StrideCare

How did you hear about us?

- ☐ Physician referral:_____
- ☐ Magazine ad:_____
- ☐ Friend/Family:_____
- ☐ Radio ad:_____
- ☐ Other_____
- ☐ Newspaper ad:_____
- ☐ Television News Show:_____
- ☐ Website:_____
- ☐ Facebook:_____
- ☐ Television ad:_____

I. PATIENT INFORMATION:

Name:_____ Date of Birth:_____ Sex:_____

Language:_____ Race:_____ Ethnicity:_____

Home Address:_____

City:_____ State:_____ Zip:_____ Marital Status_____

Home Phone #:_____ SS #:_____

Employer:_____ Work #:_____

Work Address:_____ City:_____ State:_____ Zip_____

Cell Phone #:_____ Voice Main: Y – N

Best Contact: Home / Work / Cell / Email Email:_____

Emergency Contact:_____ Relationship:_____ Phone #_____

By providing an email you agree to receive updates, news, and general information from StrideCare. We respect your right to privacy and will not share your information.

II. INSURANCE INFORMATION:

(Primary) Please complete if other than self

Insurance Co.:_____
Policy #:_____
Group #:_____
Name of Guarantor:_____
Insured's Date of Birth:_____
Insured's ID or SS:_____
Employer (if group policy)_____

(Secondary) Please complete if other than self

Insurance Co.:_____
Policy #:_____
Group #:_____
Name of Guarantor:_____
Insured's Date of Birth:_____
Insured's ID or SS:_____
Employer (if group policy)_____

PAYMENT OF BENEFITS

I direct payments to StrideCare of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, but not to exceed the reasonable and customary charges for those services.

_____

Signed (Insured Person) Date

RELEASE OF INFORMATION

I hereby authorize StrideCare to release any information acquired in the course of my examination or treatment.

Name: Relationship: Contact:

Name: Relationship: Contact:

_____

Signed (Patient) Date

StrideCare

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plan, and my other healthcare providers.

_____ _____

Patient/Parent/Guardian Signature Date

By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS\HIV and medicines used to treat mental health issues such as depression.

HIPAA POLICIES & PROCEDURES

Notice of Privacy Practices for Protected Health Information (PHI)

STRIDECARE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective date: September 23, 2013

StrideCare is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information about the medical care we provided to you.

Example of Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services. Your health information is also subject to electronic disclosure for treatment, payment and health care operations.

Your Health Information Rights

The health and billing records we maintain are the physical property of StrideCare. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI (i.e., PHI that is not electronically encrypted);
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket and the disclosure is not otherwise required by law;
- Request that you be allowed to inspect and copy the information about you that we maintain in StrideCare's designated record set. You may exercise this right by delivering your request, in writing, to StrideCare;
- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to StrideCare. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by StrideCare, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;

- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to StrideCare.
- If we engage in fundraising activities and contact you to raise funds for StrideCare, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules;
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to StrideCare (except to the extent action has already been taken based on a prior authorization).

Patient Rights and Responsibilities

The Patient has the right to:

- Be treated with respect, consideration and dignity;
- Be provided with information concerning services available at StrideCare, such as provisions for after-hours and emergency care, fee for services, and payment policies;
- Expect full recognition of individuality, including personal privacy in treatment and care. In addition, all disclosures and records will be treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse their release;
- Receive treatment that supports and respects their individuality, choices, strengths, and abilities;
- Receive a referral to another healthcare institution if StrideCare is unable to provide health services for the patient;
- Consent to photographs of the patient before a patient is photographed;
- File a grievance if concerned about the care they received;
- Free from restraint or seclusion, abuse, neglect, exploitation, coercion, manipulation, sexual abuse, and sexual assault;
- Receive copies of his or her medical records upon request; and
- Be informed of any human experimentation or other research and/or education projects that StrideCare may be performing that may affect his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.

