Performance Sport & Spine

1575 Old Alabama Rd. Suite 105
Roswell, GA. 30076
(404) 721-4406

Last Name: _____ First: _____ Middle: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Telephone #: _____ Social Security #: _____

Age: _____ Birthdate: _____ Present Weight: _____ Height: _____ Feet: _____ (inches)

Sex: (☐M ☐F) Marital Status: (☐M ☐S ☐W ☐D) Spouse's Name: _____ No. Children: _____

E-mail Address: _____ Person Responsible for this Account: _____

Work Phone: _____ Ext.: _____ Referred By: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Occupation_Employer: _____ Years Employed: _____

Address: _____ City: _____ State: _____ Zip: _____

Job Title: _____ Job Description: _____

Are your pain/symptoms From Auto Accident? ☐ Yes ☐ No Date of Accident: _____

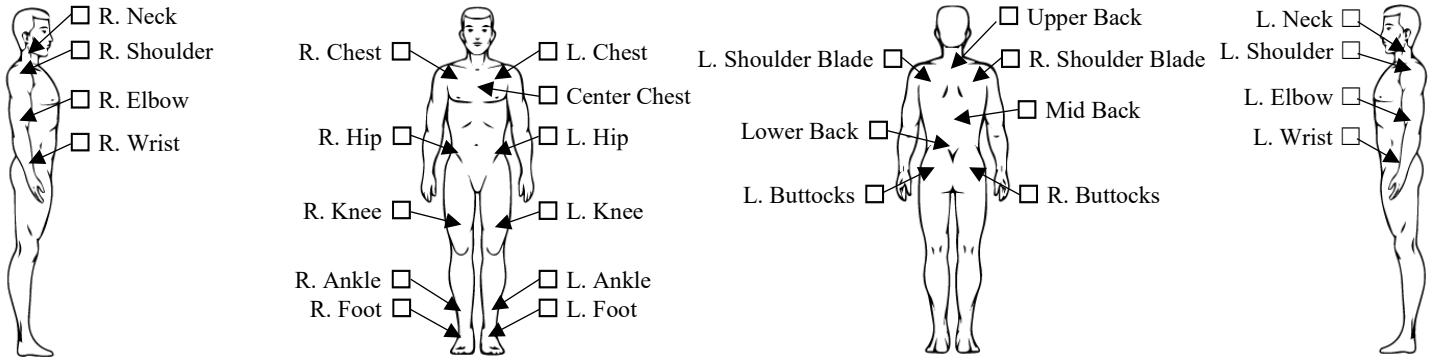
Please describe your problem and how it began: ***Date problem began:*** _____

_____

_____

Current Health Condition

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury ☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

Were you experiencing these symptoms before? ☐Yes ☐No Explain: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us? _____

_____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

CONSTITUTIONAL: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Chills ☐ Fatigue ☐ Night Sweats ☐ Weight Loss ☐ Weight Gain ☐ Fever ☐ Daytime Drowsiness

EYES/VISION: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Blindness	☐ Change in Visio	☐ Field Cuts	☐ Photophobia
☐ Blurred Vision	☐ Double Vision	☐ Glaucoma	☐ Tearing
☐ Cataracts	☐ Eye Pain	☐ Itching	☐ Wear Glasses/Contacts

Patient/Guardian Signature: _____ Date: _____

RESPIRATION: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Bleeding ☐ Ear Drainage ☐ Hearing Loss ☐ Nosebleeds ☐ Sore Throat
☐ Dentures ☐ Ear Pain ☐ History of Head Injury ☐ Postnasal Drip ☐ Tinnitus
☐ Difficulty Swallowing ☐ Fainting ☐ Hoarseness ☐ Rhinorrhea ☐ TMJ Problems
☐ Discharge ☐ Frequent Sore Throats ☐ Loss of Sense of Smell ☐ Sinus Infections
☐ Dizziness ☐ Headaches ☐ Nasal Congestion ☐ Snoring

EARS, NOSE & THROAT: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Asthma ☐ Coughing Up Blood ☐ Sputum Production
☐ Cough ☐ Shortness of Breath ☐ Wheezing

CARDIOVASCULAR: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Angina (Chest Pain or Discomfort) ☐ High Blood Pressure ☐ Shortness of Breath With Exertion or Exercise
☐ Chest Pain ☐ Low Bread Pressure ☐ Swelling of Legs
☐ Claudication (Leg Pain/Ache) ☐ Orthopnea (Difficulty Breathing Lying Down) ☐ Ulcers
☐ Heart Murmur ☐ Palpitations ☐ Paroxysmal Nocturnal Dyspnea (Walking at Night w/ Shortness of Breath
☐ Heart Problems ☐ Varicose Veins

