# EXODUS
## SPINE & PAIN MEDICINE

8950 W. Emerald St. Suite 168, Boise, ID 83704 P:208-947-7246
409 E. Elm St. Caldwell, ID 83605 F:208-297-7772

Dear: _____

Your appointment is on: _____ **Please Check In At: _____**

Thank you for scheduling your first appointment with Exodus Pain Clinic. We are looking forward to meeting you and working with you to improve your quality of life.

Appointment times are in high demand, and highly valuable. In order to ensure a pleasant experience for each patient, we have implemented the following policies:

All patient forms must be completed upon arrival. Please arrive **AT CHECK IN TIME.** This allows our staff to enter all of your medical/contact information. If you come to your visit without the forms completed, we **will** reschedule your appointment. **Copays are due at Check in.**

If for any reason you are unable to make your first visit please contact us at least 24 hours before your scheduled appointment. **You may not be permitted to reschedule if you no show or same day cancel your initial intake appointment. This will be at the discretion of management.**

Prior to your first appointment please verify that you have active coverage. If you have multiple insurances, please let our receptionist know which one is your primary, secondary, etc. In the event your insurance requires a referral, please obtain this before your first appointment. **Even with insurance, you are ultimately responsible for all costs of treatment**.

We appreciate your decision in choosing Exodus Pain Clinic, we look forward to seeing you. If you have any questions, please contact us at (208) 947-7246.

Sincerely,

Exodus Spine & Pain Staff

# EXODUS
## SPINE & PAIN MEDICINE

**PATIENT REGISTRATION**

Patient Name: _____ DOB: _____

Address: _____ City: _____ Zip Code: _____

Preferred Contact Phone #: _____ Alt #: _____SSN: _____

**Telephone Authorization:**

May we leave a detailed message on the preferred contact phone listed above? YES NO

Email (please print legibly): _____

Name of Primary Care Physician: _____ (REQUIRED)

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Race: ☐American Indian ☐Asian ☐Native Hawaiian ☐African American ☐White ☐Hispanic ☐Other: _____

☐Check box if declining to answer

**EMERGENCY CONTACT:** If you would like to authorize an individual to speak to our staff (Dr, NP, MA, or Reception) regarding your ***appointments/health care and/or treatment***. Please list their information below:

1. Name: _____ Relationship: _____Phone: _____
2. Name: _____ Relationship: _____Phone: _____
3. Name: _____ Relationship: _____Phone: _____

**Insurance Information**

**Primary Insurance:** _____

Policy Holder: _____ DOB: _____

Member/Subscriber #: _____ Group #: _____

**Secondary Insurance:** _____

Policy Holder: _____ DOB: _____

Member/Subscriber #: _____ Group #: _____

**All information stated above is to the best of my knowledge, true and accurate.**

**Signature: _____ Date: _____**

EXODUS
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# PRIVACY PRACTICES

This document describes how your health information may be used or given to others. It also explains how to access this information. Please review it carefully; you may request a copy of this document at any time.

**Typical Uses and Disclosure of Health Information**

We will keep your health information confidential, using it only for the following purposes:

**1. Treatment:** We may use your health information to provide you with our professional services. We have established privacy practices to assure non-essential persons do not view your information.

**2. Disclosures:** We may disclose your healthcare information with other healthcare professionals who provide treatment and/or services to you. These professionals will have a privacy and confidentiality policy also. Information may also be shared with your family/friends/caregiver ***you choose*** to have involved in your care, only if you agree that we may do so. If you wish to restrict information, please let us know in writing; 1) the information you wish restricted 2) whom you want the limits applied to.

**3. Payment:** We may use and disclose your health information to seek payment for services we provide you. This may include our business office staff and insurance companies, or other business involved in the process of mailing statements and/or collecting unpaid balances.

**4. Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of emergency involving your care, your location, your general condition or death. You may designate an emergency contact and we will use our professional judgement to determine which information will be disclosed. We will also use our professional judgement to make reasonable inference of your best interest by allowing your designee to pick up prescriptions, x-rays, or other similar forms unless you have advised us otherwise.

