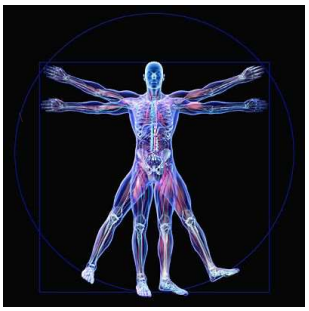

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New Patient Packet

Purpose: Consult/ Take Over Care/ Supportive Care/ IME/ Social Security Evaluation

Patient Information

Name: _____ Date: _____

Address: _____

Phone Number: _____ Social Security number: _____

Age: _____ Sex: Male/ Female Date of Injury: _____

May our office leave a message on your answering machine? YES NO

Employer's Information

Employer Name: _____

Address: _____

Phone: _____

Emergency Contact (Local friend or relative not living with you)

Contact Name: _____

Relationship: _____

Address: _____

Phone Number: _____

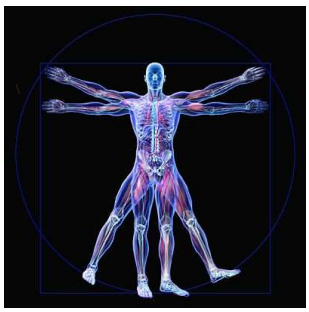
Release of information

To the extent necessary to determine insurance benefits, liability for payment, and to obtain reimbursement, Sanjay R Patel PLLC may disclose portions of the patient's medical record and account file to any person or cooperation which may be liable for all or any portion of this patient's charges. Including but not limited to insurance companies, health care service plans, attorney's offices, or worker's compensation carrier.

By signing below, I give my consent for my information to be provided to the above parties;

_____ _____

Signature of patient, or legal representative Date



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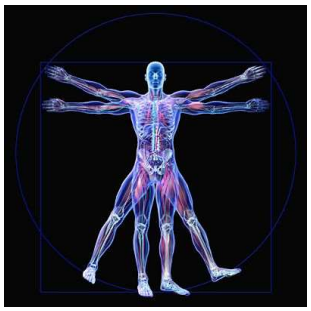
1. Who referred you?
   _____
2. What was your date of injury?
   _____
3. Who were you employed by when you were injured?
   _____
4. What was your job title?
   _____
5. How long have you been with this employer doing this type of work?
   _____
6. Did you like or enjoyed your work?
   YES NO
7. Did you like your employer?
   YES NO
8. Do you think they are fair and are there to help you get better?
   YES NO
9. What type of work did you do before this injury and for how long?
   _____
10. Describe below how you were injured in detail.
    _____
    _____
    _____
    _____
11. What body part(s) did you injured?
    _____
12. Did you seek medical treatment right away? If yes what happened?
    _____
    _____
13. If not, then how long did it took for you to eventually receive medical treatment?
    _____
14. What type of treatment have you been given?
    _____
15. Did any of the treatment you have been given helped?
    _____
16. How do you feel now?
    Better Same Worse
17. Are you currently working?
    YES NO
18. If not, when was the last time you worked?
    _____
19. Do you plan to return to this type of work?
    YES NO
20. Are you currently taking any medications for the injury? If yes, which ones help you?
    _____
21. What makes your pain feel better?
    _____
22. If you have pain please list form worst to least painful areas are;
    Worse _____
    Mild _____
    Least _____
    What makes your pain better and worse?
    _____



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Past Medical History

Please check off any medical conditions mention below that may apply to you.
_____ Prostate Disease
_____ High Blood Pressure
_____ Cancer Breast Disease
_____ Hypothyroid/Hyperthyroid/ Asthma
_____ COPD (Chronic obstructive pulmonary disease)
_____ High Cholesterol
_____ Heart/ GERD (Gastroesophageal reflux disease)
_____ Fibromyalgia
_____ Diabetes, Type: _____
_____ Other: _____

Past Family Medical History: _____

Past Surgical Procedures: _____
_____

Current Medications: _____
Medication Allergies: _____ Causes: _____

Social History

Marital Status? SINGLE MARRIED DIVORCED WIDOW
Do you have children? YES NO If yes, number of children? _____
Do you smoke? YES NO If yes, how many a day? _____
Do you drink Alcohol? YES NO If yes, how often? _____
Do you or have you used recreational drugs? YES NO
If yes, What kind and How often? _____

Please check off any of the symptoms below if you have experience them in the past 2 weeks.