GASTROINTESTINAL: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Abdominal Pain ☐ Diarrhea ☐ Indigestion ☐ Abnormal Stool Caliber ☐ Vomiting
☐ Belching ☐ Difficulty Swallowing ☐ Jaundice ☐ Abnormal Stool Color ☐ Vomiting Blood
☐ Black – Tarry Stools ☐ Heartburn ☐ Nausea ☐ Abnormal Stool Consistency
☐ Constipation ☐ Hemorrhoids ☐ Rectal Bleeding

FEMALE: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Birth Control ☐ Cramps ☐ Irregular Menstruation ☐ Vaginal Bleeding
☐ Breast Lumps/pain ☐ Frequent Urination ☐ Pregnancy ☐ Vaginal Discharge
☐ Burning Urination ☐ Hormone Therapy ☐ Urine Retention

MALE: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Burning Urination ☐ Frequent Urination ☐ Prostate Problems
☐ Erectile Dysfunction ☐ Hesitancy/ Dribbling ☐ Urine Retention

ENDOCRINE: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Cold Intolerances ☐ Excessive Hunger ☐ Goiter ☐ Unusual Hair Growth
☐ Diabetes ☐ Excessive Thirst ☐ Hair Loss ☐ Voice Changes
☐ Excessive Appetite ☐ Abnormal Frequency of Urination ☐ Heat Intolerance

SKIN: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Changes in Nail Texture ☐ Hair Loss ☐ Itching ☐ Skin Lesions / Ulcers
☐ Changes in Skin Color ☐ Hives ☐ Paresthesia's ☐ Varicosities
☐ Hair Growth ☐ History of Skin Disorders ☐ Rash

NERVOUS SYSTEM: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Dizziness ☐ Limb Weakness ☐ Numbness ☐ Slurred Speech ☐ Tremor
☐ Facial Weakness ☐ Loss of Consciousness ☐ Seizures ☐ Stress ☐ Unsteadiness of Gait/Loss of Balance
☐ Headache ☐ Loss of Memory ☐ Sleep Disturbance ☐ Strokes

PSYCHOLOGIC: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Anhedonia ☐ Behavioral Changes ☐ Convulsions ☐ Memory Loss
☐ Anxiety ☐ Bi-Polar Disorder ☐ Depression ☐ Mood Changes
☐ Loss or Change in Appetite ☐ Confusion ☐ Insomnia

HEMATOLOGIC: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Anaphalaxis ☐ Itching ☐ Chronic Nasal Congestion ☐ Sneezing
☐ Food Intolerances ☐ Acute Nasal Congestion ☐ Rash

ALLERGY: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ Anema ☐ Blood Clotting ☐ Bruising Easily ☐ Lymph Node Swelling
☐ Bleeding ☐ Blood Transfusion ☐ Fatigue

Patient/Guardian Signature:_____ Date:_____

PAST HEALTH HISTORY

Fill out carefully as these problems can affect your overall course of care.

PREVIOUS CARE FOR SAME CONDITION: ☐ I have not seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If Yes, Who? (Name):_____

Type of Treatment:_____ Was the treatment beneficial in resolving condition? ☐ Yes ☐ No

Explain:_____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.			
Medication	***Dosage***	***For What Condition?***	***How long have you been taking this?***

CHILDHOOD ILLNESS(es): LIST all health conditions. CHECK all CURRENT conditions.

☐ ADD
☐ Atopic Dermatitis (Eczema)
☐ Allergies/Hay fever
☐ Anemia
☐ Asthma
☐ Bedwetting
☐ Cerebral Palsy
☐ Chicken Pox
☐ Crohn's/Colitis
☐ Depression
☐ Diabetes
☐ Ear Infections
☐ Fetal Drug Exposure
☐ Rash
☐ Headaches
☐ Hepatitis
☐ HIV
☐ Measles
☐ Mumps
☐ Psoriasis
☐ Food Allergies:
☐ Scoliosis
☐ Seizer Disorder
☐ Sickle Cell Anemia
☐ Spina Bifida
☐ Other:

SURGERY(ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

☐ Angioplasty
☐ Appendectomy
☐ Caesarian Section
☐ Cardiac Catheterization
☐ Carpal Tunnel Repair
☐ Coronary Artery Bypass
☐ Cosmetic
☐ D&C
☐ Dental Surgery
☐ Gall Bladder
☐ Hemorrhoidectomy
☐ Hernia Repair
☐ Hysterectomy
☐ Joint Reconstruction
☐ Joint Replacement
☐ Knee Repair
☐ Laminectomy
☐ Mastectomy
☐ Pacemaker Insertion
☐ Rotator Cuff
☐ Spinal Fusion
☐ Tonsillectomy
☐ Other:

ADULT ILLNESS(es): LIST all health conditions. CHECK all CURRENT conditions.

