

MERIDIAN HEALTH GROUP

OFFICE POLICY

Welcome to Meridian Health Group!

- At Meridian Health Group (MHG), our goal is to provide you with the best quality, professional, medical services. This includes treating our patients with respect, maintaining strict confidentiality (see below), and informing our patients about their condition, diagnosis and treatment options. We strive to make every patient comfortable during the treatment process and to maximize his/her level of function and quality of life.

Confidentiality

- MHG takes patient confidentiality very seriously, keeping patient information and treatment plans strictly private. Confidentiality and release of records is explained in our "Notice of Privacy Practices Summary". If you would like additional privacy during check-out, please ask for a private room.

Cancellation/No Show Policy

- Office hours are Monday through Thursday 8:00 a.m. to 7:00 p.m. Our office is closed Friday –Sunday. It is essential you are on-time for your appointment and call at least 24 hours in advance when you are unable to keep your scheduled appointment. Failure to show up for your appointment or cancel without 24 hours notice will result in a \$65.00 charge.

Reminder Calls

- Please note that while we attempt to make reminder calls for appointments, you are ultimately responsible for maintaining your appointment schedule and fees associated with failing to show up for your appointment or cancelling without 24 hours notice

Prescription Refills

- All prescription refill requests must be taken care of during the time of your appointment. MHG charges a \$10 fee for each prescription refill request taken outside of an office visit. Please make sure at the time of your appointment that you have enough medication to last until your next visit. If you do have to leave a refill request message, please leave only one message per prescription as multiple messages for the same prescription will delay the process. We do not process requests for refills on Fridays, Saturdays or Sundays. After requesting a refill, please contact your pharmacy to find out when the medication is available for pickup.

After-Hours Emergencies

- For after-hours psychiatric emergencies, please contact the crisis line at 317-621-5700 or dial 9-1-1. For after-hours medical emergencies, please call 9-1-1 or go to your local emergency care facility. It is important for you to take all medications with you to the emergency room.

Emergency Office Closings

- Due to the unpredictability of adverse weather conditions or other emergencies, MHG reserves the right to close the office without advance notice. We will make every attempt possible to notify our patients when their appointment is cancelled in these situations, but reaching every patient may not be possible. Our after-hours voicemail system is changed frequently to reflect any changes in our office hours during an emergency situation.

Responsibility for Services

- You, the patient, are financially responsible for all care provided by MHG. As such, it is important that you are knowledgeable of your insurance coverage before arriving for each appointment. All fees, co-payments, co-insurance, etc. are due at the time of service. Failure to make required payment at the time of service will result in an additional \$10 charge. As a courtesy to you, MHG will attempt to verify, pre-certify and submit insurance claims, provided your insurance information is up-to-date, including a copy of the current insurance card. Please notify MHG if your insurance coverage changes to avoid uncovered procedures. Failure to make payment for services rendered may jeopardize your ability to schedule future appointments with MHG. MHG DOES NOT BILL OR ACCEPT SECONDARY INSURANCE with the exception of Medicare as a secondary. The patient is responsible for all balances due, including those they are submitting to secondary insurance. If you have any problems meeting these financial obligations, we encourage you to contact our Patient Accounts department at 317-428-4105.

Collections

- If collection efforts become necessary, eligible past due balances will be sent to a collections agency. Any accounts in collections will be considered delinquent and may prevent you from scheduling future appointments and/or may result in your discharge from MHG.

Documents, Letters, Disability Forms, Depositions, etc.

- Any document you request to be written, completed or filed by MHG (i.e. miscellaneous forms, disability forms, written letters, depositions, etc.) will be subject to a fee based on the type of form and the number of pages required. Documents will not be released until payment has been received.

Your Satisfaction is Important to Us

- Please feel free to speak directly to your provider during office visits about any concerns you may have with your care or treatment plan.

