VINCENT M. FORTANASCE, M.D.
Diplomate, American Board of Psychiatry and Neurology
Diplomate, American Society of Neurorehabilitation
Diplomate, American Board of Forensic Medicine
Clinical Professor of Neurology, USC

M. LORRAINE PURINO, M.D.
Diplomate, American Board of Psychiatry and Neurology
Added Qualification, Neuromuscular Medicine
Diplomate, American Board of Neuromuscular and
Electrodiatnostic Medicine

Vincent M. Fortanasce, MD, Inc. A Professional Corporation (VMFMD, Inc.)
665 West Naomi Avenue, Suite 201, Arcadia, CA 91007 Phone: (626) 445-8481 Fax: 626-574-9669

Today's Date:_____

PATIENT INFORMATION				
Last Name		First Name		Middle Initial
★ Referring Physician		City	State	Phone #
Home Address		City	State	Phone #
Home Phone #		Cell Phone #		Work Phone #
E-Mail Address		Ethnicity:	Weight:	Height:
★ Birth Date	Age	Dominant Hand: **L / R**	Gender: **M / F**	Language
Primary Physician		City	State	Phone #
Emergency Contact		Relationship		Phone #

INSURANCE INFORMATION		
Primary Medical Insurance	**Policy #**	**Subscriber (If not patient)**
Secondary Medical Insurance	**Policy #**	**Subscriber (If not patient)**

Assignment and Release

I, the undersigned, coverage with the above company and assign directly to VMFMD Inc. all medical benefits, if any, otherwise payable to me. I understand for services rendered that I am financially responsible for all charges whether paid or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____ _____

Signature of Insured / Guardian Relationship to Patient Date

CONSENT FORMS

NOTICE OF PRIVACY PRACTICES

Your Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to receive a printed copy of this notice.
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to inspect and copy, amend and submit corrections your protected health information.
5. The right to request restrictions on the use and disclosure of your protected health information.

Duties of Vincent M. Fortanasce M.D. Inc.

We are required by law to maintain the privacy of your protected health information and to give this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in the notice.

Revising Privacy Practices

We reserve the right, as legally permitted, to amend or modify our privacy practices and policies. These changes in our practices and policies may be required because of changes in federal and state laws and regulation. Upon request, we will provide you the revised notice at the time of your office visit. These will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may request access to your records by contacting our receptionists. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

HIPAA CONSENT TO TREATMENT

I understand that, under the Health Insurance Portability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among other healthcare providers.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of your Notice of Privacy Practices containing a more complete description of the users and the disclosures of my health information. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

MEDICATION REFILL CONSENT

I understand that prescriptions may be filled and refilled via telephone or using an online service. I have been made aware that in utilizing this service, pharmacists will have access to view all of the medications I am taking at the present time.

My Local Pharmacy: _____ Cross-Streets: _____ & _____

Mail Order Pharmacy: _____ Phone # _____

Patient Signature: _____ **Guardian Signature:** _____

Printed Name: _____ **Guardian Name:** _____

Date of Signature: _____ **Relation to Patient** _____

REASON FOR YOUR VISIT

Why are you seeking help now? _____

Is this the result of a specific injury or accident? YES / NO

a) If yes, when was the date of the accident? _____
b) What type of accident was it? _____

Health prior to present illness? _____

Approximate date of onset and present type of onset?

Sudden (within 24 hours). Please specify: _____
Gradual (more than 1 day). Please specify: _____

Progression (please circle): WORSENING IMPROVING STAYING THE SAME

What brings on the problem/makes it worse? _____

Name of previous doctors seen for the above illness? _____

Previous examinations:	Date of examination (approximate)
EEG (brainwave)	_____
EMG	_____
Spinal Tap / Lumbar Puncture	_____
MRI	_____
MRA	_____
CT Scan	_____
X-Ray	_____
Ultrasound	_____

Other doctors' treatment for the problem? _____
_____

Are you or do you anticipate involvement in a litigation (lawsuit)? _____

MEDICAL HISTORY	SURGICAL HISTORY

MEDICATIONS ☐ See below. ☐ See attached list.			
Name	Strength & Dose	Duration (Start/end date)	Outcome (Check)
			☐ Effective ☐ Contraindicated ☐ Intolerant ☐ Failed
			☐ Effective ☐ Contraindicated ☐ Intolerant ☐ Failed
			☐ Effective ☐ Contraindicated ☐ Intolerant ☐ Failed
			☐ Effective ☐ Contraindicated ☐ Intolerant ☐ Failed
			☐ Effective ☐ Contraindicated ☐ Intolerant ☐ Failed
			☐ Effective ☐ Contraindicated ☐ Intolerant ☐ Failed
			☐ Effective ☐ Contraindicated ☐ Intolerant ☐ Failed
			☐ Effective ☐ Contraindicated ☐ Intolerant ☐ Failed