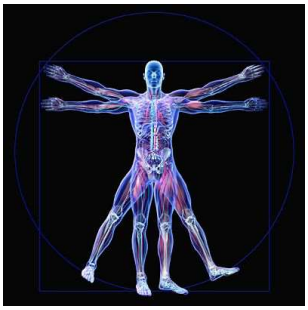
_____ Fever	_____ Palpations	_____ Depression
_____ Blurry Vision	_____ Cough	_____ Urinary Incontinence
_____Diminished Hearing	_____ Shortness of Breath	_____ Rash
_____ Double Vision	_____ Itching	_____ Dizziness
_____ Blurry Vision	_____ Constipation	_____ Headaches
_____ Vomiting	_____ Diarrhea	_____ Memory Loss
_____ Tinnitus	_____ Heartburn	_____ Easy Bruising
_____ Chest Pain	_____ Nausea	_____ Sleep Disturbance

Current Work Status

(Please check the one that applies to you)

_____ Working Full Time
_____ Working Part Time
_____ Unemployed (Disabled)
_____ Unemployed (Not Disabled)
_____ Retired
_____ Student
_____ Other: _____

Work restrictions: _____
_____
_____
Length of time unemployed?
_____ Months _____ Years
Are you unemployed because of pain? YES NO



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Symptom Diagram

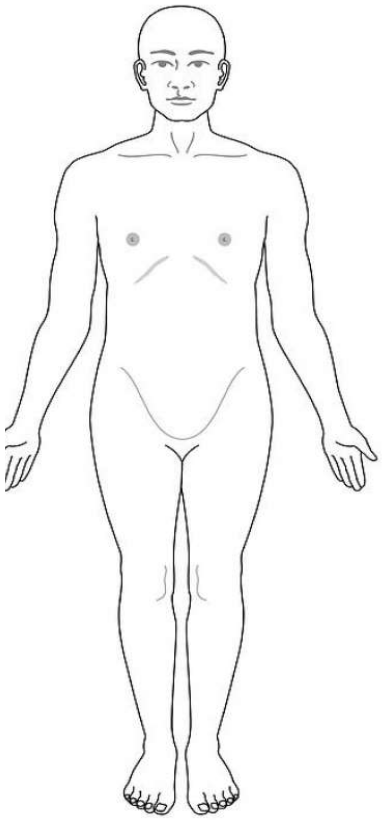
Please make sure to fill this form accurately.

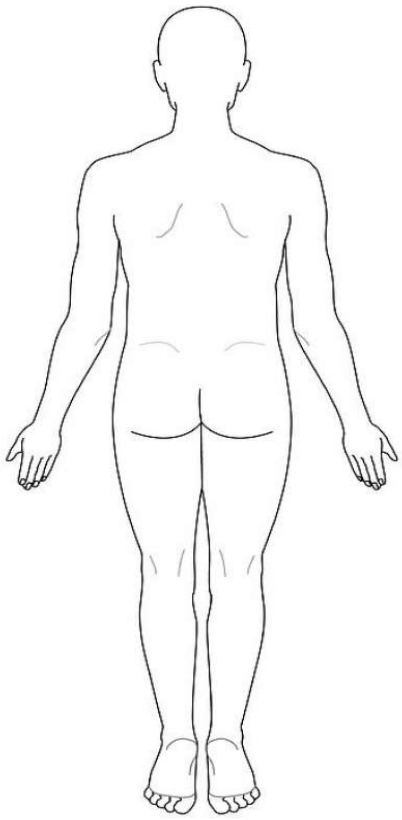
On the below diagram mark the areas where you feel the described sensations using the de appropriate symbols. Mark all areas of radiating pain, make sure all affected areas are included.