MISSED APPOINTMENTS/CANCELLATION POLICY

MHG has a policy of charging a fee for missing an appointment or canceling with less than 24 hours notice. Office hours are Monday through Thursday 8am-7pm. This policy is explained on the first visit to MHG.

The fee for a missed appointment without 24 hours notice is \$65.00, payable prior to the next scheduled appointment. I understand that if for any reason I do not keep the next two scheduled appointments without appropriate notification, I will be considered a "self-discharge" which will prevent me from scheduling any future appointments at MHG.

By initialing below, I am confirming my understanding of the missed appointment/cancellation policy and I will be responsible for paying the fee(s) when missed appointment(s) occur.

Initial Here

PATIENT RIGHTS

MHG affirms equal opportunity rights and does not discriminate on the basis of age, color, national origin, race, religion, sex, physical challenges or mental challenges in admission/access to treatment. Each patient has the following unconditional rights:

1. To be referred to an appropriate facility if the patient does not meet MHG admission criteria.
2. To be informed of the steps involved in receiving services.
3. To preserve confidentiality under federal and state laws relating to the receipt of services.
4. All patients will be asked to sign a consent form for treatment. If the patient is a minor or considered incompetent, a parent or guardian will be asked to sign the consent form on his/her behalf. The facility will not provide treatment to those adults refusing service and also to minors without parental consent.
5. To make an informed decision to either accept or refuse treatment. A voluntary patient is entitled to refuse treatment provided he/she has not been adjudicated incompetent. An involuntary patient who wishes to refuse treatments offered is entitled to petition the committing court or hearing office for such consideration. In the absence of such a petition, MHG may proceed with the proposed treatment. Whenever a patient gives informed consent to receive services, the consent must be made in writing and include the medical record of the patient.
6. To receive humane care and protection.
7. To practice his/her religion of choice.
8. To contact and consult with counsel and/or private practitioners selected by the patient at his/her expense.
9. To inspect and copy his/her medical record. MHG maintains the right to withhold all or part of any medical record from the patient if:
 - Withholding is necessary to protect the confidentiality of other sources of information.
 - It is determined the information requested is detrimental to the physical or mental health of the patient; or if MHG believes, the patient has potential to cause harm to him/herself or to someone else.
 - The patient's consent to inspect his/her medical record is not given freely, voluntarily, or without coercion.
 - Granting the request will cause substantial harm to the relationship between the patient and the facility, or the facility's ability to provide services in general.

A patient's review of his/her medical record shall be documented in his/hers' medical record. Any denial of the patient's right to review his/her medical record shall also be documented in his/hers' medical record, along with the reason(s) for such denial.

MHG uses patient satisfaction surveys as a method of responding to suggestions, concerns or grievances. Any suggestions, concerns or grievances made through this survey in writing or verbally will be brought to the attention of the patient's advocate and will be addressed as stated in the policy and procedures manual.

If your suggestion, concern or grievance is not addressed to your satisfaction, you may contact the Health Professions Bureau at 402 W. Washington Street, Room 41, Indianapolis, IN, 46204, or by phone at 317-232-2960.

All patients have the right to have all forms read to them, to ensure complete and thorough understanding.

Initial Here

NOTICE OF PRIVACY PRACTICE

This notice describes how your medical information 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 Meridian Health Group (MHG), its medical staff members and employees may disclose your protected health information (PHI) for purposes of treatment, payment and health care operations, and for other purposes that are permitted or required by law.

I. OUR RESPONSIBILITIES:

MHG takes the privacy of your health information seriously. We are required by law to maintain the privacy of your health information and provide you with this Notice and Privacy Practices. We will abide by the terms of this Notice of Privacy Practices.

We reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that we maintain.

II. WHAT IS “PROTECTED HEALTH INFORMATION” (PHI)?

Protected health information (PHI) is demographic and individually identifiable health information that will or may identify the patient and relates to the patient’s past, present or future physical or mental health or condition and related health care services.