ALLERGIES	REACTIONS
1)	
2)	
3)	
4)	

Are you allergic to IV contrast or shell fish? ☐ **YES** ☐ **NO**

FAMILY HISTORY			
Family Member	**Living (L), Deceased (D), Unknown (U)**	**Age**	**Medical Conditions**
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister			
Brother			
Son			
Daughter			

PATIENT HISTORY	
Social History Birthplace: Education Completed: Marital Status:	**Work History** Occupation: Employer: Toxin exposure:
Tobacco Use Yes No Quit year _____ Packs per day:	**Alcohol Use** Yes No # of Drinks per Week _____
Caffeine Use Coffee Tea Energy Drinks Other None # of Drinks per Day _____	**Exercise** Yes No ☐ 1x /week ☐ 2-3x /week ☐ 4+ /week

SELF-ASSESSMENTS
Please use a few words that you feel best describes you.
What type of person do I feel I am now?
How would my (pick one) husband, wife, mother, best friend answer the above question?

REVIEW OF SYSTEMS			
SYSTEM	**NO**	**YES**	**COMMENTS**
ALLERGIC / IMMUNOLOGIC			
Low resistance to infection	_____	_____	
Environmental allergies	_____	_____	
CARDIOVASCULAR			
Chest pain or angina	_____	_____	
Irregular heart rhythm	_____	_____	
CONSTITUTIONAL			
Recent weight changes	_____	_____	
Recurrent fevers, chills, sweats	_____	_____	
Extreme fatigue	_____	_____	
Frequent nausea/vomiting	_____	_____	
Difficulty sleeping	_____	_____	
EAR, NOSE, AND THROAT			
Change in hearing	_____	_____	
Ringing in the ears	_____	_____	
Recent nose bleeds	_____	_____	
Chronic sinus problems	_____	_____	
EYES			
Loss of vision	_____	_____	
Blurring of vision or double	_____	_____	
vision	_____	_____	
Glaucoma			
ENDOCRINE			
Heat or cold intolerance	_____	_____	
Excess thirst or urination	_____	_____	
GASTROINTESTINAL			
Change in appetite	_____	_____	
Severe heart burn	_____	_____	
Vomiting blood	_____	_____	
Frequent diarrhea	_____	_____	
Constipation	_____	_____	
Black/bloody stools	_____	_____	
Abdominal pain	_____	_____	
GENITOURINARY			
Blood in urine	_____	_____	
Burning with urination	_____	_____	
Difficult/frequent urination	_____	_____	
Lack of bladder control	_____	_____	

SYSTEM	NO	YES	COMMENTS
Sexually transmitted disease	_____	_____	
Change in sexual function	_____	_____	
HEMATOLOGIC / LYMPHATIC			
Easy bruising	_____	_____	
Frequent bleeding	_____	_____	
Enlarged lymph nodes	_____	_____	
INTEGUMENT			
Unusual or prolonged rashes	_____	_____	
Breast pain or lump	_____	_____	
Change in hair or nails	_____	_____	
MUSCULOSKELETAL			
Joint swelling	_____	_____	
Difficulty walking	_____	_____	
NEUROLOGICAL			
Headaches	_____	_____	
Numbness / tingling	_____	_____	
Weakness or paralysis	_____	_____	
Convulsions or seizures	_____	_____	
Change in memory / concentration	_____	_____	
Black-outs or dizziness	_____	_____	
Memory loss or confusion	_____	_____	
Falls or near falls, last 6 months	_____	_____	
Other neurological problems			
PAIN			
Joint stiffness or pain	_____	_____	
Muscle pain	_____	_____	
Neck pain	_____	_____	
Back pain	_____	_____	
Other pain (specify)	_____	_____	
PSYCHIATRIC			
Nervousness	_____	_____	
Depression	_____	_____	
Other	_____	_____	
RESPIRATORY			
Breathing problems	_____	_____	
Shortness of breath	_____	_____	
Coughing up blood	_____	_____	
Chronic cough	_____	_____	

Fill this out to see if you may have a Sleep Disorder.

