



Welcome to our Practice! We appreciate you choosing us for your healthcare needs.

Following are all forms necessary for your upcoming visit, including a personal history form for patients with musculoskeletal problems. These forms allow us to obtain as much information as possible to better evaluate and treat your problem. ***Bring the completed forms with you on your appointment date. Please do not fax or mail these forms!***

You need to arrive 30 minutes before the time of your appointment. Please bring all medications, your medical insurance card (a physical copy/not electronic), and the names, addresses, and telephone numbers of all doctors involved in your care.

We need the following information from your referring doctor:

- ***A referral number if required by your insurance plan***
- ***Recent laboratory reports***
- ***The last office note from your referring doctor to let us know why you are being sent for the appointment***
- ***X-ray reports (if you have had a recent x-ray and this is the reason you are being seen) – Do not bring CDs or discs, only the report***

Please arrange to have this information faxed in advance from your physician's office or bring it with you at the time of your appointment. Please verify with your physician's office to make sure the requested information has been sent prior to your scheduled appointment. You may also check with us to ensure we have received your records. Our fax number is (804) 915-0036.

Additionally, we request that you kindly give us a 24-hour notice if cancellation is necessary. Otherwise, you will be billed for the cost of the missed appointment. Please note that if your appointment is rescheduled or cancelled twice, no further appointments will be allowed with our practice. We may be contacted at (804) 346-1551.

Thank you for your cooperation.

Rheumatology Division
7650 East Parham Road, MOB II, Suite 304
Henrico, Virginia 23294
(On the campus of Parham Doctors' Hospital)

Authorization for Release of Protected Health Information

Name of Patient: _____ Date of Birth: _____

The office of Virginia Physicians, Inc. is authorized to release protected health information as described below for the identified patient.

Entity to Receive Information.

Check each person or class of persons that you approve to receive information.

Description of information to be released.

Check each that can be given to person/entity on the left in the same section.

☐ Voice Messages on _____ number.

☐ Appointment Reminders

☐ Lab Results

☐ Other

☐ Spouse or Significant Other:

Phone Number: _____

☐ Appointment Reminders

☐ Lab Results

☐ Treatment Notes and Record

☐ Discuss Treatment

☐ Other Person

Relationship: _____

Phone Number: _____

☐ Appointment Reminders

☐ Lab Results

☐ Treatment Notes and Record

☐ Discuss Treatment

☐ Other Person:

Relationship: _____

Phone Number: _____

☐ Appointment Reminders

☐ Lab Results

☐ Treatment Notes and Record

☐ Discuss Treatment

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing.

Date

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

PATIENT INFORMATION

Address: _____
First Middle Last Suite/Apt. #: _____ City/State: _____ / _____ Zip: _____

Home#: _____ Work#: _____ Cell# _____ **May Leave Confidential/detailed message regarding:** (check all that apply)

Pharmacy Name and Address: _____ Phone #: _____

RESPONSIBLE PARTY (PLEASE COMPLETE IF OTHER THAN SELF)

Address: _____

Home#: _____ Work#: _____ Cell#: _____ May leave message at: ☐ Home ☐ Work ☐ Cell

EMERGENCY CONTACT

Address: _____ Suite/Apt. #: _____ City: _____ State: _____ Zip: _____

Home#: _____ Work#: _____ Cell#: _____ May leave message at: ☐ Home ☐ Work ☐ Cell

E-PRESCRIBING MEDICATION HISTORY CONSENT

I have been given an opportunity to ask questions about the e-prescribing process and have had those questions answered to my satisfaction. I hereby consent to the practice requesting and using my medication history from other health care providers or third party pharmacy benefit payors for treatment purposes in connection with the e-prescribing process.

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I have received a copy of Virginia Physicians, Inc.'s Notice of Privacy Practices. I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.*

Please complete front and back

AUTHORIZATION AND ASSIGNMENT- REQUIRED FOR ALL PATIENTS

I authorize Virginia Physicians, Inc. to release information required by my insurance company. I authorize payment of benefits directly to Virginia Physicians, Inc. I understand that I am financially responsible to Virginia Physicians, Inc. for charges not covered by this assignment and in the event of default; I agree to pay all costs of collections including reasonable attorney's fees. This authorization and assignment will remain in effect until a notification of change is received by Virginia Physicians, Inc.

Medicare Assignment Agreement- Medicare Patients Only

I authorize Virginia Physicians, Inc. to release information needed for Medicare claims to the Centers for Medicare & Medicaid Services or its intermediaries or carriers.

FINANCIAL POLICY

Thank you for choosing the Rheumatology Division of Virginia Physicians, Inc. as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete this information before seeing the doctor.

General Information: Payment in full is due at the time of service. We accept cash, check/debit, Amex, Discover, MasterCard, and Visa.

Regarding Insurance: We accept most major insurance plans, but you are responsible for checking with your carrier to see if services at our office will be covered. We *do not* participate with any Medicaid plans. We may accept assignment of insurance benefits; however we do require that all co-payments be made at the time of service. The balance is your responsibility whether your insurance company pays or not. It is your responsibility to notify us of any changes in your policy information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical plans. You will be responsible for these balances. Additionally, it is your responsibility to obtain and track referrals for your visits.

Minor Patients: The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for full payment.

Returned Checks: There will be a \$25 fee on all returned checks. Future payments must be made by cash or credit card only.

Collection Fees: In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees.