☐ ADD
☐ Alzheimer's
☐ Anema
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Cerebral Palsy
☐ Crohn's/Colitis
☐ CRPS (RSD)
☐ CVA (Stroke)
☐ Cystic Kidney Disease
☐ Depression
☐ Diabetes (Insulin dep)
☐ Diabetes (Non-Insulin)
☐ Eczema
☐ Emphysema
☐ Eye Problems
☐ Heart Disease
☐ Hepatitis
☐ HIV
☐ Hypertension
☐ Influenza Pneumonia
☐ Liver Disease
☐ Lung Disease
☐ Lupus Erythema (Discord)
☐ Lupus Erythema (Systemic)
☐ Multiple Sclerosis
☐ Unspecified Pleural Effusion
☐ Pneumonia
☐ Psoriasis
☐ Psychiatric Problems
☐ Scoliosis
☐ Seizures
☐ Shingles
☐ Past History of Similar Symptoms
☐ STD's (Unspecified)
☐ Suicide Attempts
☐ Vertigo
☐ Other:

INJURY(ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

☐ Back Injury
☐ Broken Bones
☐ Disabilities
☐ Fall (Severe)
☐ Fracture
☐ Head Injury (Loss of Consciousness)
☐ Head Injury (No Loss of Consciousness)
☐ Industrial Accident
☐ Joint Injury
☐ Laceration (Severe)
☐ Motor Vehicle Accident
☐ Soft Tissue Injury (Mild)
☐ Soft Tissue Injury (Moderate)
☐ Soft Tissue Injury (Severe)
☐ Other:

Patient/Guardian Signature:_____ Date:_____

FAMILY HISTORY: Mark all that apply below. List any specific conditions past or present after has/had:

General Family	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____
Father	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____
Mother	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____
Parental Grandfather	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____
Parental Grandmother	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____
Maternal Grandfather	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____
Maternal Grandmother	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____
Son(s)	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____
Daughter(s)	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____
Brother(s)	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____
Sister(s)	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had:_____

SOCIAL HISTORY: Mark all that apply below.

Alcohol:	☐ Social Consumption Only	☐ Beer	☐ Liquor	☐ Wine
	_____Oz_____Glasses	☐ Day	☐ Week	☐ Month
Diet:	☐ High Fat	☐ High Fiber	☐ High Protein	☐ High Salt
	☐ Low Calorie	☐ Low Carb	☐ Low Salt	☐ Low Sugar
Drugs:	☐ Deny Any Illegal Drug Use	☐ Deny Use of IV Drugs	☐ Have Not Used Drugs Since:____	☐ Have Used Drugs For:___
Tabaco:	☐ Deny Tabaco Use	☐ Do Not Smoke Cigars, Cigarettes, Pipe	☐ Live With a Smoker	☐ Quit Smoking
	☐ Smoke;#_____Per	☐ Day	☐ Week	☐ Month
	☐ Chew:#_____Cans Per	☐ Day	☐ Week	☐ Month

Insurance Information:

Who Is Responsible For Your Bill? You and… (Mark Appropriate Boxes) ☐ Myself ONLY

☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other:_____

Personal Health Insurance Carrier:_____ Health ID Card #:_____

Policy #:_____ Group #:_____

Policy Holder's Name:_____ Carriers Phone #:_____

Policy Holder's Date of Birth:_____ Primary Care Physician:_____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐ YES ☐ NO Date:_____

Carrier:_____ Policy #:_____

Carriers Phone #:_____ Adjuster:_____

Claim #:_____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name:_____

Patient/Guardian Signature:_____ Date:_____

(STAFF USE)

Effective Date:_____ CoPay/Coinsurance:_____ # of Visits Annually:_____

Ind, Deduct:_____ Deductible Met:_____ # of PT Visits Year:_____

O.O.P. Max:_____ Maximum $ Per Visit:_____ Maximum $ per Year:_____

Family Deductible:_____ Family Deductible Met:_____

Needs Referral:_____ ASHN:_____ ACN:_____

Is 97140 Covered?_____ Is E0720 Covered_____ 4th Q Rollover?_____

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Patient Name:_____

1. Authorization the release Medical Information (HIPPA) & Identity

I authorize this office to release any medical information to receiving payment from my insurance company, attorney, or claims adjuster. I certify under penalty of perjury, that all information given to this clinic is correct and that I am not using a false identity. I am aware that a full copy of my Protection of Health Information privacy rights are posted in the reception area and I can have a copy at any time on request. I hereby authorize you, your employees and agents to furnish anyone designated in writing by them, all copies of records and reports, concerning any condition that I may have had in the past, now have, or may have in the future. I give permission to use my address, phone number, email, and clinical records to contact me with appointment reminders, phone messages, emails, birthday cards, holiday related cards, or any other related information. I can revoke this authorization at any time in written form.