Symbols to be drawn on diagram below and meanings;

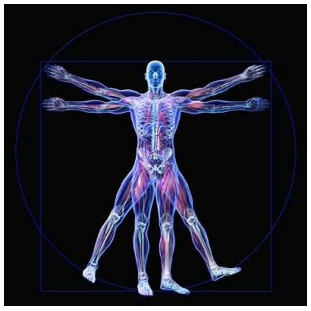
ACHES ^^^^^^
Numbness 000000
Pins/ Needles ******
Burning XXXXXX
Stabbing //////

YOUR RIGHT SIDE





YOUR RIGHT SIDE



Patient Name: _____
Gender: Female/ Male
Date: _____

Opioid Risk

Circle each number that applies to you.

	Female	Male
Family history of substance abuse		
1. Alcohol	1	3
2. Illegal drugs	2	3
3. Rx Drugs	4	4
Personal history of substance abuse		
1. Alcohol	3	3
2. Illegal drugs	4	4
3. Rx Drugs	5	5
History of preadolescent sexual abuse	**3**	**0**
Ages between 16-45 years old	**1**	**1**
Psychological Disease		
1. ADD, OCD, bipolar, schizophrenia	2	2
2. Depression	1	1

For office use only:

Scoring Totals: _____

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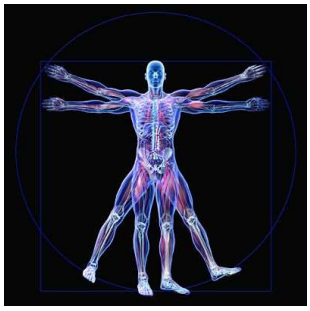

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Narcotic Agreement

Please read and sign below. Agreement will be renewed every twelve (12) months.

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve your ability to do daily activities. Along with opioid treatment, other medical care may be prescribed. For example, this may include exercise, use of non- narcotic analgesics, physical therapy, psychological counseling, or other treatment. I understand that compliance with the following guidelines is important in continuing pain treatment with Dr. Sanjay R Patel.

1. I understand that I have the following responsibilities:

A. I will take medications only at the dose and frequency prescribed.
B. I will not increase or change medications without the approval of this provider.
C. I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
D. I will not request opioids or any other pain medicine from providers other than from this one. This provider will approve or prescribe all other mind and mood-altering drugs.
E. I will inform this provider of all other medications that I am taking.
F. I will obtain all medications from one pharmacy, when possible. By signing this agreement, I give consent to this provider to talk with the pharmacist.
G. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced with a single calendar year. I will keep all medications from children.
H. I agree to participate in psychiatric or psychological assessments, if necessary.
I. If I have an addiction problem I will not use illegal, street drugs, or alcohol. This provider may ask me to follow through with a program to address this issue. For example; A 12 step program and securing a sponsor, individual counseling, and inpatient or outpatient treatment.

2. I understand that in the event of an emergency, this provider should be contacted and the problem will be discussed with the emergency room or other treating provider**.**

3. I am responsible for signing a consent form to request record transfer to this doctor. No more than 3 days of medication may be prescribed by the emergency room or other provider without this provider's approval.

4. I understand that I will consent to random drug screening.

- A drug screen is a lavatory test in which a sample of urine or blood is checked to see what drugs you have been taking.

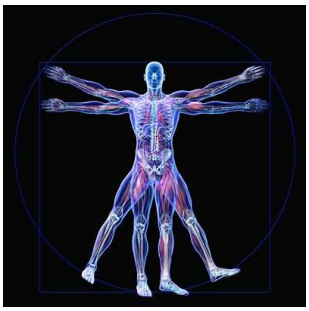
5. I will keep my schedule appointments and/or cancel my appointment in a minimum time of 24 hours prior to my appointment.