**5. Healthcare Operations:** We may use or disclose protected health information for certain internal health care operations that are necessary to providing health care services and ensure our patients receive quality care. For example, we may use information from your medical records to review the performance or qualifications of physicians and staff, train staff, or make business decisions affecting Exodus Spine and Pain Medicine Clinic and its services.

**6. Required by Law:** We will disclose your healthcare information where required by law, court, or administrative orders, subpoena, discovery request, or other lawful process. Also, for the use as requested lawfully by national security, intelligence and other State and/or Federal officials, if you are an inmate.

**7. Abuse or Neglect:** We may disclose your healthcare information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes, or if you are homicidal or suicidal. This information will be disclosed only to the extent necessary to prevent serious threat to your health or safety or that of others.

**8. Public Health Responsibilities:** We will disclose your health information to report problems with products, reactions to medications, product recalls, disease or infection exposure and to prevent and control disease, injury or disability.

**9. Marketing/Research:** We will not use your health information for marketing or research without your written consent.

**10. Appointment Reminders:** We may use/disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, postcards, and/or letters.

**11. Access:** You may inspect and receive copies of your health information, or that of an individual for whom you are a legal guardian. There may be a small fee for copies and postage and we may request you make an appointment to review your chart. If you wish any of your health information to be amended, you must submit your request in writing with an explanation of why you feel it should be changed. Under certain circumstances, your request may be denied.

**12. Complaints:** You have the right to fil a complaint with us if you feel we have not complied with our Privacy Practices. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us.

**Contact:** Exodus Pain Clinic 8950 W Emerald, Boise, ID 83704 by mail or (208) 947-7246 by phone.

**Signature: _____** **Date: _____**

EXODUS
SPINE & PAIN MEDICINE

# FINANCIAL POLICY

Welcome to Exodus Pain Clinic ("Clinic"). This form sets forth the Clinic's financial payment policy. We ask all patients to review and sign this Financial Agreement.

As a recipient of medical care, the Patient is responsible for all charges regardless of the circumstances for reimbursement.

**1. Insurance:** The Clinic accepts assignment and participates in most insurance plans. If the Patient's insurance is not a plan we participate in, payment in full is expected at each visit. It is the Patient's responsibility to know his/her insurance benefits. it is the Patient's responsibility to communicate with his/her insurer with any questions regarding the available coverage to receive the maximum benefit.

**2. Patient payment:** All copayments and deductibles are to be paid at the time of service. This arrangement is part of the Patient's contract with his/her insurance company.

**3. Registration:** All Patients must complete the Patient information form, which will be entered into the Clinic's computer system to maintain accurate information for proper billing. The Patient must provide a copy of the driver's license and current valid insurance card to provide proof of insurance. If the Patient fails to provide the correct insurance information and/or insurance changes in a timely manner, the Patient may be responsible for the entire balance of the claim.

Most insurance companies have time filing restrictions; if a claim is not received within 90 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

**4. Claims:** The Clinic will submit the Patient's claims to the insurance company of record and will reasonably assist the Patient to get your claims paid. However, should the insurance company of record does not accept information provided, it is the patient's responsibility to cooperate and comply with the insurance company's requests for additional and/or different information. The Patient's insurance benefit is a contract between the Patient and the insurance company, i.e., the Clinic not party to that contract.

**The balance of the claim is the Patient's responsibility irrespective of his/her insurance company's reimbursement.**

**5. Credit and collection:** If your account is more than 90 days past due, (without payment activity) you will receive a letter stating that you have 10 days to pay your account in full. Accounts with no activity for 120 days may be sent to a collection agency. If an account is sent to collection, it is the policy of this office to discharge the patient and possibly immediate family members from the practice.

**6. Missed appointments:** The Clinic will charge $50 for missed appointments and $100 for missed procedures not canceled within 24-hours prior to the patient's appointment. These charges will be Patient's responsibility and billed directly to the Patient. Repeat offenders will be subject to dismissal from the practice.