PRIMARY SLEEP COMPLAINTS			
Do you snore at night?	☐ No	☐ Yes	☐ Occasionally
Have you been told you have pauses in your breathing while asleep at night?	☐ No	☐ Yes	☐ Occasionally
Do you have difficulty falling asleep at the beginning of the night?	☐ No	☐ Yes	☐ Occasionally
Do you have difficulty staying asleep throughout the night?	☐ No	☐ Yes	☐ Occasionally
Have you been told you make kicking/twitching movements while asleep?	☐ No	☐ Yes	☐ Occasionally
Do you experience excessive tiredness during the day?	☐ No	☐ Yes	☐ Occasionally
Do you awaken feeling paralyzed?	☐ No	☐ Yes	☐ Occasionally
Do you experience sudden loss of strength in your arms or legs during the day?	☐ No	☐ Yes	☐ Occasionally
If yes, are these brought upon by a sudden frightening event or laughter?	☐ No	☐ Yes	☐ Occasionally
Do you experience morning headaches?	☐ No	☐ Yes	☐ Occasionally
Do you experience choking/gasping episodes?	☐ No	☐ Yes	☐ Occasionally
Do you experience chest pain?	☐ No	☐ Yes	☐ Occasionally

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

0 = Would <u>never</u> doze 1 = <u>Slight</u> chance of dozing 2 = <u>Moderate</u> chance of dozing 3 = <u>High</u> chance of dozing

- Sitting and reading: _____
- Sitting inactive in a public place (i.e. theatre or meeting): _____
- As a passenger in a car for an hour without a break: _____
- Lying down to rest in the afternoon: _____
- Sitting and talking to someone: _____
- Operating a car, while stopped for a few minutes in traffic: _____

Total Score: _____

Fill this out if you have Headaches.

1. **A.** How many days in the past month did you spend with headache/migraine?
   (Include ALL days with any headache pain of any kind, even those you didn't feel you needed to take any medication for or only took an over-the-counter medication.) **_____ day(s)**

   B. How many days in the past month did you spend without ANY headache pain Of any kind **(Headache-free days)** ? **_____days(s)**

   C. Now subtract **B** from 31 and enter that number: **_____days(s)**

   In **A or C, did you enter 15 or more?** **Circle: Yes or No**

2. Did any of your heachaches/migraines last more than 4 hours if you didn't treat them? **Circle: Yes or No**

3. Have you ever been diagnosed as having chronic headaches (including chronic tension-Type or chronic sinus headaches)? **Circle: Yes or No**

4. Have you ever been diagnosed as having migraines? **Circle: Yes or No**

5. Do your heachaches/migraines impact your daily life? **Circle: Yes or No**
   Rate the impact of your headaches/migraines on your daily life:

   1 2 3 4 5 6 7 8 9 10

   Mild **Severe**

   How many days in the past month have your headaches/migraines severely Affected your daily life? **_____days(s)**

6. In the past month, did you take anything to treat your headaches/migraines? **Circle: Yes or No**
   If "yes", how many days in the past month did you take something to treat Your headaches/migraines (including over the counter drugs, prescription Medication, and vitamins/herbal remedies)? **_____days(s)**

   Please List What You Took:

   _____
   _____
   _____
   _____

☐ **CHECK HERE IF YOU ANSWERED "YES" TO BOTH 1 AND 2 AND AT LEAST ONE**

OF THE OTHER QUESTIONS. YOU MAY HAVE CHRONIC MIGRAINE.

HEADACHES / MIGRAINES

Fill this out if you have Neck or Back Pain.