Patient/Guardian Signature:_____Date:_____

Consent of the above for the treatment of minor (Patients under the age of 18)

2. Informed Consent and Release of Liability

I hereby request, consent and authorize World Wide Wellness and whomever they may designate as agents, doctors, independent contractors or representatives of this corporation to perform services; including but not limited to diagnostic tests, physical examination, and any treatment or therapy. I will at all times honor this corporate structure and will under no circumstances seek damages or hold responsible any doctor, therapist, employee, individual or stock holder of this corporation. This entire disclosure and waiver is presented to me as an effort to make me better informed, so that I may give of withhold my consent, release and waiver liability. This entire agreement applies to all my present and future care.

Communication is essential, if I am uncomfortable or concerned about any procedure or have side effects I am to stop the procedure immediately, tell the doctor or therapists immediately, and immediately fill out an incident report.

Treatment is hands on or by machine and with any procedure there are risks and side effects possible. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. If massage is involved, it is strictly for therapeutic purposes only. **You will feel sore after treatment.**

Side effects many include but are not limited to dizziness, pain, disc herniation's, bruising, death, burns, worsening of symptoms, stroke, numbness, fractures and other effects that we are unable to predict. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. In cases of underlying physical defects, deformities or pathologies - may render the patient susceptible for injury. It is the responsibility of the patient to make it known to the chiropractor or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, past surgeries, pregnancy, cancer, fractures, tumors, aneurisms or other deformities.

I understand this is a chiropractic clinic that treats musculoskeletal pain and injuries, related only to chiropractic subluxations. Our scope of practice and training does not include the treatment, evaluation or diagnosis of cancer, fractures, tumors, organ pathology, diabetes, vascular, or any medical related pathology. I am advised to consult with my medical doctor about all health issues. I have been also advised to ask questions and communicate.

I certify that no guarantee has been made as to the results that may be obtained, and seek care at my own risk. I understand that all of the above is legally binding and that this contract can only be modified by addendum signed by both parties. If you do not understand any of the above please ask questions and do not sign below. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices. I have had the opportunity to have any questions answered to my satisfaction.

I have fully evaluated the risks and benefits of undergoing treatment, and freely decided to undergo the recommended treatment and herby give my full consent to treatment. I have read, agreed to and understand all of the above.

Patient/Guardian Signature:_____Date:_____

Consent of the above for the treatment of minor (Patients under the age of 18)

3. Request for Payment of Benefits DIRECTLY to Provider of Care / Assignment

I hereby authorize and direct my insurance company, insurance administrator or attorney to pay by check, and for it to be mailed directly to our office the expense benefits allowable, as payment toward the total charges for professional services rendered. I agree to pay, in a current manner, any balances of said applicable charges. I agree that this office be given power of attorney to endorse any and all drafts for payment of my bill. I understand and agree that health and accident insurance policies are an arrangement between an insurance carries and myself. I permit this office to endorse remittances for the conveyance of credit to my account. All co pays and deductibles are due at the time of service. I understand that I will be responsible for all collection or court fees involved if the account has to be sent to collections. I irrevocability request and direct that payment be sent directly to this clinic.

Patient/Guardian Signature:_____Date:_____

Consent of the above for the treatment of minor (Patients under the age of 18)

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Subluxation: A misalignment of any bones of the human body, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our chiropractic method of correction is by specific adjustments of the spine and axial skeleton.

Health: A state of harmony within the body, where every cell, tissue, and organ are functioning as efficiently as possible. Health is not merely the absence of disease or symptoms.
We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Patient Name:_____

Patient/Guardian Signature:_____Date:_____

Consent of the above for the treatment of minor (Patients under the age of 18)

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CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

Patient Name:_____

Patient/Guardian Signature:_____Date:_____

Consent of the above for the treatment of minor (Patients under the age of 18)

Performance Sport & Spine

1575 Old Alabama Rd. Suite 105 Roswell, GA. 30076 Phone: (404) 721-4406

MEDICAL RECORDS REQUEST

Date:_____

To:_____

_____

_____

I, _____ hereby request that my complete medical records be released to:
(Print Name)

Performance Sport and Spine
1575 Old Alabama Rd. Suite 105
Roswell, Georgia. 30076

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at any time.