**7. Returned Checks:** The Clinic will charge $35 for the returned checks and the Patient will be denied any future payments by check.

**Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.**

EXODUS
SPINE & PAIN MEDICINE

## PATIENT FINANCIAL AGREEMENT

**This Form is a legally binding Financial Agreement between Exodus Pain Clinic, PLLC ("Clinic") and the Patient.**

I _____ understand that as a recipient of medical care I am responsible for all charges regardless of my circumstances for reimbursement.

I understand that a fee is charged for all visits, examinations, and/or treatments. I agree that the determination of the professional services to be rendered by my physician/provider and the fees to compensate him/her for these services are matters which concern my physician/provider and me. I understand that I have the primary duty and obligation to pay for the services rendered, notwithstanding any contract I may have with any third-party payer (for example, insurance company, employer, etc.).

I authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or my dependents.

I further expressly agree and acknowledge that my signature on this document authorizes my physician/provider and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to Exodus Pain Clinic, PLLC, all benefits. Insurance companies provide an explanation of benefits outlining payments and patient's financial responsibility under their contract with the patient. I understand I am financially responsible to the Clinic for all charges incurred and not paid by the third-party insurance. I further acknowledge that any insurance benefits received by the Clinic, will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my personal responsibility.

**PLEASE INITIAL EACH LINE:**

_____ I acknowledge that I have received a copy of the financial policy

_____ I understand and agree that all copayments are due and to be paid at the time of service.

_____ I understand and agree that there is a $35.00 service charge for a returned check.

_____ I understand and agree that full payment is due within 90 days from the date of service and are not contingent upon receiving a statement.

_____ I understand and agree that unpaid charges over 90 days will receive a letter for final demand of payment.

_____ I understand and agree that accounts with no activity for 120 days may be forwarded for further collection action, except as otherwise arranged with the Clinic, or mandated by law.

_____ I understand and agree that the Clinic will charge $50 for missed follow up appointments and $100 for missed procedure appointments that are not canceled within 24-hours prior to the patient's appointment.

_____ I understand and agree that should I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the Clinic will be included in my final bill.

**I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:**

**1.** Providing Exodus Pain Clinic, PLLC, with complete and accurate billing information, including, but not limited to, a current insurance card, authorization numbers, and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized**. 2.** I give my consent to Exodus Pain Clinic, PLLC to provide medical care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

**I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE:**

**Signature: _____ Date: _____**

EXODUS
SPINE & PAIN MEDICINE

## NO SHOW/MISSED APPOINTMENT POLICY

We, at Exodus Spine and Pain Medicine understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: **208-947-7246.**

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted two (2) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

**PLEASE REVIEW THE FOLLOWING POLICY:**

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinicians
2. If less than a 24-hour cancellation is given this will be documented as a "Same-day Cancellation" appointment.
3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
4. After the first "No-Show/Missed" appointment, you will receive a phone call & letter warning that you have broken our "No-Show" policy. Our staff will assist you to reschedule this appointment if needed.
5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive another notification letter from our office and ***will be assessed a $50.00 follow up no show fee or a $100.00 procedure no show fee, whichever is applicable.***
6. ***Fees must be paid before you can reschedule any future appointments.***
7. If you have 3 "No-Show/Missed" "Same-Day Cancellation" appointments within a one-year time, you will receive a second $50 follow or $100 procedure no show fee assessment. Dismissal from the practice will be considered. ****You will be notified by letter if the dismissal was approved. ****

***I have read and understand Exodus Spine and Pain No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify the clinic appropriately if I have difficulty keeping my scheduled appointments.***

_____ _____ _____

Print Patient Name | Date of Birth | Date

_____ _____

Patient Signature or Parent/Guardian if minor | Relationship to Patient

# EXODUS SPINE & PAIN MEDICINE

## LONG TERM CONTROLLED SUBSTANCE/NARCOTIC AGREEMENT

_____ Initial – If this line is initialed, I do not want controlled prescriptions. However, if I ever get controlled substances, I will need to sign this agreement in full.