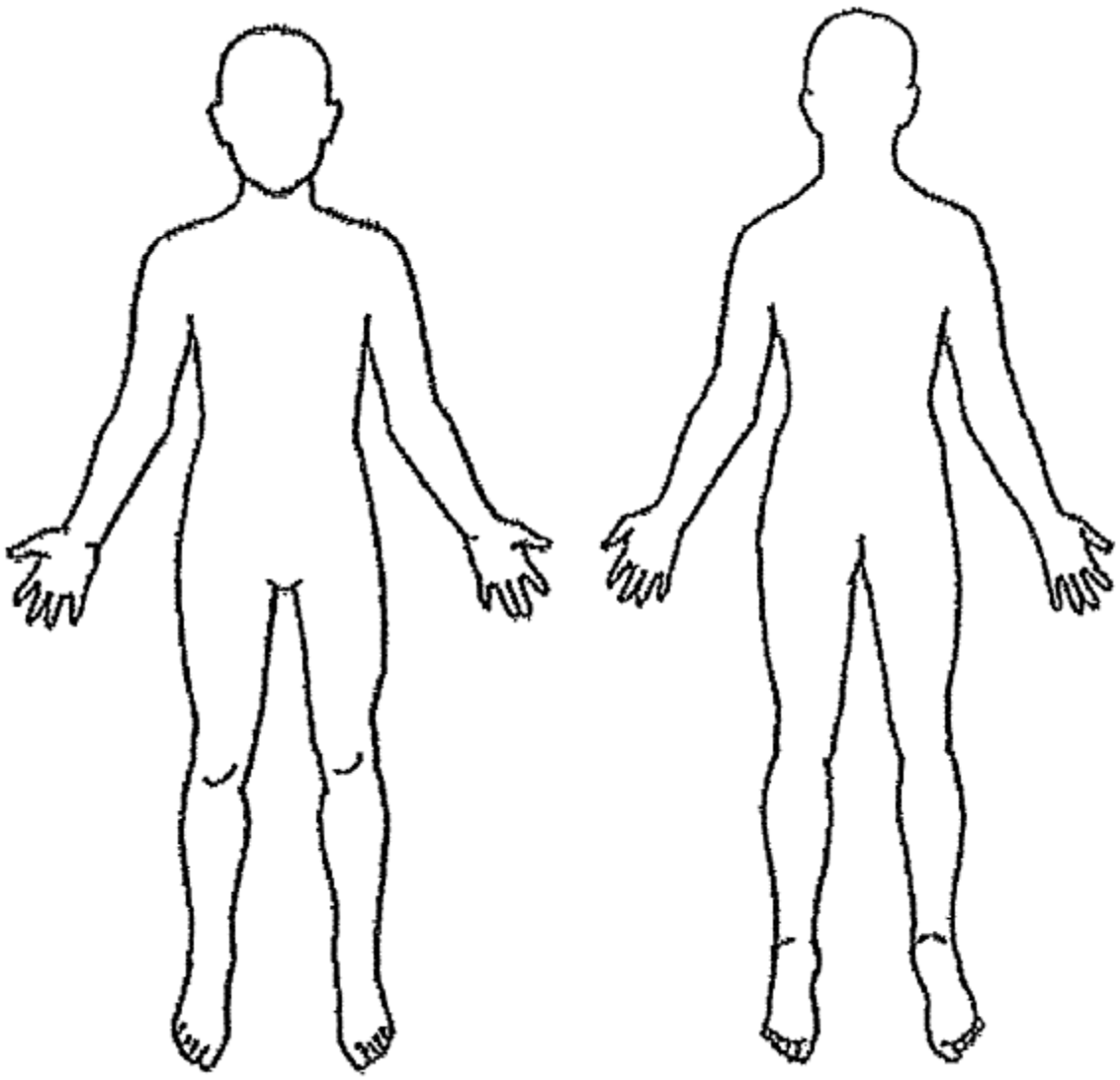
HISTORY OF PAIN										
Chief complaint of pain location:										
When the symptoms originally began:			Developed gradually ☐			Developed suddenly ☐				
If it was because of an injury, how did the injury occur?										
(Circle one) Symptoms are: **Worse** **Better** **Unchanged**										
What is the ratio of your **neck pain** to your **arm pain**? (Ex: 100% neck / 0% arm)										
100/0	90/10	80/20	70/30	60/40	50/50	40/60	30/70	20/80	10/90	0/100
Rate the pain in your **neck and arms** on a scale of 1 – 10, 10 being the worst pain. _____										
What is the ratio of your **back pain** to your **leg pain**? (Ex: 100% neck / 0% arm)										
100/0	90/10	80/20	70/30	60/40	50/50	40/60	30/70	20/80	10/90	0/100
Rate the pain in your **back and legs** on a scale of 1 – 10, 10 being the worst pain. _____										
(Circle one) Do you have numbness in your upper extremities? **Yes** **No**								**Specify:**		
(Circle one) Do you have numbness in your lower extremities? **Yes** **No**								**Specify:**		
(Circle one) Do you have weakness in your upper extremities? **Yes** **No**								**Specify:**		
(Circle one) Do you have weakness in your upper extremities? **Yes** **No**								**Specify:**		

TREATMENT HISTORY	
What past treatments have made your neck and arm pain BETTER? (ice, medication, therapy, acupuncture…)	
What past treatments have made your neck and arm pain WORSE?	
What past treatments have made your back and leg pain BETTER?	
What past treatments have made your back and leg pain WORSE?	
Have you had spinal surgery? **Yes** **No**	If yes, when? _____ Where? _____ By who? _____ Did you experience a pain-free interval after surgery? **Yes / No** If yes, for how long? _____

PAIN DIAGRAM

Please mark all the areas on your body where you feel the described sensations. Use the appropriate symbol.

Active Pain ^^^^	Numb OOOO	Pins & Needles ++++	Burning XXXX	Radiating ////



How bad is your pain now? (1 = No Pain 10 = Excruciating Pain)

1 2 3 4 5 6 7 8 9 10

How consistent is your pain?

Continuous Positional Intermittent (On/Off) Unable to Rate