III. WHAT DOES “HEALTH CARE OPERATIONS” INCLUDE?

Health care operations include activities such as communications among health care providers, conducting quality assessment and improvement activities; evaluating the qualifications, competence, and performance of health care professionals; training future health care professionals; contracting with insurance companies; conducting medical review and auditing services; compiling and analyzing information in anticipation of or for use in legal proceedings; and general administrative and business functions.

IV. HOW IS MEDICAL INFORMATION USED?

MHG uses medical records as a way of recording health information, planning care and treatment as a tool for routine health care operations. Your insurance company may request information such as procedure and diagnosis information that we are required to submit in order to bill for treatment we provide to the patient.

V. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTH OPERATIONS

- Medical information may be used to justify needed patient care services, (i.e. lab tests, prescriptions, treatment protocols).
- We will use medical information to establish a treatment plan.
- We may disclose protected health information to another provider for treatment (i.e. referring physicians, specialists and other providers at MHG).
- We may submit claims to your insurance company containing medical information and we may contact their utilization review department to receive pre-certification (prior approval for treatment).
- We may use the emergency contact information you provided to contact you if the address of record is no longer accurate.
- We may contact you to remind you of the patient’s appointment by calling you or mailing a postcard.
- We may contact you to discuss treatment alternatives or other health related benefits that may be of interest.

VI. WHY DO I HAVE TO SIGN A CONSENT FORM?

When you, the patient or the parent or guardian of a patient, sign a consent form, you are giving MHG permission to use and disclose protected health information for the purposes of treatment, payment and health care operations. This permission does not include psychotherapy notes, alcoholism and drug abuse treatment records and other privileged categories of information which require a separate authorization. You will need to sign a separate authorization to have protected health information released for any reason other than treatment, payment or health care operations.

VII. WHAT ARE PSYCHOTHERAPY NOTES?

Psychotherapy notes are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the patient’s medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

VIII. WHY DO I HAVE TO SIGN A SEPARATE AUTHORIZATION FORM?

In order to release patient protected health information for any reason other than treatment, payment and health care operations, we must have an authorization signed by the patient or the parent or guardian of the patient that clearly explains how they wish the information to be used and disclosed.

IX. CAN I CHANGE MY MIND AND REVOKE AN AUTHORIZATION?

You may change your mind and revoke an authorization, except (1) to the extent that we have relied on the authorization up to that point, (2) the information is needed to maintain the integrity of the research study, or (3) if the authorization was obtained as a condition of obtaining insurance coverage. All requests to revoke an authorization should be in writing.

X. WHEN IS MY AUTHORIZATION / CONSENT NOT REQUIRED?

The law requires that some information may be disclosed without your authorization in the following circumstances:

- In case of an emergency
- When there are communication or language barriers
- When required by law
- When there are risks to public health
- To conduct health oversight activities
- To report suspected abuse or neglect
- To specified government regulatory agencies
- In connection with judicial or administrative proceedings
- For law enforcement purposes
- To coroners, funeral directors, and for organ donation
- In the event of a serious threat to health or safety

XI. YOUR PRIVACY RIGHTS

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. You have the right to inspect and copy your health information.

This means you may inspect and obtain a copy of your PHI that is contained in a “designated record set” for so long as we maintain the PHI. A designated record set contains medical and billing records and any other record MHG uses in making decisions about your health care. You may not however, 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 certain PHI is subject to laws that prohibit access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact our Clinic Administrator if you have questions about access to your medical record.

2. You have the right to request a restriction of your health information.

This means you may ask us to restrict or limit the medical information we use or disclose for the purposes of treatment, payment or health care operations. MHG is not required to agree to a restriction that you may request. We will notify you if we deny your request. If we do agree to the request restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting our Clinic Administrator.

3. You have the right to request to receive confidential communications by alternative means or at alternative locations.

We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. We will not request an explanation from you as the basis for the requests must be made in writing to our Clinic Administrator.

