NEVADA ADVANCED PAIN SPECIALISTS

Denis G. Patterson, DO
Board Certified Pain Medicine
Board Certified Physical Medicine & Rehabilitation

Ali Nairizi, MD, MS
Board Certified Pain Medicine
Medical Director, American Board of Anesthesiology

5078 Longley Lane
Reno, NV 89511

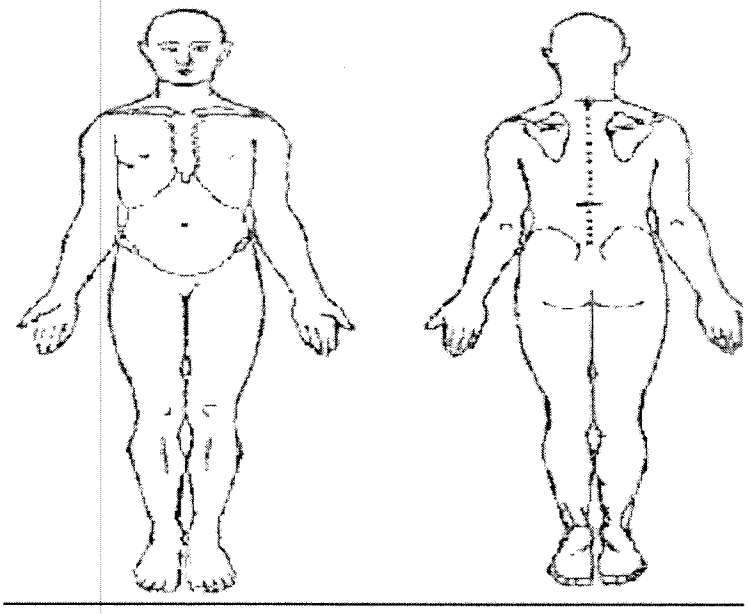
2385 E. Prater Way #204
Sparks, Nevada 89434

tel: 775.284.8650
fax: 775.284.8654
www.nvadvancedpain.com

Patient's name_____ Date_____ Age_____ Gender M / F

Referred by_____

Please mark where your pain is:



Please Circle Yes or No

Unexplained Weight Loss	Y N
Fatigue/Fever	Y N
Nausea/Vomiting	Y N
Dizziness	Y N
Ringing in the ears	Y N
Fainting spells	Y N
Bowel/bladder problems	Y N
Night pain	Y N
Changed by position?	Y N
Headaches	Y N

Reason for therapy_____

How did your injury occur_____

Pain Location_____

Average pain level 0 1 2 3 4 5 6 7 8 9 10

Aggravating Factors_____

Pain level at its worst 0 1 2 3 4 5 6 7 8 9 10

Alleviating Factors_____

Pain level at its best 0 1 2 3 4 5 6 7 8 9 10

Description of pain_____ Getting Better Y/N

How long have you had your symptoms?_____

Occupation_____

Duties_____

Difficulty with activities_____

Goals for physical therapy_____

Hobbies_____

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Living Environment (House/apt, how many stories etc)_____

Family members that live with you _____

Do you smoke?_____Smoke Pack/day_____Alcohol Drinks/day_____Pregnant_____months

What other treatment have you had for this problem?_____

Do you exercise? If so, what type and how often?_____

Past Medical History_____

History of cancer?_____ Diabetes?_____

List any surgeries_____

Medications_____

_____Helping Y /N

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CENTER FOR INJURY REHABILITATION

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Physical Therapy Cancellation Policy

To gain the most benefit from our office and to ensure that other patients receive the highest level of care, it is essential to keep all of your scheduled appointments. Due to the fact that we spend so much one-on-one time with our patients, to be fair to the therapist it is important that you maintain your scheduled appointment time.

If you cancel an appointment within 24 hours of your appointment time a cancellation fee of $50 each visit may be charged to you prior to your next appointment. Insurance companies do not cover this fee. There are exceptions for emergencies.

We appreciate your understanding in this manner. We strive to provide the best quality care for our patients.

Acknowledgement of Cancellation Policy

I have read and understand the Physical Therapy Cancellation Policy.

Patient Name

Patient Signature and Date

Signature of office personnel

Date

Physical Therapy No Show Policy

Should you need to cancel your appointment, you must call and notify us prior to your scheduled appointment time.

If you fail to do so, you will be charged a fee of $50.00 and we will not be able to schedule any future appointments with you until the fee is paid.

If you miss three appointments without notifying us, we will no longer be able to see you as a patient.

Patient Signature:_____ Date: _____

Staff Signature: _____ Date: _____

Thank you,

Jamie Pribyl and Staff