6. I understand that this provider may stop prescribing opioids or change my treatment plan if;

- I do not show improvement in pain form opioid or physical activity has not improved.
- My behavior is inconsistent with the responsibilities outline in the number 1 above.
- I give, sell, or misuse the opioid medication.
- I develop rapid tolerance or loss of improvement from treatment.
- I obtain opioids from another physician
- I refuse to cooperate when asked to get a drug screen
- If an addiction problem is identified as a result of prescribed treatment or any other addictive substance
- If I am unable to keep follow up appointments.

Patient signature: _____ Date: _____

Physician signature: _____ Date: _____



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Your Safety risks while working under the influence of opioids

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgement, drowsiness, and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

Possible side effects;

• Change in thinking abilities • Nausea • Constipation • Vomiting • Breathing to slowly • Sleepiness or drowsiness	• Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles	• Over-dose can stop your breathing and lead to death • Aggravation of depression • Dry mouth

All side effects mention above may be made worse if you mix opioids with other drugs, including alcohol.

Possible Risks;

Physical Dependence: This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the followings:

• Runny nose • Abdominal cramping • Rapid heart rate	• Diarrhea • Sweating • Nervousness	• Difficulty sleeping for several days • Goosebumps

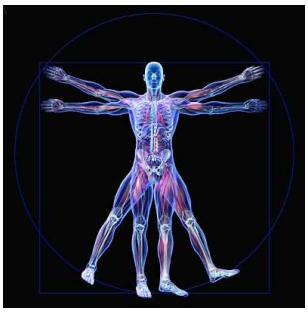
Psychological dependence: This means it is possible that stopping the drug will cause you to miss or crave it.
Tolerance: This means you may need more and more drag to get the same effect.
Addiction: A small percentage of patients may develop addiction problems based on genetic of another provider.
Problems with Pregnancy: If you are pregnant or contemplating pregnancy, discuss with your provider.

Recommendations to manage your medications;

- Keep a diary of the pain medication you are taking, the dosage, time of day your taking you medication, their effectiveness, and any side affects you may have.
- Use medication reminder pill box that you can purchase at your pharmacy that is already divided into the days of the week and times of the day so it is easier to remember when to take medication.
- Take along only the amount of medications you need when leaving home so there is less risk of losing all your medications at the same time.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and understand that my treatment with opioids will be carried out as described above.

Patient Signature: _____ Date: _____



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Urine Drug Testing Disclosure

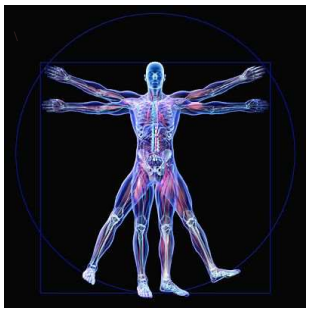
Our office as a service to our patient and in trying to maintain the integrity of urine drug testing does our testing through Advanced Diagnostics. Please note our physician does have a financial interest in this lab and you as a patient have the right to do your urine drug testing at another facility or may be required by your insurance to use a specific laboratory.

Prescription Dispensing Disclosure

Our office offers as a service to our patients, dispensing of some prescribed medications. Please note that you have a choice between obtaining the prescription from our office or having us provide you with a prescription that can be filled at the pharmacy of your choice.

By signing below, I declare this was explained to me, and any questions I may have had were answered.

Patient Signature: _____ Date: _____



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Authorization for Release of Medical Records

By my signature below, I authorize you to discuss or release the following information:

_____

Pertaining to my medical condition, services rendered me, or treatment given to me.