**I understand the following:**

_____ Initial – Early refills will not be given.

_____ Initial – I cannot call after regular hours or weekends for prescription refills.

_____ Initial – All controlled substances must be obtained from the same pharmacy where possible. Should the need arise to change pharmacies, our office must be notified.

My preferred pharmacy is: _____

Name Cross Streets Phone

_____ Initial – I am expected to inform our office of any new medications, medical conditions, and any adverse effects I experience from any medications. I consent to have my electronic prescription history from all physicians reviewed.

_____ Initial – These drugs should not be stopped abruptly, as withdrawal symptoms will likely develop.

_____ Initial ***– Prescriptions and/or medications WILL NOT be replaced if they are lost, stolen, get wet, are destroyed, etc. UNDER NO CIRCUMSTANCE WILL THEY BE REPLACED. They are patient's responsibility.***

_____ Initial – ***It is not advisable and it is illegal in the State of Idaho to drive while taking narcotics.***

_____ Initial – I WILL NOT request or accept pain medication from any other physician or individual while receiving medication from Exodus Pain Clinic. I understand by doing so I could be endangering my health and it is illegal. Exceptions will be made ONLY IF I have discussed this with Dr Marsh or while I am admitted to the hospital.

_____ Initial – Use of prohibited substances can interfere with my opioid therapy and cause adverse effects. Therefore, I agree to notify my provider of the use of all substances: to include, marijuana, alcohol, and illicit drugs. I understand that I should not be using these substances while on opioid therapy.

_____ Initial – Medication changes will NOT be made over the phone. A doctor visit is required to reevaluate medications. I WILL NOT DESTROY ANY OF MY UNUSED MEDICATION. I WILL BRING IN ALL MEDICATIONS IN THEIR ORIGINAL CONTAINERS TO GET A NEW PRESCRIPTION IF MY CURRENT ONE IS NOT EFFECTIVE FOR MY TREATMENT.

_____ Initial – I will take the medication at the dose and frequency prescribed by my provider. I UNDERSTAND THAT I AM NOT TO INCREASE THE DOSE OF MY MEDICATION. By doing so I may no longer receive controlled substances from Exodus Pain Clinic physicians.

_____ Initial – ***Prescriptions may take up to 48 hours to refill. I will be responsible and plan accordingly in order to get my refills on time and will also plan for weekends/holidays so I will not run out of my medication. <u>Same day requests or walk in requests WILL NOT be honored or filled.</u>***

_____ Initial – Opioids have common potential side effects that include: constipation, sweating, itching/rash, and allergic reactions. Drowsiness may occur when starting or increasing dosage. I will refrain from driving motor vehicles or operating machinery until drowsiness subsides.

_____ Initial – I will be randomly drug tested by my physician to monitor my compliance with proper medication use. I waive certain privacy rights so that my physician may talk to other healthcare providers, family members, and even law enforcement officials. I also agree to come into the office when asked and submit to a drug screen or produce unused portions of medications to verify they are being taken correctly.

_____ Initial – I can become dependent on opioid medications which in a small number can lead to addiction. If addiction occurs my physician will discontinue the medication and I will be referred to a drug treatment program.

_____ Initial – I fully understand that if I violate any of the above conditions that my controlled substance prescriptions and/or treatment with Exodus Pain Clinic may be immediately terminated and I risk being discharged from the clinic. I also understand that this may result in withdrawal symptoms.

Patient Name (print): _____ Date: _____

Patient Signature: _____ Witness Initials: _____

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**ATTENTION PATIENTS! PLEASE FILL THIS OUT COMPLETELY. THIS MUST BE COMPLETED FOR AUTHORIZATIONS ON ANY IMAGING OR OTHER TREATMENTS.**

PATIENT NAME:_____ DOB:_____. Date: _____

Height: _____ Weight:_____

Have you had severe to moderate pain for at least 3 months? ☐YES ☐NO

When was the onset of your pain? MONTH/YEAR: _____

How does the pain affect your activities and daily living? (i.e. walking, sleeping, getting dressed, bathing etc.)

