TIER 1 ORTHOPEDIC AND NEUROSURGICAL INSTITUTE
105 S. Willow Avenue | 35 Taylor Ave., Ste 103-B
Cookeville, TN 38501 | Crossville, TN 38555

Patient Info:	Last:	First:	MI:
	DOB:	Gender: O M O F	SS#:
Mailing Address:	Street:	City:	State: Zip:
	Apt #:	Email:	
	Home Ph: ( )	Day Ph: ( )	Cell Ph: ( )
Pharmacy Info:	Name of Pharmacy:	City:	
Language:	O English O Spanish O French O Arabic O Decline O Other (please specify)_____		
Emergency Contact:	Name:	Contact's Phone: ( )	
	Relationship to Patient: O Spouse/Partner O Child O Other Relative O Friend O Other		
Responsible Party:	Last:	First:	MI:
	SS#:	DOB:	Gender: O M O F
	Cell Phone: ( )	O Parent O Spouse O Legal Guardian O Other	
Primary Care Physician:		Referring Physician:	

Reason for today's visit:

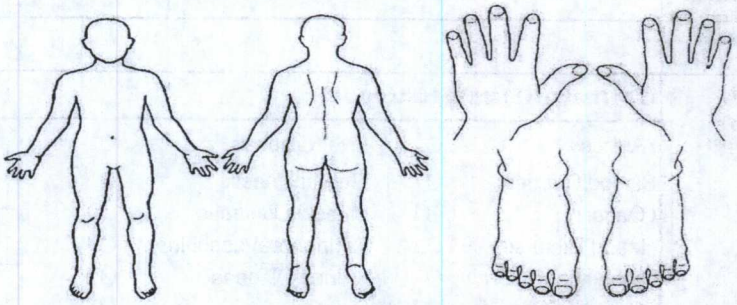
When did problem start_____/_____/_____

Where is your pain? (check all that apply):

O Neck
O Thoracic Area
O Lumbar Area
O Left Arm
O Right Arm
O Left Leg
O Right Leg

Using the symbols below, mark on the images where you feel the following:

Numbness ==== Pins and Needles *00000* Burning *xxxxx*
Stabbing ///// Aching +++++



Which are you?

O Right Handed O Left Handed O Ambedextrous

How severe is your pain today? None 0 1 2 3 4 5 6 7 8 9 10 Severe

Review of Symptoms:	**O I have NO other symptoms or complaints.**
	(please check all that apply)
Constitutional:	O Chills O Fatigue O Fever O Night Sweats O Weight Gain O Weight Loss
Eyes:	O Eye Pain O Double Vision O Vision Changes
HEENT:	O Headache O Hearing Loss O Ringing in Ears O Nose Bleed O Neck Tenderness O Sore Throat O Vertigo O Ear Pain O Tinnitus O Snoring O Hoarseness O Problem Swallowing
Respiratory:	O Persistent Cough O Coughing up Blood O Shortness of Breath O Recent Infection O Known TB Exposure
Cardiovascular:	O Chest Pain O Heart Murmur O Irregular Heartbeat O Syncope/Fainting O High Blood Pressure O Leg/Ankle Swelling
GI:	O Nausea O Heartburn O Reflux O Blood in Stools O Diarrhea O Vomiting
Genitourinary:	O Blood in Urine O Incontinence O Painful Urination O Frequent Urination
Integument:	O Rash O Hives O Bruise Easily
Endocrine:	O Recent Fatigue O Excessive Thirst O Cold Intolerance O Heat Intolerance
Musculoskeletal:	O Joint Pain O Muscle Pain O Leg Pain
Neurological:	O Tingling/Numbness O Speech Difficulties O Poor Coordination O Memory Difficulties O Muscle Weakness
Psychiatric:	O Anxiety O Depression O Panic Attacks O Insomnia
Hematologic:	O Bleeding Tendency O Bruising Tendency O Anemia O Blood Clots O DVT

Medical History:

O I have NO medical history.

O *AIDS/HIV	O Congestive Heart Failure	O Fibromyalgia	O Lyme Disease	O *Previous MRSA
O Alzheimer's	O COPD/Emphysema	O *Hepatitis	O MI/Heart Attack	O Psoriasis
O Anemia	O Coronary Artery Disease	O High Blood Pressure	O Obesity	O Pulmonary Embolism
O Arthritis	O Depression	O Inflammatory Bowel	O Osteoporosis	O Scoliosis
O Asthma	O *Diabetes	O *Kidney Disease	O Parkinson's	O Seizures
O *Blood Clot	O Excessive Bleeding	O *Liver Disease	O *Peptic Ulcers	O *Sleep Apnea
O Cancer, Type: _____			O *Pregnant (currently)	O Stroke
O Other: _____				O Thyroid Disease

Surgical History:

O I have NO surgical history.

Have you ever had any problems with anesthesia? O Yes O No

Do you have a(n) O*Pacemaker O Defibrillator O Implanted nerve or bladder stimulator O Stent

Name of Surgery:	Side:	Name of Surgery:	Side:
_____	O R O L O Both	_____	O R O L O Both
_____	O R O L O Both	_____	O R O L O Both
_____	O R O L O Both	_____	O R O L O Both
_____	O R O L O Both	_____	O R O L O Both
_____	O R O L O Both	_____	O R O L O Both

Current Medication List:

Please list all prescriptions, over-the- counter medications, supplements, and vitamins, or provide a list to the front desk staff.

O I do NOT take any medications. O List provided

Medication Name:	Dosage:	Times per Day:

Family History/ Allergies:

O I have NO family history.

Arthritis	O	Liver Disease	O
Blood Disorder	O	Mental Illness	O
Cancer	O	Muscle Disease	O
Heart Disease	O	Peripheral Vascular	O
Diabetes	O	Kidney Disease	O
Genetic Disease	O	Stroke	O
Hypertension	O	Thyroid Disorder	O

O I have NO medical/food allergies.

List all medication/food allergies:

Social History:

Have you ever used tobacco? O Never O Former O Decline to Answer
O Current Every Day O Current Some Days Type: _____

Alcohol Use: O None O Rarely O Socially O Daily O Alcoholism

Recreational drug use: O None O Rarely O Socially O Daily O Drug Addiction

Medical Information Contacts:

Other than your insurance company and health care providers involved in your care, whom can we talk with about your health care information?

Name:	Relation:
Name:	Relation:

Consent for Treatment, Patient Financial Responsibility, and Notice of Privacy Practices

I authorize Tier 1 Orthopedic and Neurosurgical Institute (Tier 1) physicians and staff to render medical treatment and evaluation as needed, including but not limited to the order of x-rays, injections, casting or other diagnostic tests and treatment that may be necessary to treat my illness or injury. I may revoke this consent at any time by written notice to Tier 1.

I acknowledge full financial responsibility for all services rendered at Tier 1; including, but not limited to; co-pays, deductibles, non-covered services, DME, and all reasonable attorney fees and collection costs in the event of default of payment as outlined in their office and Financial Policy guidelines. I consent for all services received to be billed to my insurance and paid directly to Tier 1 according to my plan benefits and policy guidelines.

I acknowledge receipt of Tier 1's Notice of Privacy Practices which contains detailed information about how the practice may use my confidential protected health information (PHI). I understand Tier 1 reserves the right to change its Privacy Practices and it will be available on their website, at the office, or mailed upon request.

Signature: Date:

Print Name: Relation:

❒ **Yes,** *sign me up for SMS text messages*

❒ **No thanks,** *I choose not to participate in SMS text*