



World-Class Team. Hometown Choice.

PETER TSAIRIS, M.D.

NAME _____

DATE _____

AGE _____

NEUROLOGICAL QUESTIONNAIRE

CIRCLE ONE

- DO YOU SUFFER FROM TENSION OR MIRGRAINE HEADACHES? YES NO
DO YOU HAVE PAIN AND/OR STIFFNESS IN YOUR NECK? YES NO
DO YOU HAVE LOW BACK PAIN? YES NO
HAVE YOU NOTICED ANY CHANGE IN YOUR EYESIGHT? YES NO
HAVE YOU EVER HAD SPOTS BEFORE YOUR EYES, DROOPY EYELIDS, BLURRING OF VISON OR DOUBLE VISION? YES NO
HAVE YOU EVER HAD COMPLETE OR PARTIAL LOSS OF VISION IN ONE OR BOTH EYES? YES NO
HAVE YOU NOTICED ANY CHANGE IN YOUR HEARING? YES NO
HAVE YOU EVER HAD EARACHES OR RUNNING EARS? YES NO
DO YOU HAVE SINUS TROUBLE? YES NO
DO YOU HACE NOSEBLEEDS? YES NO
HAVE YOU HAD ANY EPISODES OF LOSS OF SPEECH OR SLURRING? YES NO
DO YOU HAVE DIFFICULTY SWALLOWING OR CHEWING? YES NO
DO YOU SUFFER FROM NAUSEA OR VOMITING? YES NO
IS THERE ANY PROBLEM WITH YOUR SENSE OF SMELL AND/OR TASTE? YES NO
DO YOU LOSE YOUR BALANCE OR STAGGER? YES NO
DO YOU HAVE DIFFICULTY WALKING? YES NO
DO YOU HAVE SPELLS OF DIZZINESS OR VERTIGO? YES NO
HAVE YOU EVER FAINTED OR BLACKED OUT? YES NO
DO YOU HAVE EPILEPSY? YES NO
HAVE YOU EVER HAD A CONVULSION? YES NO

DO YOU SUFFER FROM UNCONTROLLABLE TENSION OR NERVOUSNESS? YES NO

DO YOU HAVE DIFFICULTY GETTING TO SLEEP (INSOMNIA) OR A PROBLEM AWAKING IN THE MORNING? YES NO

DO YOU EVER FEEL DROWSY OR SLEEPY? YES NO

DO YOU HAVE AN EMOTIONAL DISORDER OR EVER BEEN UNDER THE CARE OF A PSYCHIATRIST? YES NO

DO YOU HAVE TROUBLE WITH YOUR THINKING OR MEMORY ABILITY? YES NO

HAVE YOU EVER LOST FEELING IN ANY PART OF YOUR BODY? YES NO

HAS ANY PART OF YOUR BODY EVER BEEN PARALYZED? YES NO

DO YOU HAVE NUMBNESS OR TINGLING IN YOUR HANDS OR FEET? YES NO

DO YOU HAVE TROUBLE WITH COORDINATION? YES NO

DO YOU HAVE MUSCLE PAIN, SORENESS, OR STIFFNESS? YES NO

HAVE YOU NOTICED MUSCLE TWITCHING, SPASMS, OR CRAMPS? YES NO

DO YOU FEEL OVERLY FATIGUED WITHOUT ENERGY? YES NO

HAVE YOU NOTICED ANY RECENT CHANGE IN YOUR HANDWRITING? YES NO

DO YOU GENERALLY FEEL CHILLY EVEN IN WARM WEATHER? YES NO

HAVE YOU HAD ANY SPONTANEOUS EPISODES OF SWEATING? YES NO

DO YOU HAVE ANY BIRTHMARKS? YES NO

DO YOU HAVE DIFFICULTY WITH BOWEL OR BLADDER FUNCTION? YES NO

DO YOU HAVE ANY SEXUAL DYSFUNCTION? YES NO

HAVE YOU HAD ANY RECENT WEIGHT LOSS OR WEIGHT GAIN? YES NO

DO YOU HAVE...
MIGRAINE HEADACHES? YES NO THYROID DISEASE? YES NO

HIGH BLOOD PRESSURE? YES NO ANEMIA? YES NO

KIDNEY OR LIVER DISEASE? YES NO HEART TROUBLE? YES NO

DIABETES MELLITUS? YES NO ARTHRITIS? YES NO

SKIN RASH OR SKIN DISEASE? YES NO FRACTURES? YES NO

NECK OR LIMB TRAUMA? YES NO TUMOR OR CANCER YES NO

SYPHILIS OR OTHER VENEREAL DISEASE? YES NO

ALLERGIES? YES NO PLEASE LIST: _____

ARE YOU ALLERGIC TO: LATEX NICKEL NONE

OTHER? _____

HAVE YOU HAD ANY MAJOR ILLNESSES? IF YES LIST TYPE AND WHEN.

HAVE YOU HAD ANY OPERATIONS? IF YES LIST TYPE AND WHEN.