What makes your pain better or worse?

Have you attended physical therapy? ☐YES ☐NO

How many visits did you attend? _____

When and where did you attend physical therapy: _____

Was there any improvement? Change to pain? _____

Have you ever tried and failed NSAIDS (aspirin, ibuprofen, etc.) or muscle relaxers? If so, list the Rx & when you failed them: _____

Have you seen a chiropractor? ☐YES ☐NO
How many times did you see the chiropractor? _____

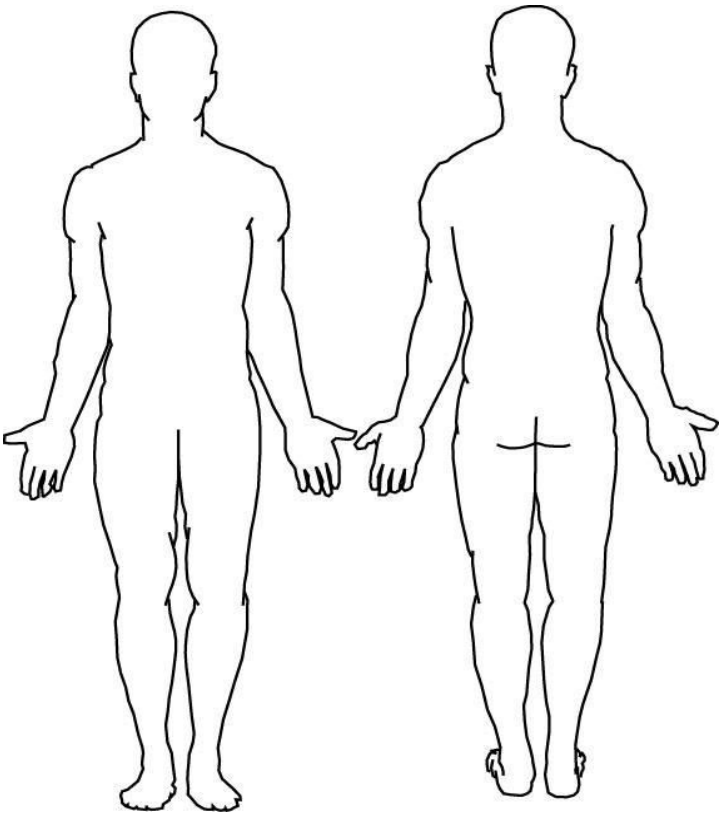
What was the name of the chiropractor or the practice name? _____

PATIENT NAME: _____ DOB: _____ DATE: _____

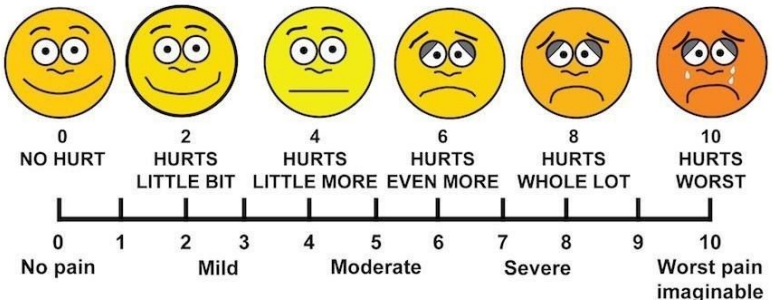
Mark all the areas of your body where you feel your pain **<u>today</u>**.