4. You have the right to request amendments to your health information.

This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with our Clinic Administrator and we may prepare a rebuttal to your statement and will provide you with a copy of this rebuttal. If you wish to amend your PHI, please contact our Clinic Administrator. Requests for amendment must be in writing.

5. You have the right to receive an accounting of disclosures of your health information.

You have the right to request an accounting of certain disclosures of your PHI made by MHG. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed by signing an authorization form, disclosures to family or friends involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Clinic Administrator. The request should specify the time period sought for the accounting. Accounting requests may not be made for periods of time in excess of six years.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.

XII. WHAT IF I HAVE A QUESTION / COMPLAINT?

If you have questions regarding your privacy rights, please contact the Director of Operations at (317) 428-4177.

Initial Here

**ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF PROTECTED HEALTH INFORMATION,
CONSENT FOR TREATMENT, GUARANTY, AND STATEMENT OF SERVICE**

I hereby assign and authorize payment be made directly to Meridian Health Group (MHG) of all of my covered health insurance benefits, including Medicare, Medicaid, Medigap, HSA, commercial, all third party payors, or private managed care plans and insurance, whether payable directly to me by any or all third party payors. I understand my health insurance plan or third party payors may not cover part or all of the medical services rendered. **MHG DOES NOT BILL OR ACCEPT SECONDARY INSURANCE** with the exception of Medicare as a secondary. The patient is responsible for all balances due, including those they are submitting to secondary insurance. **I fully understand I am financially responsible for and agree to pay all charges not paid by my health insurance plans or payors, including deductibles and co-insurance regardless of reason given for non-payment. I agree to immediately forward all payments, explanations of benefits, and correspondence sent directly to me from any and all third party payors related to care rendered by MHG and agree that failure to do so will make me responsible for the entire billed charge.** My assignment of benefits covers MHG physicians for all services rendered and to be rendered in the future until this assignment is revoked. This assignment of benefits **supersedes** any previous assignments or agreements I made with my insurance company, including Blue Cross Blue Shield and their related companies or any other third party payor to pay me directly. A copy of this form shall be considered as valid as the original.

I understand MHG, is a multi-specialty clinic and files claims on my behalf as a courtesy. I agree that I am financially responsible for any facility fees, laboratory test charges, and x-ray charges incurred on my behalf for care rendered. I acknowledge some or all of my care, including laboratory testing, x-rays, and physician services may be provided by out-of-network providers, and that I am financially responsible for any increased co-pays, deductibles, and non-covered services provided on an out-of-network basis.

I have disclosed the names of all my health insurance plans and third party payors, including secondary plans, and I represent such health care coverage is in full force and effect at this time. I also agree to promptly notify MHG, of any change in my health insurance plan and/or coverage as well as any changes in my address and phone number. I understand that my failure to do so will make me fully responsible for the entire bill. In consideration of the services furnished to me, I hereby agree to pay any balance due **within (30) days** from presentation of my bill. If my account should become delinquent, and collection efforts become necessary, I agree to pay 1% per month delinquency charges and any reasonable collection and/or attorney fees incurred. I further agree that Hamilton County, Indiana will be the venue for any collection efforts including small claims court and for any and all other litigation required to collect amounts due.

I understand it is ultimately **my responsibility** to obtain all required authorizations and/or precertifications for medical services that are required by my health insurance plan and/or third party payors. I acknowledge that this is **not** the responsibility of MHG. **I also acknowledge no guarantees have been made by any employee of MHG or any other party about: (1) my treatment; (2) whether it will be paid for by any third party payor(s) or health insurance plans; or (3) whether any care rendered by MHG including but not limited to physician services and radiology services are in or out of network with my insurance plans.** I agree to **fully cooperate** with MHG to assist in their efforts to get claims paid on my behalf but understand that ultimately I am financially responsible for, and agree to pay, and unconditionally guaranty payment, of all charges not paid by my health insurance plan or third party payors.