Sanjay R Patel MD PLLC
11030 N. Tatum Blvd. Building F, suite 101
Phoenix, AZ 85028

Patient Name: _____
Social Security: _____
Date of Birth: _____

This authorization to release medical information is being requested of you in compliance with the general terms of the confidentiality of medical information.

This authorization (circle one) **DOES/ DOES NOT** to testing HIV status.

This authorization shall remain in effect for _____ and understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Sanjay R Patel MD PLLC, in writing.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits (If applicable).

I may inspect or copy any information used or disclosed under this agreement.

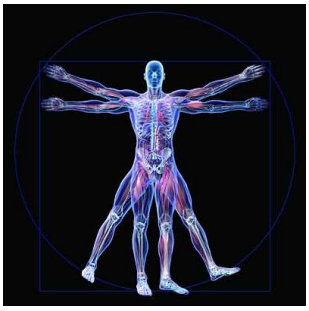
I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above ma be re-disclosed and would no longer be protected by these regulations.

_____ _____
Signature of patient/ parent/ conservator/ guardian/ or patients representative **Date**

_____ _____
Print name of patient representative **Relation to patient**

Note: You have the right to know specifically what information you are authorizing for release (ex. results for a lab test performed on 01/04/03, or if your entire medical record is included, all health information). You have them right to know the name(s) of the other identification of the person(s) or organization(s) authorized to release the information (ex. the names of your health care provider(s)). You have the right to know who is going to use it and what it is going to be used for (Ex. John Smith, PhD/ Research).

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM



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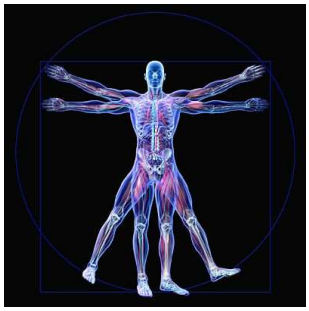
Pain Scale

Circle the number that best applies to you. (Circle One)

1. Does your pain interfere with your normal work inside and outside home?
   Work Normally — Unable to work
   0-----1-----2-----3-----4-----5-----6-----7------8------9----10
2. Does your pain interfere with your personal care (such as washing, dressing, etc.)?
   Take care of myself completely — Need help with all my personal care
   0-----1-----2-----3-----4-----5-----6-----7------8------9----10
3. Does your pain interfere with Traveling?
   Travel anywhere — Only travel to see doctors
   0-----1-----2-----3-----4-----5-----6-----7------8------9----10
4. Does your pain affect your ability to sit or stand?
   No Problems — Cannot sit/stand at all
   0-----1-----2-----3-----4-----5-----6-----7------8------9----10
5. Does your pain affect your ability to lift overhead, grasp objects, or reach things?
   No Problems — Cannot do at all
   0-----1-----2-----3-----4-----5-----6-----7------8------9----10
6. Does your pain affect your ability to lift objects of the floor, bend, stoop, or squat?
   No Problems — Cannot do at all
   0-----1-----2-----3-----4-----5-----6-----7------8------9----10
7. Does your pain affect your ability to walk or run?
   No Problems — Cannot walk/run at all
   0-----1-----2-----3-----4-----5-----6-----7------8------9----10
8. Has your income decreased since your pain began?
   No Decrease — Lost all income
   0-----1-----2-----3-----4-----5-----6-----7------8------9----10
9. Do you have to take pain medication every day to control your pain?
   No medication needed — on pain medication throughout the day
   0-----1-----2-----3-----4-----5-----6-----7------8------9----10
10. Does your pain force you to see doctors as much or more often than before your pain began?
    Never see doctors — See doctors weekly
    0-----1-----2-----3-----4-----5-----6-----7------8------9----10
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    No Problem — Never see them
    0-----1-----2-----3-----4-----5-----6-----7------8------9----10
12. Does your pain interfere with recreational activities and hobbies that are important to you?
    No Interference — Total Interference
    0-----1-----2-----3-----4-----5-----6-----7------8------9----10
13. Do you need help of your family and/or friends to complete everyday tasks because of your pain?
    Never need help — Need help all the time
    0-----1-----2-----3-----4-----5-----6-----7------8------9----10
14. Do you now feel more depressed, tense, or anxious than before your pain began?
    No Depression/Tension — Severe Depression/ Tension
    0-----1-----2-----3-----4-----5-----6-----7------8------9----10
15. Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?
    No Problems — Severe Problems
    0-----1-----2-----3-----4-----5-----6-----7------8------9----10