Please use the provided key:

Aching ---------- Tingling – 00000000 Burning – XXXXXX Sharp/Stabbing - //////////



## PAIN MEASUREMENT SCALE




****<u>Circle a number on the scale ABOVE that best represents your pain level TODAY**</u>**

Pain Level with medication: _____ Pain Level without medication: _____

Pain is **AGGRAVATED** by: _____

Pain is **RELIEVED** by: _____

PATIENT NAME: _____ DOB: _____ DATE: _____

# Medical History

Current Physician Name/Number:_____(_____)_____-_____

Current Pharmacy Name/Number:_____(_____)_____-_____

## Current/Past Medications

| Name | Dose | Frequency | Start | End | Dr | Purpose |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
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## Surgical Procedures

| Date | Procedure | Surgeon | Notes |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Current Medical Problems

| Illness | Start Date | Treating Physician | Treatment Notes |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |

**Please list all your allergies and your reactions**:_____

_____

_____

_____

# Family History

M = Mother F = Father S = Sister B = Brother

| Illness | M | F | S | B | Illness | M | F | S | B |
|---|---|---|---|---|---|---|---|---|---|
| Alzheimer's | | | | | Migraine Headaches | | | | |
| High Blood Pressure | | | | | Cancer | | | | |
| Stroke | | | | | Epilepsy | | | | |
| High Cholesterol | | | | | Diabetes | | | | |
| Blood Clots | | | | | Heart Disease | | | | |
| Muscular Weakness | | | | | Arthritis | | | | |
| Other Dementia | | | | | Allergic Diseases | | | | |
| Depression | | | | | Drug Addiction | | | | |
| Alcoholism | | | | | | | | | |

# Social History

Are You?: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐Have a Significant Other

Do You?:

1. Smoke: ☐NO ☐YES How many per day? _____
2. Drink: ☐NO ☐YES How many per day? _____ ☐Socially ☐Rarely ☐Moderately
3. Use Marijuana: ☐NO ☐YES How often? _____
4. Use Kratom: ☐NO ☐YES How much/how often? _____
5. Use Illegal Substances: ☐NO ☐YES Which ones? _____In the Past?: _____

_____

Have you ever been treated for, or do you feel you have problems with alcohol or any type of substance abuse?
☐NO ☐YES Explain:_____

_____

_____

Have you ever been hospitalized for psychiatric condition? ☐NO ☐YES; When/Where?: _____

Do you have a history of prescription or street drug abuse? ☐NO ☐YES, explain: _____

Does anyone in your family have a substance abuse history? ☐NO ☐YES, explain: _____

Is there any substance abuse in your household? ☐NO ☐YES, explain kind: _____

Work: ☐Full Time ☐Part Time ☐Retired ☐Disabled ☐Unemployed

What kind of work do you do? _____
_____

What kind of recreational activities do you partake in? _____
_____
_____

# Sleep Apnea Screening Questionnaire

Patient Name_____DOB:_____
Primary Care Provider_____Clinic Name_____

| | | | |
|---|---|---|---|
| **Snoring** | | | |
| 1. | Do you snore on most nights (more than 3 nights per week)? | Yes | ❒2 |
| | | No | ❒0 |
| 2. | Is your snoring loud (can it be heard through a door or a wall)? | Yes | ❒2 |
| | | No | ❒0 |
| **Sleep Noises** | | | |
| 3. | Has anyone ever told you you stop breathing or gasp During your sleep? If No, do you ever wake up gasping for air? | Never | ❒0 |
| | | Occasionally | ❒3 |
| | | Frequently | ❒5 |
| **Collar Size** | | | |
| 4. | What is your collar size? Approximate if you don't know | Male <17 in | ❒0 |
| | | Male >17 in | ❒5 |
| | | Female <16 in | ❒0 |
| | | Female >16 in | ❒5 |
| **Daytime Sleepiness** | | | |
| 5. | Do you feel that you are tired all day even after sleeping all night? | Yes | ❒2 |
| | | No | ❒0 |
| | Do you ever fall asleep while driving or when stopped at a light? | Yes | ❒2 |
| | | Yes | ❒0 |
| **Hypertension** | | | |
| 6. | Have you had or are you being treated for high blood pressure? | Yes | ❒1 |
| | | No | ❒0 |
| **Medications** | | | |
| 7. | Do you take pain medication **OR** anxiety medication (benzodiazepines) at night before bed | Yes | ❒1 |
| | | No | ❒0 |

