY: _____

DO YOU DRINK? YES NO QUANTITY/PER DAY: _____

DO YOU HAVE AN IMPLANTED DEVICE? YES NO

DIABETIC HISTORY

ARE YOU A DIABETIC? YES NO DIAGNOSIS DATE: _____

SUGARS CONTROLLED? YES NO CURRENT A1C: _____

ARE YOU BEING TREATED FOR DIABETES BY PCP? YES NO

IF NOT, WHO IS TREATING IT? _____

NEUROPATHY HISTORY

CHIEF COMPLAINT (circle all that apply): PAIN NUMBNESS

LOCATION OF SYMPTOMS: TINGLING SHOOTING SHOCKS

_____ PAIN WITH TOUCH

_____

_____ BURNING ACHING

_____

DATE OF DIAGNOSIS: _____ DIAGNOSED BY:_____

IF BY EMG/NCS, WHAT WAS THE DATE OF STUDY?_____

I, _____, have reviewed the above information and certify that the information provided by myself is true and correct to the best of my knowledge.

SIGNATURE: _____

DATE: _____