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Today's Date: _____

PATIENT INFORMATION				
Last Name		First Name		Middle Initial
Home Address		City	State	Zip Code
Home Phone #		Cell Phone #		Work Phone #
E-Mail Address		Ethnicity:	Weight:	Height:
		(Circle one) Single / Married / Divorced / Widowed		
★ Birth Date	Age	Dominant Hand: L / R	Gender: M / F	Language
Referring 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)
<p>Assignment and Release</p> <p>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.</p>		
_____	_____	_____
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 rights to inspect, 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

What condition(s) are you seeking help for 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 litigation (lawsuit)? _____

MEDICAL HISTORY	SURGICAL HISTORY

MEDICATIONS <input type="checkbox"/> See attached list. <input type="checkbox"/> I do not take any medications at this time.			
Name	Strength & Dose	Duration (Start/end date)	Outcome (Check)
			<input type="checkbox"/> Effective <input type="checkbox"/> Contraindicated <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed
			<input type="checkbox"/> Effective <input type="checkbox"/> Contraindicated <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed
			<input type="checkbox"/> Effective <input type="checkbox"/> Contraindicated <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed
			<input type="checkbox"/> Effective <input type="checkbox"/> Contraindicated <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed
			<input type="checkbox"/> Effective <input type="checkbox"/> Contraindicated <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed
			<input type="checkbox"/> Effective <input type="checkbox"/> Contraindicated <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed
			<input type="checkbox"/> Effective <input type="checkbox"/> Contraindicated <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed
			<input type="checkbox"/> Effective <input type="checkbox"/> Contraindicated <input type="checkbox"/> Intolerant <input type="checkbox"/> 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	
<u>Social History</u> Birthplace: Education Completed: Marital Status:	<u>Work History</u> Occupation: Employer: Toxin exposure:
<u>Tobacco Use</u> Yes No Quit year _____ Packs per day:	<u>Alcohol Use</u> Yes No # of Drinks per Week _____
<u>Caffeine Use</u> Coffee Tea Energy Drinks Other None # of Drinks per Day _____	<u>Exercise</u> Yes No <input type="checkbox"/> 1x /week <input type="checkbox"/> 2-3x /week <input type="checkbox"/> 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	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	(circle one) (circle one)
EAR, NOSE, AND THROAT Change in hearing Ringing in the ears Recent nose bleeds Chronic sinus problems	_____ _____ _____ _____	_____ _____ _____ _____	
EYES Loss of vision Blurring of vision Double vision Glaucoma	_____ _____ _____ _____	_____ _____ _____ _____	
ENDOCRINE Heat or cold intolerance Excess thirst or urination	_____ _____	_____ _____	(circle one)
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	_____ _____ _____ _____	_____ _____ _____ _____	(circle one)

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 Difficulty concentrating Black-outs or dizziness Memory loss or confusion Falls or near falls, last 6 months Sudden, frequent, uncontrollable crying/laughing	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Where? (circle one) (circle one) (circle one)
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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
Have you been told you have pauses in your breathing while asleep at night?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
Do you have difficulty falling asleep at the beginning of the night?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
Do you have difficulty staying asleep throughout the night?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
Have you been told you make kicking/twitching movements while asleep?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
Do you experience excessive tiredness during the day?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
Do you awaken feeling paralyzed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
Do you experience sudden loss of strength in your arms or legs during the day?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
If yes, are these brought upon by a sudden frightening event or laughter?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
Do you experience morning headaches?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
Do you experience choking/gasping episodes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally
Do you experience chest pain?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally

EPWORTH SLEEPINESS SCALE
<p>How likely are you to doze off or fall asleep in the following situations?</p> <p>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</p> <ul style="list-style-type: none"> • 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: _____ <p>Total Score: _____</p>

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.

