WOODLANDS MEDICAL

PATIENT INFO

Name:
(FIRST) (MI) (LAST)

Address:
(STREET) (CITY) (STATE) (ZIP)

Home Phone: Cell Phone: Work Phone:

Email Address:

DOB: / / SSN: Gender: Race: Ethnicity:

Driver's License #: State:

Marital Status: S M W Spouse's Name:

Your Employer: Occupation: F/T or P/T

Employer Address:
(STREET) (CITY) (STATE) (ZIP)

How did you hear about us? _____ Primary Care Physician: _____

Preferred Pharmacy: Pharmacy Address or City:

INSURANCE INFORMATION

Insurance Type (circle one): Personal Pay Health Medicare PI/Auto Worker's Comp

Insurance Carrier Name:

Member/Identification #: Group/Plan #:

Primary Insured's Name (If Different From Patient): Relationship to Patient:

Primary Insured's DOB: / / Primary Insured's Phone:

Primary Insured's Employer:

Person Responsible for account: Relationship: Contact number:

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient or Parent/Guardian Signature **Date:**

WOODLANDS MEDICAL

PATIENT INTAKE FORM

Patient Name: _____ **Date:** _____

Today's problem will be filed as: □ Insurance/ Self Pay □ Auto Accident □ Workman's Compensation

HT: _____ **WT:** _____ **DOB:** _____ **Gender:** _____ **Age** _____ **BP** _____ **P** ___ **O** ___ **O2** ____

Chief Complaint: _____

Are you being treated elsewhere for this? □ Yes □ No Where? _____

Drug Allergies: _____ **Specific Side Effects:** _____
Drug Allergies: _____ **Specific Side Effects:** _____

Medication: _____ **Dosage:** _____
Medication: _____ **Dosage:** _____
Medication: _____ **Dosage:** _____
Medication: _____ **Dosage:** _____
Medication: _____ **Dosage:** _____
Medication: _____ **Dosage:** _____

Immunizations:

Last Tetanus: _____ **Last Hepatitis B:** _____ **Last Pneumonia:** _____

Last Zostervax: _____ **Last Flu:** _____ **Last Covid:** _____

Past Medical / Surgery History:

Medical condition: _____ **Type of Surgery:**_____ **Year:** _____

Medical condition: _____ **Type of Surgery:**_____ **Year:** _____

Medical condition: _____ **Type of Surgery:**_____ **Year:** _____

Last Colonoscopy: _____ **Last Mammogram:**_____ **Last Pap Smear:** _____

Social History:

Occupation: _____ **Alcohol Consumption:** □ Yes □ No How much? _____

Tobacco Use: □ Yes □ No **How much?** _____ **How many children do you have?** _____ Male _____ Female

Do you exercise? □ Yes □ No **How much?** _____ **Recreational Drug use:** □ Yes □ No **How often?** _____

Family History of Serious Illness:							
Relationship	**Age**	**Health Condition**	**Cause of Death**	**Relationship**	**Age**	**Health Condition**	**Cause of Death**
Father				**Mother**			
Grandmother				**Grandmother**			
Grandfather				**Grandfather**			
Other				**Other**			
Other				**Other**			