DO YOU SMOKE? YES NO IF SO, HOW MUCH? _____

DO YOU HAVE 2 OR MORE ALCOHOLIC DRINKS PER DAY? YES NO

PHARMACY NAME: _____ PHONE #: _____

LIST NAME AND DOSAGE OF ANY MEDICATIONS:

CIRCLE ANY TESTS OR EXAMINATIONS OF THE NERVOUS SYSTEM YOU HAVE HAD.

- | | | |
|-------------------------------|--------------------------|-----------|
| ELECTROENCEPHALOGRAM (EEG) | ELECTROMYOGRAM (EMG) | MYELOGRAM |
| EVOKED POTENTIAL STUDIES (EP) | CT SCAN (HEAD OR SPINE) | ANGIOGRAM |
| LUMBAR PUNCTURE | MRI SCAN (HEAD OR SPINE) | |

HAVE YOU EVER HAD X-RAYS? IF YES LIST WHERE AND WHEN?

FAMILY HISTORY: DO ANY OF YOUR BLOOD RELATIVES SUFFER FROM...

HEART TROUBLES?

A NERVOUS BREAKDOWN?

HIGH BLOOD PRESSURE?

NEUROLOGICAL DISEASE?

ANEMIA?

PLEASE CIRCLE: STROKE, EPILEPSY, BRAIN TUMOR, MULTIPLE SCLEROSIS, ALZHEIMER'S, MUSCULAR DISORDER, ALS, NEUROPATHY, MYOSITIS, OR MUSCULAR DYSTROPHY

DIABETES?

OTHER? _____

WHERE IS YOUR PAIN NOW?

Using the appropriate symbols, mark all of the areas on your body where you feel the sensations described below