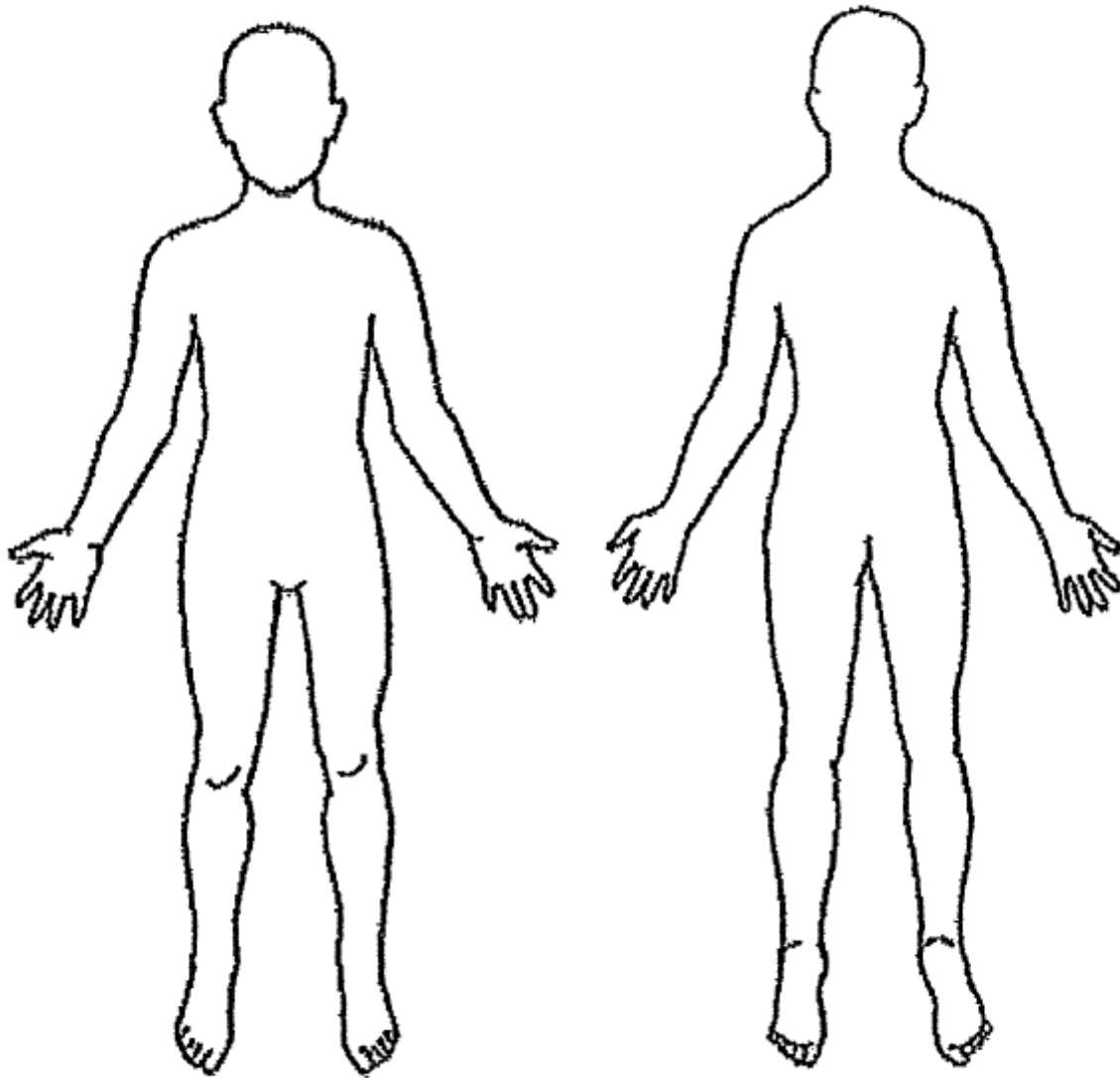
HISTORY OF PAIN										
Chief complaint of pain location:										
When the symptoms originally began:						Developed gradually <input type="checkbox"/>		Developed suddenly <input type="checkbox"/>		
If it was because of an injury, how did the injury occur?										
(Circle one) Symptoms are: Worse 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 lower 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