For the conditions listed below, please check the "past" column if you have had the condition in the past.
If you presently have a condition listed below, please check the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	Mucus/Phlegm	□	□	Prostate Problems
□	□	Neck Pain	□	□	Sore Throat	□	□	HIV/AIDS
□	□	Upper Back Pain	□	□	Ear Pain	□	□	Weight Gain
□	□	Mid Back Pain	□	□	Ear -brown discharge	□	□	Chills
□	□	Low Back Pain	□	□	High Blood Pressure	□	□	Fever
□	□	Shoulder Pain	□	□	Diabetes	□	□	Abnormal Weight Gain/Loss
□	□	Elbow/Upper Arm Pain	□	□	Heart Attack	□	□	Ulcer
□	□	Wrist Pain	□	□	Excessive Thirst	□	□	Hormonal Replacement
□	□	Hand Pain	□	□	Chest Pains	□	□	Hepatitis
□	□	Hip Pain	□	□	Frequent Urination	□	□	Liver/Gall Bladder Disorder
□	□	Knee Pain	□	□	Stroke	□	□	General Fatigue
□	□	Ankle/Foot Pain	□	□	Tobacco Use	□	□	Malaise
□	□	Jaw Pain	□	□	Angina	□	□	Muscular Incoordination
□	□	Joint Pain/Stiffness	□	□	Drug/Alcohol Dependence	□	□	Right Hand Dominant
□	□	Arthritis	□	□	Kidney Stones	□	□	Left Hand Dominant
□	□	Rheumatoid Arthritis	□	□	Allergies	□	□	Visual Disturbances
□	□	Cancer	□	□	Kidney Disorders	□	□	Dizziness
□	□	Tumor	□	□	Depression	□	□	Light Headedness
□	□	Asthma	□	□	Bladder Infection	□	□	Vertigo
□	□	Dysphagia/Breath	□	□	Systemic Lupus	□	□	Loss of Hearing
□	□	Chronic Sinusitis	□	□	Painful Urination			
□	□	Facial Pain/sinus pressure	□	□	Epilepsy			
□	□	Chronic Sinusitis	□	□	Loss of Bladder Control			
□	□	Postnasal Drip	□	□	Dermatitis/Eczema/Rash			
□	□	Nasal obstruction/congestion	□	□	Change in vision, Blurred vision			**Females Only**
□	□	Nose bleeds	□	□	Eye pain, Eye discharge	□	□	Abdominal Pain
□	□	Purulent (yellow-green) drainage	□	□	Wear Glasses	□	□	Birth Control Pills
□	□	Rash	□	□	Wear Contact Lenses	□	□	Pregnancy

1. What activities do you do at work?

Sit	□ Most of the day	□ Half of the day	□ A little of the day
Stand	□ Most of the day	□ Half of the day	□ A little of the day
Computer Work	□ Most of the day	□ Half of the day	□ A little of the day
On the Phone	□ Most of the day	□ Half of the day	□ A little of the day
Drive	□ Most of the day	□ Half of the day	□ A little of the day
Other Activities	□ Perform manual labor	□ Read a lot	□ Travel frequently

2. What activities do you enjoy outside of work?

_____

_____

_____

3. Have you ever been hospitalized? □ Yes □ No If yes, why?

_____

_____

4. Have you had past trauma such as car accidents (ever?), falls, sports injuries, etc? □ Yes □ No

If yes, what and when?

_____

_____

5. Is there anything else you wish to let the doctor know about your visit today? □ Yes □ No

If yes, what?

_____

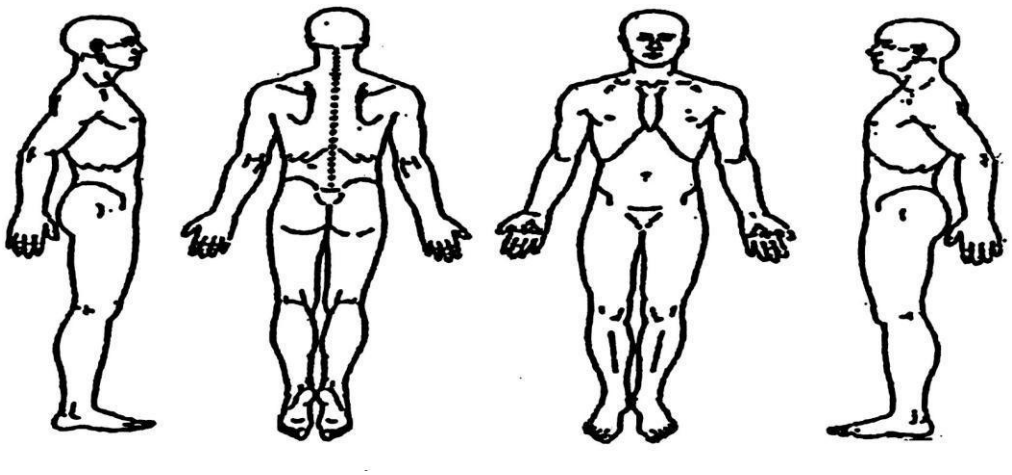
_____

Patient or Parent/Guardian Signature _____ **Date** _____

If you are being seen by our Physical Medicine team, please complete questions 6 – 15:

Patient Name: _____ **Date:** _____

6. Indicate on the drawings below where you have pain/symptoms:



7. How would you describe the type of pain?

□	Sharp	□	Numb
□	Dull	□	Tingly
□	Diffuse	□	Sharp with motion
□	Achy	□	Stabbing with motion
□	Shooting	□	Electric-like with motion
□	Stiff	□	Other: _____