PATIENT NAME:_____

PATIENT ADDRESS:_____

PATIENT'S DATE OF BIRTH:_____

PATIENT/GUARDIAN SIGNATURE:_____
Consent of the above for the treatment of minor (Patients under the age of 18)

Performance Sport & Spine

1575 Old Alabama Rd. Suite 105 Roswell, GA. 30076 Phone: (404) 721-4406

DIAGNOSIS SHEET

Last Name: _____ First: _____ Middle: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Telephone #: _____ Social Security #: _____

Age: _____ Birthdate: _____ Present Weight: _____ Height: _____ Feet: ____ (inches)

Sex: ☐M ☐F Marital Status: ☐M ☐S ☐W ☐D Spouse's Name: _____ No. Children: _____

ESQ: _____ Tel: _____ DOI: _____/_____/_____ 1st DOS: _____/_____/_____

Nonallopathic Lesions, Not Elsewhere Classified

☐	M99.01	Segmental Somatic Dys. Cervical	☐ M99.05	Segmental Somatic Dys. Pelvis
☐	M99.02	Segmental Somatic Dys. Dorsal	☐ M99.06	Segmental Dys. Lower Extremities
☐	M99.03	Segmental Somatic Dys. Lumbar	☐ M99.07	Segmental Dys. Upper Extremities
☐	M99.04	Segmental Somatic Dys. Sacrum	☐ M99.08	Segmental Somatic Dys. Rib Cage

Dorsopathies

☐	M50.20	Cervical disc displacement, unspecified	☐ M54.30	Sciatica
☐	M51.26	Lumbar disc displacement	☐ M54.32	(L) Sciatica
☐	M54.2	Cervicalgia	☐ M54.31	(R) Sciatica
☐	M53.1	Cervicobrachial Syndrome (diffuse)	☐ M54.14	Radiculopathy: thoracic region
☐	M54.12	Radiculopathy: cervical region	☐ M54.15	Radiculopathy: thoracolumbar region
☐	M54.13	Radiculopathy: cervicothoracic region	☐ M54.06	Panniculitis of neck and back region
☐	M54.6	Pain in thoracic spine	☐ M54.42	(L) Lumbago With Sciatica
☐	M54.5	Lumbago	☐ M54.41	(R) Lumbago With Sciatica

Disorders of Muscle, Ligaments and Fascia

☐	M24.20	Laxity of ligament	☐ M62.81	Muscle Weakness
☐	M35.7	Hypermobility syndrome	☐ M60.09	Myositis
☐	M62.838	Myospasm	☐ M79.1	Myalgia

Other Neurological Symptoms

☐	G58.0	Intercostal Neuralgia	☐ R20.1	Hypoesthesia of Skin
☐	R51	Headache	☐ R20.3	Hyperesthesia of Skin

Sprains and Strains

☐	S63.509A	Wrist	☐ S33.8XXA	Lumbosacral (joint) (ligament)
☐	S63.501A	(R) Wrist	☐ S33.9XXA	Sacroiliac region, unspecified
☐	S63.502A	(L) Wrist	☐ S13.4XXA	Neck
☐	S83.90XA	Knee	☐ S23.3XXA	Thoracic
☐	S83.91XA	(R) Knee	☐ S33.5XXA	Lumbar
☐	S83.92XA	(L) Knee	☐ S23.41XA	Sacrum

Pain in Joint

☐	M25.511	(R) Shoulder Region	☐ M25.551	(R) Hip
☐	M25.512	(L) Shoulder Region	☐ M25.552	(L) Hip
☐	M25.521	(R) Upper Arm	☐ M25.561	(R) Knee
☐	M25.522	(L) Upper Arm	☐ M25.562	(L) Knee
☐	M77.11	(R) Tennis Elbow	☐ M25.571	(R) Ankle and Foot
☐	M77.12	(L) Tennis Elbow	☐ M25.572	(L) Ankle and Foot
☐	M77.01	(R) Golfers Elbow	☐ _____	_____
☐	M77.02	(L) Golfers Elbow	☐ _____	_____
☐	M25.531	(R) Wrist	☐ _____	_____
☐	M25.532	(L) Wrist	☐ _____	_____
☐	M79.641	(R) Hand	☐ _____	_____
☐	M79.642	(L) Hand	☐ _____	_____