**OFFICE USE ONLY:**

*6 or more: high probability of OSA, Notify PCP to initiate Sleep Referral* **Total Score _____**

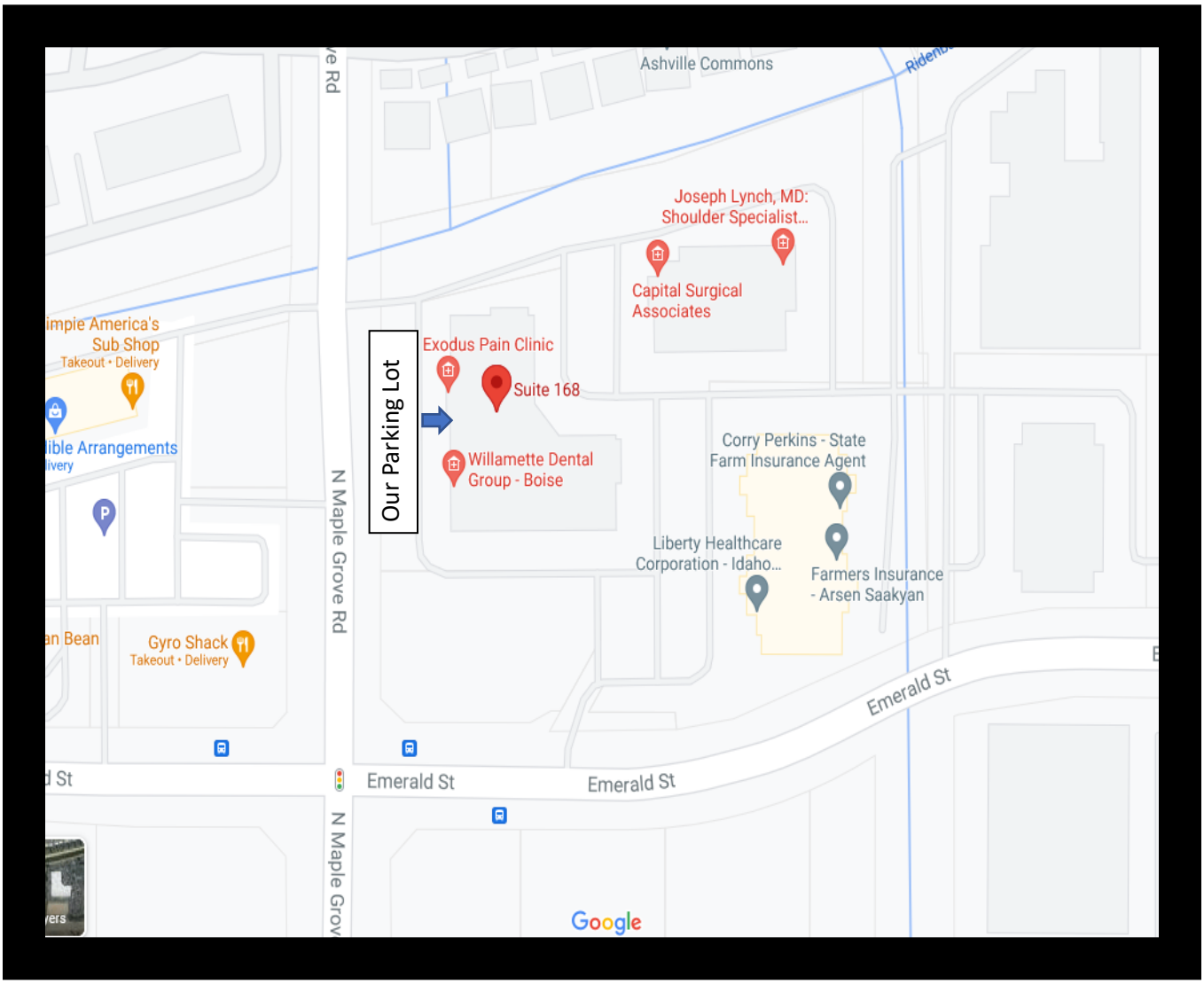
☐ **This patient has been identified as HIGH RISK FOR SLEEP APNEA based on the above assessment. Please contact your patient to schedule a follow up appointment**