I also authorize the release of protected health information as may be required for: (1) my treatment; (2) to process insurance claims; (3) to answer any inquires from third parties that result from actions initiated by the patient; and (4) to support the operation of this medical practice. It is expressly understood this information will be used only for these purposes. **I acknowledge that I have had an opportunity to review and ask questions regarding the HIPAA privacy notice. I understand that I have the right to refuse treatment, to refuse to allow the participation of students in my care, or to refuse to participate in experimental research.**

I have read the above and consent to the terms and conditions stated.

Signature(s) of patient and/or insured

Date

Patient's social security number

Patient's date of birth



Personal Data Form

Meridian Health Group
 12772 Hamilton Crossing Blvd
 Carmel, IN 46032
 (317) 814-1000 (317) 814-1015 FAX

Demographic Information			
Name: (Last, First, Middle Initial)			Date
Date of Birth (MM, DD, YY)	Age	Sex: Male Female	What is your primary language?
Race: (circle one) Caucasian African American Latin American Asian American Indian Biracial			
Why are you coming to Meridian Health Group? (choose all that apply) Chronic Pain Mental Health Oral Pain Other: _____			

Physicians to whom we should send a copy of your records			
Name	Address	Phone	FAX
Name	Address	Phone	FAX
Name	Address	Phone	FAX

Physicians from whom we should request a copy of your past records			
Name	Address	Phone	FAX
Name	Address	Phone	FAX
Name	Address	Phone	FAX

Health Questionnaire			
Rate your PHYSICAL HEALTH (circle one) Good Average Below Average Poor			
Rate your MENTAL HEALTH (circle one) Good Average Below Average Poor			
Height (approximate) _____ feet _____ inches	Weight (approximate) _____ pounds	Have you gained or lost weight recently? Over how many weeks? gained _____ pounds or lost _____ pounds over _____ weeks	
Date of Last Medical Exam	Name of Primary Care Physician		Phone Number
Date of Last Psychiatric Visit	Name of Psychiatrist		Phone Number

Pain Information
<i>If you have Physical Pain, please answer this section</i>
Describe the event(s) surrounding the onset of your pain and progression (including date of injury). Is your pain the same or getting better or worse?
How long have you had this pain? _____ years _____ months
How many physicians have been involved in the treatment of your pain since it began? (circle one) 0-3 4-5 6-10 11-15 16-20 More than 20
Approximately how many emergency room visits have you had in the past year for pain? _____ emergency room visits
Circle the number between 0 and 10 which represents the intensity of your average daily pain. (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)
How long has the pain been at this level? _____ years _____ months _____ days
Circle the number between 0 and 10 which represents the intensity of your worst daily pain. (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)
Circle all the things that make your pain worse. Sitting Standing Rest Heat Cold Walking Exercise Sex Touch Other: _____
Circle all the things that make your pain better. Sitting Standing Rest Heat Cold Walking Exercise Sex Touch Other: _____

Circle the word(s) that best describe the types(s) of pain you are experiencing:
Sharp Dull Aching Stabbing Electrical Numbness Tingling Burning Cold Throbbing Other: _____

Circle one of the following words that most accurately describe your pain.
No Pain Mild Pain Discomforting Distressing Horrible Excruciating Other: _____

Check the nerve blocks, injections or procedures that you have had related to your pain.