8. How long have you had this problem? _____

9. How do you think your problem began? _____

10. How often do you experience your symptoms?

□ Constantly (76-100% of the Time)
□ Frequently (51-75% of the Time)
□ Occasionally (26-50% of the Time)
□ Intermittently (1-25% of the Time)

11. On a scale from 0-10 (10 being the worst), how would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

12. What aggravates your problem?

_____

_____

13. What alleviates your problem?

_____

_____

14. How are your symptoms changing with time?

□ Getting worse □ Staying the same □ Getting better

15. Have you ever had any form of manual mobilization or manipulation from a Doctor of Chiropractic or Doctor of Osteopathic medicine? □ Yes □ No

If yes, when was your last treatment? _____

Any comments regarding past care:

_____

_____

_____

Patient or Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Name if applicable (printed) _____

Family Medicine Consent to Treat

Purpose of this Consent Form: This form is provided to patients of the Woodlands Medical Group. (the "Clinic"). We want to let you know about the care and treatment that you will receive from the Clinic, and to obtain your consent to allow us to provide your care. In the case of patients under the age of 18, or other individuals who may not be capable of making informed choices about their healthcare, we provide this form to their parents, guardians or caregivers to evaluate and sign on behalf of the patient.

General Consent and Conditions of Treatment: I consent to the treatment that will be provided by the Clinic primary care providers, as well as their assistants and other Clinic staff members. I understand that a medical record will be prepared and maintained about me by the Clinic, and that I am entitled to obtain a copy of my medical record by signing a Medical Records Authorization Form provided by the Clinic for that purpose.

Communication With Health Care Providers: To safeguard my health information, I understand that the Clinic's practice is to convey test results to patients by phone, mail (to the address provided by the patient or caregiver) or in person. I understand that the Clinic's policies do not permit discussions about my health information, or transmission of my test results via email, since email is generally not a secure method of communication. I understand that I always have the option to call the Clinic or make an appointment to come in to discuss my test results or health issues with a provider.

Emergency Situations: I understand that in emergency situations, it may be necessary or advisable for the Clinic to perform services and/or procedures that may not be fully discussed with me (or my parent or caregiver) in advance. I consent to these services and/or procedures under those circumstances.

Billing and Collection: I give the Clinic permission to share my information with my insurance company for the purpose of seeking payment, as well as any third-parties that may be involved in billing or collection services for the Clinic. If I don't want certain information shared with my insurance company, I have the right to notify the Clinic before any billing takes place, but understand that I must also pay for the treatment that I do not want shared in full, at the time the treatment is provided to avoid sharing the information with my insurance company.

Work-Related Injuries or Disabilities: I understand that if I receive treatment for a work-related injury or illness, some of my information will be shared with my employer or its workers' compensation insurance carrier, in connection with evaluation of my claim, and in order to help my employer address any safety issues at the workplace. I also understand that if I request special accommodations based upon a disability, a limited amount of my medical information may be shared with my employer, to the extent warranted to evaluate or confirm my disability.

Authentication: I understand that the Clinic will require patients to provide identification in connection with visits to the Clinic or in connection with any telephone calls in which personal information may be requested. This helps the Clinic ensure that it is not divulging personal information nor treating an unauthorized person. If I cannot provide the necessary identification, I may not be able to receive treatment or receive the information that I am seeking from my medical record until I am able to satisfy the Clinic's authentication requirements. Such documents will include my valid driver's license and/or a picture I.D. from my employer.

Personal Belongings: I understand that the Clinic takes steps to ensure that the waiting room and other areas of the Clinic are safeguarded. However, I understand that I am solely responsible for any personal belongings that I bring with me to the Clinic, including jewelry and other valuables.

Notice of Privacy Practices: By signing this form, I acknowledge receipt of the Clinic's Notice of Privacy Practices.

Validity of Consent: I understand that this Consent Form shall be valid as long as I am a patient with Woodlands Medical Group. I have the right to withdraw my consent at any time. If I choose to do so, I must provide that withdrawal in writing, to the Clinic.

The withdrawal of consent will only apply after it is received, and not to any information for which I previously provided consent.

I HAVE READ OR HAD READ TO ME THIS CONSENT FORM AND UNDERSTAND AND ACCEPT ITS TERM.