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· Second Opinions
· Interventional Pain
Management Procedures

11030 N Tatum Blvd.
Building F, Suite 101
Phoenix, AZ 85028
Phone: 602.889.9880
Fax: 480.304.9328

Beck Depression Inventory (Short Form)

Instructions: This is a questionnaire. On this questionnaire are groups of statements.
Please read the entire group of statements in each section. Then pick out the one statement in that group that best describes the way you feel **TODAY**, that is, right now. Circle besides the statement you have chosen. If several statements in the group seem to apply equally well. **Circle each one**.

BE SURE TO READ ALL THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

1.

A. I do not feel sad
B. I feel sad or unhappy
C. I am unhappy or sad all of the time and cannot snap out of it
D. I am so unhappy or sad that I cannot stand it

2.

A. I am not particularly pessimistic or discouraged about the future
B. I feel discouraged about the future
C. I feel I have nothing to look forward to
D. I feel that the future is hopeless and that things can not improve

3.

A. I do not feel like a failure
B. I feel I have failed more than the average person
C. As I look back on my life all I can see is a lot of failures
D. I feel I am a complete failure as a person (parent, husband, wife)

4.

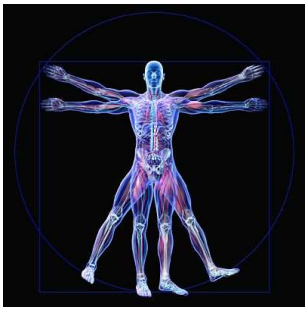
A. I am not particularly dissatisfied
B. I do not enjoy things the way I used to
C. I feel quite guilty
D. I feel as though I am very bad or worthless

5.

A. I do not feel particularly guilty
B. I feel bad or unworthy a good part of the time
C. I feel quite guilty
D. I feel that is my fault the reason I am like this

6.

A. I do not feel disappointed in my self
B. I am disappointed in myself
C. I am disgusted with my self
D. I hate myself



Board Certified
Physical
Medicine &
Rehabilitation
Brain Injury
Medicine
Sanjay R. Patel, M.D.

Pain
Management
Interventional
Procedures
Anesthesiologist
Paul G. Gaitan, M.D.

Board Certified
Family Practice
Laavanya C. Raju, M.D.

· Physical Medicine
· Rehabilitation
· Pain Medicine
· Supportive Care
· Trigger Point Therapy
· Selective Pain Management
Electromyography/
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7.

A. I do not have any thoughts about harming myself
B. I feel I would be better off dead
C. I have definitive plans about committing suicide
D. I would kill myself if I could

8.

A. I have not lost interest in other people
B. I am less interested in other people than what I used to be
C. I have lost all of my interest in other people and have very little feelings for them
D. I have lost all of my interest in other people and do not care about them at all

9.

A. I make decisions about as well as ever
B. I try to put off making decisions
C. I have a great difficulty in making decisions
D. I can not make decisions anymore

10.

A. I do not feel I look any worse than what I used to
B. I am worried that I am looking old or unattractive
C. I feel that there are permanent changes in my appearance that make me look unattractive
D. I feel that I am ugly or repulsive looking

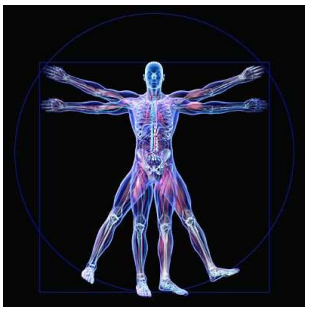
11.