<u>Modality</u>	<u>How Many</u>	<u>When</u>	<u>Modality</u>	<u>How Many</u>	<u>When</u>
<input type="checkbox"/> Sympathetic Block			<input type="checkbox"/> Physical Therapy		
<input type="checkbox"/> Facet Block			<input type="checkbox"/> Acupuncture		
<input type="checkbox"/> Epidural Steroid			<input type="checkbox"/> Cupping		
<input type="checkbox"/> Trigger Point Injection			<input type="checkbox"/> Chiropractic		
<input type="checkbox"/> TENS Unit			<input type="checkbox"/> Massage Therapy		
<input type="checkbox"/> Spinal Cord Stimulator			<input type="checkbox"/> Traction		
<input type="checkbox"/> Selective Nerve Block			<input type="checkbox"/> Rhizotomy		
<input type="checkbox"/> Intrathecal Pump			<input type="checkbox"/> Other: _____		

Hospitalizations and Past medical History

Have you ever been hospitalized before? (circle one) **YES** **NO**

If yes, please explain:

Do you have any chronic medical problems? (circle one) **YES** **NO** (Circle below where applicable)

Addiction	Cancer	Fibromyalgia	High Cholesterol	Reflux Disease
Anxiety Disorder	Depression	Heart Disease	Migraines/Headaches	Seizures
Arthritis	Diabetes	High Blood Pressure	Neuropathy	Sleep Disorder

If yes, please explain:

Surgery

Have you had surgery in the past (not previously mentioned) **YES** **NO**

If yes, please explain:

Please review the list below. If you have now, or had in the past, a problem in any areas, please circle "YES" and explain in the space provided.

<u>General</u>			<u>Explanation for "YES" answers</u>
Weight Gain/Loss	NO	YES	
Night Sweats	NO	YES	
Fever/Chills	NO	YES	
Skin Disease	NO	YES	
Head Trauma	NO	YES	
Eye disease/poor vision	NO	YES	
Ear pain/hearing disorder	NO	YES	
Nose/Sinus	NO	YES	
Throat/Neck	NO	YES	
Jaw/Teeth/TMJ	NO	YES	

<u>Lungs and Chest</u>			Explanation for "YES" answers
Asthma	NO	YES	
Emphysema	NO	YES	
Lung Cancer	NO	YES	
Tuberculosis	NO	YES	
Pneumonia	NO	YES	
Other	NO	YES	

<u>Heart and Blood Vessels</u>			Explanation for "YES" answers
Heart Attack	NO	YES	
Angina	NO	YES	
High Blood Pressure	NO	YES	
Heart Surgery	NO	YES	
Irregular Heartbeat	NO	YES	
Poor Circulation in Legs	NO	YES	
Blood Clot in Legs	NO	YES	
Sores that Won't Heal	NO	YES	
Shortness of Breath	NO	YES	
Swelling Arm/Leg	NO	YES	
Other	NO	YES	

<u>Urinary/Genital</u>			Explanation for "YES" answers
Kidney Stones	NO	YES	
Urinary Infections	NO	YES	
Difficulty Urinating	NO	YES	
Dialysis	NO	YES	
STD	NO	YES	
Loss of Bladder Control	NO	YES	
Other	NO	YES	

<u>Bones/Joints/Muscles</u>			Explanation for "YES" answers
Broken Bones	NO	YES	
Arthritis	NO	YES	
Osteoporosis	NO	YES	
Fibromyalgia	NO	YES	
Lupus	NO	YES	
Other	NO	YES	

<u>Nervous System</u>			Explanation for "YES" answers
Headache	NO	YES	
Dizziness	NO	YES	
Seizures	NO	YES	
Stroke	NO	YES	
Brain/Spinal Cord Injury	NO	YES	
Multiple Sclerosis	NO	YES	
Other	NO	YES	

<u>Spine</u>			Explanation for "YES" answers
Neck Injury/Pain	NO	YES	
Back Injury/Pain	NO	YES	
Disc Problems	NO	YES	
Other	NO	YES	

<u>Blood</u>			Explanation for "YES" answers
Anemia (Low Blood)	NO	YES	
Easy Bruising	NO	YES	
Easy Bleeding	NO	YES	
Transfusions	NO	YES	
AIDS/HIV Positive	NO	YES	
Other	NO	YES	