Emergency Contact Name/Relationship: _____

Emergency Contact Phone Number: _____

Secondary Contact/Number: _____

Patient Name (Printed) _____ Date _____

Patient or Parent/Guardian Signature _____

Parent/Guardian name and relationship (printed) _____

Staff Signature _____ Date _____

Physical Medicine Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the bloodstream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniation: Disk herniation that creates pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if the results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name/Relationship: _____

Emergency Contact Phone Number: _____

Secondary Contact/Number: _____

Patient Name (Printed) _____ Date _____

Patient or Parent/Guardian Signature _____

Parent/Guardian name and relationship (printed) _____

Staff Signature _____ Date _____

Insurance Verification Disclosure/Agreement

As a courtesy, Woodlands Medical Group & Nobility Medical Group will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient or Parent/Guardian Signature _____

Parent/Guardian name and relationship (printed) _____

Staff Signature _____ Date _____

View External Prescriptions Agreement

I authorize Woodland's Medical to view my external prescription history from the external source.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

My signature certifies that I have read and understood the scope of my consent and I authorize the access.

Patient Name: _____ Date: _____

Signature: _____

HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes: All Patient Medical Records

Persons Authorized to Use or Disclose Information to:

Name(s):

_____

Information listed above will be used or disclosed by:

Woodlands Medical Group and/or Nobility Medical Group

Expiration Date of Authorization

This authorization is effective through 12/2025 unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Woodlands Medical Office Manager to use my protected information for the listed reasons.

Patient Name (Printed) _____ Date _____

Best contact email: _____

Patient or Parent/Guardian Signature _____

Parent/Guardian name and relationship (printed) _____

Staff Signature _____ Date _____

Dear Patient:

This office has joined Nobility Medical Group, PA, (Woodlands Medical Group), a multidisciplinary doctor group. We have done this for various reasons, with the most important one being that our facility can enjoy a more comprehensive approach to your health by utilizing an integrative health care model. This means the incorporation of Medical and Osteopathic physicians, who are directly involved in your healthcare, into our scope of various services. As such, certain services and diagnostics will be administered, when clinically warranted, and billed under the Nobility Medical Group, PA. As such, when you receive your explanation of benefits from your health insurance company, it will indicate the date of services and procedure codes and payments made to Nobility Medical Group, PA. During your primary care appointments, you will be seen by a Nurse Practitioner or a Physician Assistant. If you prefer to see Dr. Pastorek we will help facilitate that for you. This office does not discriminate groups based on sex, age, race, ethnicity, nationality, disability, mental illness or ability, sexual orientation, gender, gender identity/expression, sex characteristics, religious, creed or individual political opinions.

If you have any questions regarding this exciting amendment to our office, please ask me.

Sincerely,

Jeremy Evans, DC
Cael Halfman, DC
Clint Camacho, DC
William Hazel, DC
Scott Wright, DC
David Foote, DC
James Kontaratos, DC

Muhammad Siddiqui, MD
Oliver Ghalambor, MD
Brittany Bradshaw, FNP-C
Kelli Mokszycki, FNP-C
Kylee Barker, PA-C
Cynthia Okeke, PA-C
Kevins Davis PA-C

Release of Medical Records

I, _____, hereby authorize the release of my medical records

◯ From ◯ To

_____

_____

_____

◯ To ◯ From

Woodlands Medical Group

□ Mail to:

□ Fax to: _____

_____
Patient Name (Printed)

_____
Patient or Parent/Guardian Signature

_____
Parent/Guardian Name and relationship (printed)

_____
Date of Birth

_____
Date Signed

ASSIGNMENT OF BENEFITS

Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Nobility Medical Group PA (Provider) (Woodlands Medical), as consideration for such

Provider services. Patient irrevocably assigns to Nobility Medical Group PA (Provider) (Woodlands Medical) any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Nobility Medical Group PA (Provider) (Woodlands Medical): (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Nobility Medical Group PA (Provider) (Woodlands Medical), and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable Assignment of Benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Nobility Medical Group PA's (Provider) (Woodlands Medical) health care services shall extend to, but not be limited to, Provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Nobility Medical Group PA (Provider) (Woodlands Medical).

By my signature be it known that I have read and fully understand the above contract.

Patient Name (Printed) _____ Date _____

Patient or Parent/Guardian Signature _____

Parent/Guardian name and relationship (printed) _____

Staff Signature _____ Date _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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