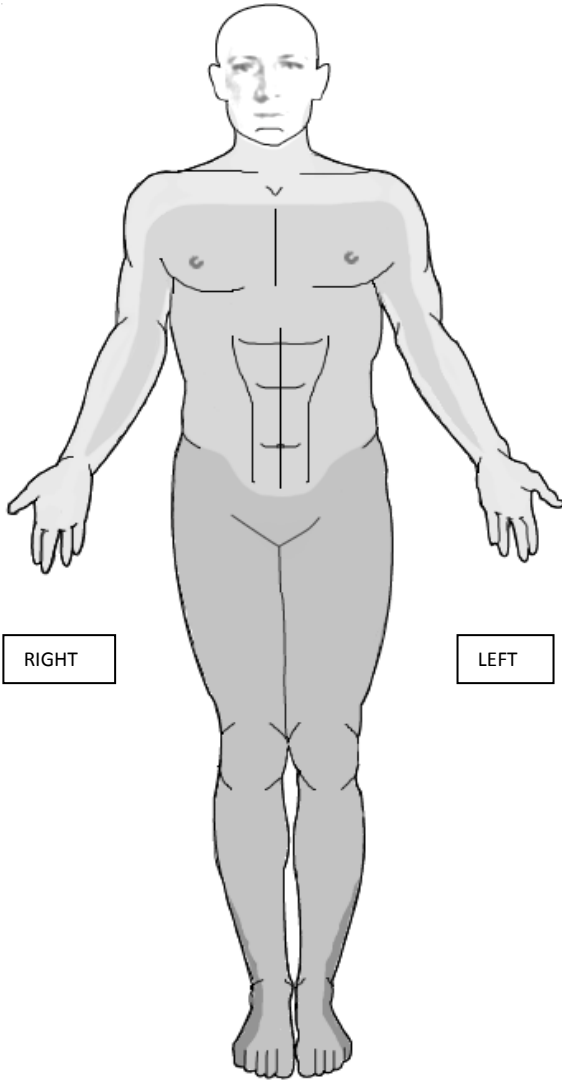
Aching
▲▲▲▲

Numbness

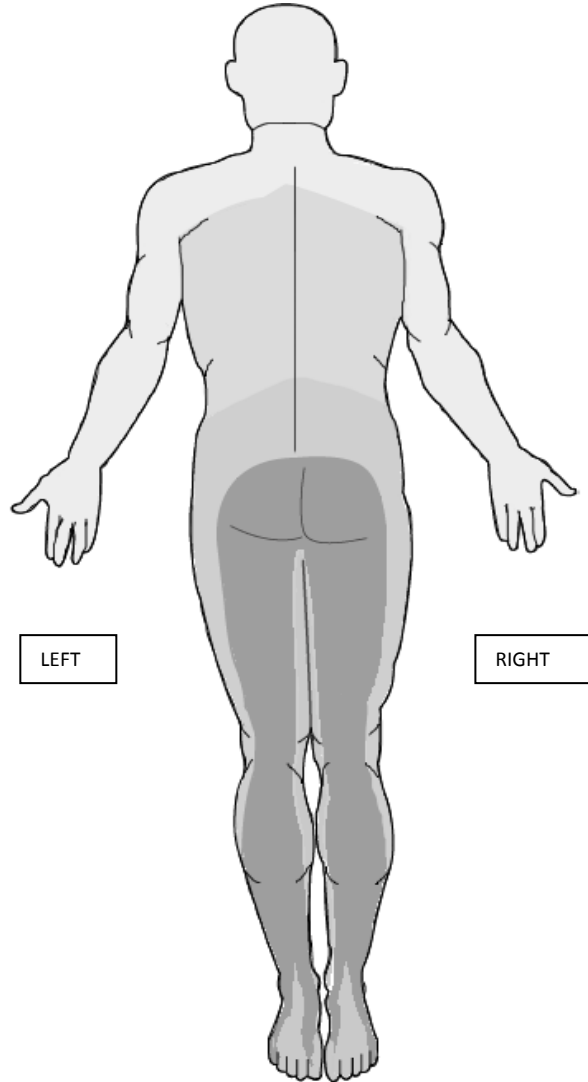
Pins/Needles
○○○○○

Burning
XXXXX

Stabbing
/////



Front



Back

Visual Analog Scale (VAS)





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Social Security # _____ Sex: M F Status: S M W D Spouse Name: _____
Legal Name _____ Date of Birth ___/___/___ Age _____
Address _____ City _____ State _____ Zip _____
Phone _____ Cell _____ Work _____
Email _____
Family Physician _____

Doctor treating you today: McBride Goldman Colizza Goldberger Lombardi Gatto Willis
Montgomery Ginsberg Polesin Tsairis Longworth

Referred by _____

Emergency Contact Name: _____ Phone#: _____

Relation: _____

INJURY/ACCIDENT RELATED TO: () WORK () SCHOOL () MOTOR VEHICLE () OTHER
Date of Injury/Accident ___/___/___ Claim Number _____

PRIMARY INSURANCE INFORMATION

Policyholder's Legal Name _____ Date of Birth ___/___/___
Social Security # _____ Home Phone _____ Work Phone _____
Home Address _____
Employer _____ Occupation _____
Employer's Address _____
Street/PO Box _____ City _____ State _____ Zip Code _____
Insurance Co _____ Effective Date ___/___/___
Group Number _____ ID # _____
Insured's Relationship to Patient _____ Co-Pay Amount _____

SECONDARY INSURANCE INFORMATION

Policyholder's Legal Name _____ Date of Birth ___/___/___
Social Security # _____ Home Phone _____ Work Phone _____
Home Address _____
Employer _____ Occupation _____
Employer's Address _____
Street/PO Box _____ City _____ State _____ Zip Code _____
Insurance Co _____ Effective Date ___/___/___
Group Number _____ ID # _____
Insured's Relationship to Patient _____ Co-Pay Amount _____

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO TRI-COUNTY ORTHOPAEDICS & SPORTS MEDICINE, P.A. AND AUTHORIZE THE FILING OF INSURANCE AND RELEASE INFORMATION NECESSARY FOR COMPLETION OF CLAIMS. I UNDERSTAND THAT ULTIMATELY I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

Signature _____ Date _____

X-RAY REQUEST POLICY

- **It is the policy of this practice that upon request, we will provide you with a copy of your x-rays on a CD disc.**

- **If you need the actual films from your exam, it is always \$15.00 for the entire set. If requesting an older set of films that were not done digitally they are free, but must be returned when you are finished with them. These films which were done in our office are stored for 7 years. After this time period they will be destroyed.**

- **Please be reminded that we need 72 hours to process your request.**

- **Be aware that films not taken in this office are the responsibility of the patient. Please take them with you. They are your property. If left in our facility, they will only be stored for 3 years. After this time period they will be destroyed.**

- **If you are a Worker's Comp patient, please contact your case manager to get authorization for any films to be rendered to you.**

- **If a request for x-rays is submitted. Pick up must be within 30 days otherwise a new request must be submitted.**

Please sign below acknowledging that you have read this policy.

Thank you.

Patient Name

Date



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CONSENT to the USE AND DISCLOSURE OF HEALTH INFORMATION
For the TREATMENT, PAYMENT or HEALTHCARE OPERATIONS

I _____ understand that as part of my treatment, Tri-County Orthopedics
(Patient Name)

originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any future care or treatment. I understand that this information serves as:

- Basis for planning my care and treatment.
• A means of communication among any other health professionals who might contribute to my care, i.e.: via facsimile, telephone, etc.
• A source of information for applying diagnosis and surgical information to my account to process for payment.
• A means by which a third-party payer can verify that services billed and accurate and actual.
• As a tool for routine healthcare operations, such as assessing quality, and reviewing the competence of healthcare officials.
• A means by which an insurance appeal at any stage, may be filed.
• I assign all benefits for my medical services to Tri-County Orthopedics.

I understand Tri-County Orthopedics will take care to ensure that any and all information pertaining to me and my treatment at this facility will be handled with an emphasis on maintaining my privacy at all times. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that this facility is not required to agree to these restrictions in the event of an emergency. I understand that I may revoke this consent in writing at any time, but not to the extent the organization has already acted in.

- I authorize Tri-County Orthopedics to release my medical records to the following friend or family member:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Name of Patient or Legal Guardian

Signature

Date