Missed Appointments: Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the minimum rate of \$50 per missed appointment. Please help us serve you better by keeping your scheduled appointments.

Fees for Letters and Forms: Your physician will be happy to fill out any necessary form that you may need. Please be advised that due to the time required to dictate and complete letters and forms there will be a fee for this service. These costs are considered non-covered by insurance companies and will be your personal responsibility.

Patient Signature (or Authorized Patient Representative)**

Date

**This signature is applicable to all items covered on this form, both front and back



Patient History Form

Date of first appointment: ____ / ____ / ____ Time of appointment: ____ Birthplace: ____
MONTH DAY YEAR

Name: ____ Birthdate: ____ / ____ / ____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: ____ Age ____ Sex: ☐ F ☐ M
STREET APT#

____ Telephone: Home: (____)
CITY STATE ZIP Work: (____)

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive/Age ____ ☐ Deceased/Age ____ Major Illnesses: ____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School ____

Occupation ____ Number of hours worked/Average per work: ____

Referred here by: (check one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: ____

The name of the physician providing your primary medical care: ____

Describe briefly your present symptoms: ____

Date symptoms began (approximate): ____

Diagnosis: ____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later):

Please list the names of other practitioners you have seen for this problem:

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions: ____

Patient's Name: ____ Date: ____ Physician Initials: ____

Please shade all the locations of your pain **over the past week on the body figures and hands.**

Example:

LEFT RIGHT

LEFT RIGHT

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment - Listening to the patient - A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ____/____/____ Date of last eye exam: ____/____/____ Date of last chest x-ray: ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ☐ Recent weight gain
amount _____
- ☐ Recent weight loss
amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat

- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty swallowing

Cardiovascular

- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory

- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting of blood or coffee ground
material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ☐ Yes ☐ No

How many days apart? _____

Date of last period? ____/____/____

Date of last pap? ____/____/____

Bleeding after menopause? ☐ Yes ☐ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ☐ Morning stiffness
Lasting how long?
_____ Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling
List joints affected in the last 6 mos.

Integumentary (skin and/or breast)

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in
the cold

Neurological System

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric

- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine

- ☐ Excessive thirst

Hematologic/Lymphatic

- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when _____

Allergic/Immunologic

- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name: _____ Date: _____ Physician Initials: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?
Cups/glasses per day? _____

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?
☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No
If yes, please list: _____

Do you exercise regularly? ☐ Yes ☐ No
Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ No ☐ Yes Describe: _____

Any other serious injuries? ☐ No ☐ Yes Describe: _____

FAMILY HISTORY

IF LIVING		IF DECEASED	
Age	Health	Age at Death	Cause
Father			
Mother			

Number of siblings _____ Number living _____ Number decreased _____

Number of Children _____ Number living _____ Number decreased _____ List ages of each _____

Health of children _____

Do you know any blood relative who has or had: (check and give relationship)

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Rheumatic fever _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Leukemia _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Bleeding tendency _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Goiter _____
<input type="checkbox"/> Colitis _____	<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Psoriasis _____	

Patient's Name: _____ Date: _____ Physician Initials: _____

PAST MEDICAL HISTORY

Do you now have or have you ever had: (check if "yes")

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

MEDICATIONS

Drug allergies: ☐ No ☐ Yes If yes, please list: _____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: <i>Helped?</i>		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICATIONS: Please review this list of “arthritis” medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: <i>Helped?</i>			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Circle any you have taken in the past</i>					
<div style="display: flex; justify-content: space-between; padding: 5px;"> Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac </div> <div style="display: flex; justify-content: space-between; padding: 5px;"> Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate </div> <div style="display: flex; justify-content: space-between; padding: 5px;"> Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac </div>					
Pain Relievers					
Acetaminophen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDs)					
Certolizumab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Golimumab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tocilizumab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient's Name: _____ Date: _____ Physician Initials: _____

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: <i>Helped?</i>			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injection or nasal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risedronate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications					
Probenecid		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others					
Tamoxifen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyaluronan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please list supplements:

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No

If yes, list:

ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ Yes ☐ No *If yes, how many?* _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function...*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Descending stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up from chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touching your feet while seated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying asleep due to pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining restful sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your sexual relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in leisure time activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With morning stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane, crutches, walker or wheelchair? (<i>circle one</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is the hardest thing for you to do? _____

Are you receiving disability? Yes ☐ No ☐

Are you applying for disability? Yes ☐ No ☐

Do you have a medically related lawsuit pending? Yes ☐ No ☐

Patient's Name: _____ Date: _____ Physician Initials: _____



**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
(to Virginia Physicians Rheumatology)**

Patient's Name _____

Date of Birth _____ SSN _____

Home _____ Work _____ Cell _____

Release records from:

Release records to:

Virginia Physicians Rheumatology

7650 East Parham Road, Suite 304

Richmond, VA 23294

Reason for request: _____

Information to be released:

_____ Completed health records

_____ Office notes - dates from _____ to _____

_____ Immunizations _____ Labs only _____ X-Rays only _____

Other: _____

I Do _____ or I Do Not _____ authorize the release of information related to:

- ☐ AIDS (Acquired Immunodeficiency Syndrome)
- ☐ HIV (Human Immunodeficiency Virus) Infection
- ☐ Psychiatric care and/or Psychological assessment
- ☐ Treatment for alcohol and/or drug abuse

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I need not sign this form in order to assure treatment.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present a written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Patient/Parent/Guardian/Representative _____

Date _____