A. I can work about as well as before
B. It takes extra effort to get started at doing something
C. I have to push myself very hard to do anything
D. I cannot do any work at all

12.

A. I do not get more tired than usual
B. I get tired more easily that what I used to
C. I get tired from doing anything
D. I get too tired to do anything

Sanjay Patel, M.D. PLLC



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Patient Bill of Rights and Responsibility Rights

Patient Rights

The observance of the following guidelines will provide more effective patient care and greater satisfaction for the patient, the doctor, and individuals that make up the organization of the office. It is in recognition of these factors to recognize these rights. The patient has the right to consider and respectful care. Patient will be respected cultural, psychosocial, spiritual, personal values, police, and preferences. Patients with vision, speech, hearing, language, and cognitive impairments are entitle to effective communication. The patient is entitled to receive his/ her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should be included, but not necessarily limited to the specific procedure and/ or treatment, the medically significant risks involved and the probable duration of disability. When there are important medical alternatives for care or treatment, or when the patient requests information concerning medical alternatives, the patient has the right to know the name of the person(s) responsible for sedation and anesthesia. The patient has the right to every consideration of his/ her privacy concerning their own care/ treatment. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to expect that all communications and records pertaining to his/ her care should be treated as confidential. Does not participate directly his/ her care must have the permission of the patient to be present. The patient has the right to obtain information for the complete and updated doctor about his/ her diagnosis, treatment, and prognosis in terms the patient can reasonably be expected to understand. The patient had the right to participate in decisions about their care, treatment, and services, and entitled to have pain assessed, managed, and treated as effectively as possible. The patient has the right and when appropriate family to be informed of unanticipated outcomes of care, treatment, and services that relate to or reviewable sentinel adverse events. The patient has the right to expect that within its capacity, this strength must provide outpatient evaluation, service, and /or referral as indicated by the urgency of the case. When medically permissible, the patient may be transferred to another facility only after he/she has received complete information and explanation if the needs and alternatives to such transfer. The patient has the right to obtain information of any relationship at this facility to other health care and educational institution to the extent that his/her care is concerned. The patient as the right to obtain information on the existence of any professional relationships among individuals, by name, who is treating him/ her. The patient has the right to expect reasonable continuous attention. The patient has the right to expect that this facility will provide a mechanism so that he/ she is informed by the physician needs health and care after discharge. The patient has the right to know the mechanisms of complaints and suggestions. The patient has the right to change your choice of doctor. The patient has the right to refuse care, treatment, and services in accordance with legislation and regulation. The patient has the right to challenge information in your medical record. The patient has the right to examine and receive pronation of his/ her account and expect ethical practice billing.

Responsibilities

The patient has the responsibility to provide the physician with the most accurate and complete information regarding present complaints, past illness, hospitalizations, medications, allergies, and unexpected changes in the patient's condition changes. The patient has the responsibility to ask questions when they do not understand what the physician tells them what they are expected to do. If the plan of care is agreed, the patient has the responsibility to follow plan of care or express concerns with compliance. The patient and the family are responsible for following the care plan preoperative and postoperative discharge. The patient and family are responsible for the results, if they do not follow plan of care. The patient is an adult, responsibility to provide him/her home from the ease of transporting and stayed with him/her 24 hours, if required by his/her doctor. The patient is responsible to inform his/her doctor about any living will, medical power, and other directive that could affect his/her care. The patient and family are responsible for following the rules and regulations of the practice concerning patient care and conduct. Patient and families are responsible for being considered for staff and ownership practices. The patient and family are responsible for promptly meet any financial obligation agreed to with practice.

By signing below, I declare I have read this entire page and understand my bill of rights, as well as my responsibility as a potential patient to this practice.

Patient signature: _____ Date: _____