X_____Date_____PCP Fax#_____
Daniel Marsh, MD/Anna Martsenyuk, APRN-CNS Sent by: _____(initials)

# REVIEW OF SYSTEMS

## Please check all boxed that apply

| | | | | |
|---|---|---|---|---|
| **General:** | ❑ Weakness<br>❑ Fatigue<br>❑ Headaches | ❑ Body Aches<br>❑Weight Gain/ Loss | ❑ Fever/Chills<br>❑ Excessive Appetite | ❑ Poor Appetite |
| **Skin:** | ❑ Hives<br>❑ Eczema | ❑ Dryness<br>❑ Itching | ❑ Rash<br>❑ Color Changes | ❑ Change in Nails |
| **Head/ Neurologic:** | ❑ Headaches<br>❑ Migraines<br>❑ Numbness | ❑ Dizziness<br>❑ Passing Out<br>❑ Tremor | ❑ Fainting<br>❑ Head Injury<br>❑ Seizures | ❑ Tingling<br>Other: |
| **Ears:** | ❑ Ringing<br>❑ Hearing Loss | ❑ Drainage<br>❑ Vertigo | ❑ Ear Ache | |
| **Eyes:** | ❑ Pain | ❑ Blurred Vision | ❑ Changes in Vision | ❑ Double Vision |
| **Nose:** | ❑ Congestion<br>❑ Hay Fever | ❑ Itching<br>❑ Sinus Pain | ❑ Nosebleeds<br>❑ Runny Nose | ❑ Snoring |
| **Throat/Mouth:** | ❑ Difficult Swallowing | ❑ Dry Mouth | ❑ Sores in Mouth | ❑ Hoarseness |
| **Respiratory:** | ❑ Asthma<br>❑ Shortness of Breath | ❑ Wheezing<br>❑ Sleep Apnea | ❑ Cough<br>❑ Pneumonia | ❑ Painful Breathing |
| **Gastrointestinal:** | ❑ Abdominal Pain<br>❑ Heartburn<br>❑ Ulcers | ❑ IBS<br>❑ Diarrhea<br>❑ Blood in Stool<br>❑ Colitis | ❑ Jaundice<br>❑ Hernia<br>❑ Bloating<br>❑ Change in Appetite | ❑ Nausea / Vomiting<br>❑ Constipation<br>❑ Excessive Gas |
| **Cardiovascular:** | ❑ Pacemaker<br>❑High Blood Pressure | ❑ Blood Clots<br>❑ Heart Attack<br>❑ Chest Pain | ❑ High Cholesterol<br>❑ Leg Edema | ❑ Rheumatic Fever<br>❑ Murmur |
| **Psychiatric/Mood:** | ❑ Depression<br>❑ Anxiousness<br>❑ Poor Energy | ❑ Short Temper<br>❑ Trouble Sleeping | ❑ Compulsive Behavior<br>❑ Mood Changes | ❑ Poor Concentration<br>❑ Stress |
| **Muscles/Bones/Joints:** | ❑ Arthritis<br>❑ Muscle/Joint Pain<br>❑ Cramps | ❑ Joint Swelling<br>❑ Fractures<br>❑ Gout | ❑ Osteoporosis<br>❑ Fibromyalgia<br>❑ Polio | Other: |
| **Back and Neck** | ❑ Back Pain<br>❑ Back Stiffness<br>❑ Sciatica | ❑ Neck Pain<br>❑ Neck Stiffness | ❑ Restricted Movement<br>❑ Disc Problems | Fractures<br>Other: |
| **Other conditions not listed:** | | | | |




**Our office is at 8950 W Emerald St., Ste. 168, Boise, ID 83704. We are located on the NE Corner of Emerald St. and Maple Grove Rd. Our office faces MAPLE GROVE. If you have any problems finding us, please call the office at 208-947-7246. Please note our phones are off from noon-1pm for lunch.**