<u>Stomach/Esophagus/Intestines</u>			Explanation for "YES" answers
Chronic Diarrhea	NO	YES	
Ulcers/Heartburn/GERD	NO	YES	
Constipation	NO	YES	
Red or Black Stools	NO	YES	
Stomach Upset from Medications	NO	YES	
Hepatitis	NO	YES	
Gallstones	NO	YES	
Anorexia/Bulimia	NO	YES	
Loss of Bowel Control	NO	YES	
Other	NO	YES	

<u>Endocrine/Lymphatic</u>			Explanation for "YES" answers
Diabetes	NO	YES	
Thyroid problems	NO	YES	
Swollen Nodes/Glands	NO	YES	
Metabolic problems	NO	YES	
Adrenal problems	NO	YES	
Other	NO	YES	

<u>Psychological</u>			Explanation for "YES" answers
Depression	NO	YES	
Memory Problems	NO	YES	
Obsessive Compulsive Disorder	NO	YES	
Counseling	NO	YES	
Suicidal Thoughts	NO	YES	
PSTD	NO	YES	
ADD/ADHD	NO	YES	
Psychiatric Hospitalization	NO	YES	
Eating Disorder	NO	YES	
Panic Attacks	NO	YES	
Hallucinations - seeing or hearing things that aren't there	NO	YES	
Excessive sleepiness	NO	YES	
Insomnia	NO	YES	
Other	NO	YES	

<u>Family Medical History</u>		
Please list any major illnesses members of your family have had, and tell us which relatives had them. Include cancer, stroke, high blood pressure, diabetes, chronic pain, depression, "nervous breakdowns", alcohol, or drugs.		
	Past and Present Medical Problem(s)	Past and Present Mental Health/Addiction Problems(s)
Father		
Mother		
Brother(s)		
Sister(s)		
Children		
Other Relatives		

Good Difficult Abuse (circle what type): <i>verbal</i> <i>physical</i> <i>sexual</i> <i>emotional</i> Neglect (please explain): _____ How was your childhood?	Other: _____
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Are any of your family members currently being seen at Meridian Health Group?	YES NO
If, yes, who?	Presenting Problem?

Have you taken any of the following medications? If so, please list reason for discontinuing.

Medication	Last Dose Amount	Stopped due to side effect? (describe briefly)	Didn't work?	Stopped working?	Reason?
Actiq/Fentanyl					
Adderall					
Ambien					
Amitriptyline/Elavil					
Atarax/Hydroxyzine					
Ativan/Lorazepam					
Avinza					
Baclofen/Lioresal					
Butorphanol/Stadol					
Celebrex					
Celexa					
Codeine					
Concerta					
Cylert/Pemoline					
Daypro/Oxaprozin					
Depakote/Valproic Acid					
Desipramine/Norpramin					
Dextromethorphan					
Dilaudid					
Doxepin/Sinequan					
Duragesic/Fentanyl					
Effexor					
Flexeril/Cyclobenzaprine					
Gabitril					
Hydrocodone (Vicodin, Lortab, Norco)					
Ibuprofen (Motrin, Advil)					
Imipramine/Tofranil					
Kadian					
Klonopin/Clonazepam					
Lamictal					
Lexapro					
Lunesta					
Methadone					
MS Contin					
Neurontin/Gabapentin					
Nortriptyline/Pamelor					
Oramorph					
Oxycodone					
Oxycontin					
Palladone					
Paxil/Paroxetine					
Prozac/Fluoxetine					
Remeron/Mirtazapine					
Ritalin/Methylphenidate					
Suboxone/Subutex					
Tegretol/Carbamazepine					
Topamax					
Toradol/Ketorolac					
Trazodone/Desyrel					
Trileptal					
Ultram/Tramadol					
Valium/Diazepam					
Wellbutrin/Bupropion					
Xanax/Alprazolam					
Zanaflex/Tizanidine					
Zoloft/Sertraline					

Do You Work?		YES	NO
If Yes:	What is your occupation?	Your employer?	
	Number of years in current positions	How many hours per day? _____ per week?	
If No:	How long have you been out of work?	What was your occupation	

If you do not work how do you spend your day?

Are you on disability?	YES	NO	For what:
Are you able to do household chores?	YES	NO	Explain:

How many years of education have you completed?		Degree(s) if college/advanced training:	
Have you ever been in the military?	YES	NO	Rank on discharge: _____ Kind of discharge: _____
List branch of service:		Number of years:	

Household			
Marital Status: (circle)			
Single	Steady Relationship	Engaged	Married: When _____
Separated: When _____	Divorced: When _____	Widowed: When _____	
Number of marriages (including present) for you:		Number of marriages (including present) for your spouse:	
Name of spouse:	Spouse's Age:	Education (in years):	
Occupation:		Are your relatives/family members supportive?	YES NO
Does anyone in your household have (or had) addiction problems (treated or untreated)? YES NO			

Children			
Information about children from this or previous relationships whether they are living in your household or not:			Living with you? (circle one)
Name	Age	Sex	YES NO
Name	Age	Sex	YES NO
Name	Age	Sex	YES NO
Name	Age	Sex	YES NO
Is your relationship with your child(ren) good? YES NO			

Daily Activities	
What are your hobbies?	
What exercises do you participate in?	
Circle the number between 0 and 10 that represents your activity level . (inactive) 0 1 2 3 4 5 6 7 8 9 10 (very active)	

Spirituality	
Do you have a religious affiliation? YES NO	If yes, what denomination?
Do you meditate or pray? YES NO	
Circle the number between 0 and 10 that represents your involvement in religious activities . (inactive) 0 1 2 3 4 5 6 7 8 9 10 (very active)	
Circle the number between 0 and 10 that represents how important your spirituality is to you . (not important) 0 1 2 3 4 5 6 7 8 9 10 (very important)	
Circle the number that represents how your spirituality affects the way that you cope with problems . (no effect at all) 0 1 2 3 4 5 6 7 8 9 10 (I use daily to help cope)	

Social

Circle the number between 0 and 10 that represents your **involvement in social activities**.
 (no involvement) **0 1 2 3 4 5 6 7 8 9 10** (actively involved)

Do you smoke? YES NO	How many packs per day?
How many years?	Tried to quit? YES NO
Do you use alcohol? YES NO	About how often?
Was there ever a time in your life when you may have had an alcohol problem? YES NO	
Did you ever use street drugs? YES NO If yes, circle what type and state when last used:	
Cocaine Ecstasy Heroin LSD Marijuana Meth Mushrooms PCP Speed IV or Nasal Street Drugs	
Other:	Last used:
Have you ever been addicted to prescription drugs? YES NO	If yes, please explain:
Have you ever been treated for substance abuse? YES NO	If yes, please explain:
Have you ever had (Circle all that apply) DUI DWI PI Drug related charges? YES NO	
If yes, when?	
Have you ever had any legal problems (problems with the police)? YES NO	
If yes, please explain:	
Do you have any current or past litigation relating to your condition? YES NO	
If yes, please explain:	
Do you have a history of bankruptcy? YES NO If yes, when:	
Are you planning to file for bankruptcy in the near future? YES NO	

Sexual History

Knowing this will help us better evaluate your functional level and monitor your progress

What is your sexual orientation? Heterosexual Homosexual Bisexual
Are you currently sexually active? YES NO
Circle the number between 0 and 10 which represents your present activity . (greatly unsatisfied) 0 1 2 3 4 5 6 7 8 9 10 (greatly satisfied)
Circle the number between 0 and 10 which represent your ability to participate in sexual activity . (unable to participate) 0 1 2 3 4 5 6 7 8 9 10 (actively participate)

Expectation

What are you hoping to achieve with your visit with Meridian Health Group?

Patient Signature

Date

Provider Signature

Date

PAIN DIAGRAM

Shade the areas of pain on the following figures and add comments about your pain.