The Patient is responsible to:

- Provide complete and accurate information to the best of his or her ability about his or her health, any medications, including over-the-counter products, dietary supplements, and any drug allergies or sensitivities;
- Be informed of the grievance procedures required by Federal, State, and Local regulations;
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such a refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow instructions of the physician or center;
- ADVANCED DIRECTIVES: Inform his or her provider about any living will, medical power of attorney, or other directive that could affect his or her care;
- If the patient has a **DNR (do not resuscitate)** the patient must notify StrideCare and bring to the patient's appointment;
- Be informed as to StrideCare's policy regarding advance directives and/or living wills;
- Inform the center of any human experimentation or other research and/or education projects that the patient may be involved in that may affect the patient's care;
- Provide a responsible adult to transport him or her home from the center and remain with him or her for 24 hours, if required by his or her provider;
- Accept personal financial responsibility for any charges not covered by his or her insurance;
- Be respectful of all the health care providers and staff, as well as other patients;
- Be informed of credentials of health care professionals is requested;
- Be considerate of other patients, personnel, and for assisting in the control of noise, smoking, and other distractions;

- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the transfer;
- Provide payment to StrideCare for copies of the medical records the patient may request;
- Have initial and regular reassessment of pain; and
- Follow the treatment plan prescribed by his or her provider.

Our Responsibilities

StrideCare is required to:

- Maintain the privacy of your health information as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice ('Notice') describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

Law Enforcement

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our patients to funeral directors as necessary for them to carry out their duties.

Website

- You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to StrideCare (as previously provided in this Notice under “Your Health Information Rights.”)

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact StrideCare/s Privacy Officer at (866) 552-4866, or in writing to us at:

Compliance Department
StrideCare
12221 Merit Drive, Suite 620
Dallas, TX 75251

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from StrideCare.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

HIPAA POLICIES & PROCEDURES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of StrideCare's Notice of Privacy Practices.

_____
Print Name

_____ _____
Patient (or Patient Representative*) Signature Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

Financial Policy and Disclosure

Patients are responsible for the payment of all services provided by StrideCare, and its subsidiaries.

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable healthcare services. Therefore, it is necessary for us to have a financial Policy and disclosure stating our requirements for payment for services provided to patients.

Self-Pay Policy

- All services rendered are charged to the patient, not to an insurance company. Once the patient elects to be self-pay, the patient is responsible for all charges, regardless of insurance coverage.
- StrideCare maintains a self-pay fee schedule for patients that do not have insurance coverage or opt not to use their benefits.
- Payment arrangements are offered at the patient's request only after the patient has exhausted supplemental financing through a third-party finance solution (e.g. Care Credit or Prosper Healthcare Lending) and meets the following criteria:
  - Down payment is equal to 75% of estimated charges
  - Payment arrangements may not extend longer than 3 months

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- Deductible, co-payments, and coinsurance will be collected when services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

Ultrasound Policy

- If you require an ultrasound for diagnosis, we will contact your insurance company and verify your benefits.
- You will be contacted if your insurance company requires a co-payment or it applies to your deductible for payment when services are rendered.

To help in this policy we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when charges are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, co-payment, coinsurance, or for the full amount if you are a self-pay patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any information with the check-out associate or front desk.

Responsible Party's Signature

Date

StrideCare

AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION

Federal privacy guidelines, HIPAA, prevent this office from disclosing protected health information (PHI) to anyone other than the patient. By signing this form, you are allowing us to communicate with designted individuals regarding your medical and financial record with this facility.

I, the undersigned, hereby authorize StrideCare to disclose PHI from my medical or financial record to the following person(s):

Name: _____

Relationship: _____ Type of Information (Circle One) Medical Financial Both

Name: _____

Relationship: _____ Type of Information (Circle One) Medical Financial Both

*****ADDITIONAL PERSONS MAY BE LISTED IF NECESSARY.*****

This authorization is given freely with the understanding that I may revoke this authorization in writing at any time, but not retroactively. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.

_____ Signature of Patient

_____ Signature of Patient's Representative

_____ Name of Patient (Print or Type)

_____ Relationship of Representative to Patient

_____ Date

_____ Date

Emergency Contact _____ **Relationship** _____ **Phone Number** _____

Please list all medications you are currently taking below

Medication:	Strength:	How often:	Why are you taking:

Please list all medication allergies

Medication:	Reaction:

StrideCare

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: _____
FIRST MI LAST

DOB: _____ / _____ / _____ Social Security #: _____

I, the undersigned, authorize the release or request access to the information specified below from:

_____
PHYSICIAN NAME

_____
PHYSICIAN ADDRESS

_____
PHYSICIAN PHONE NUMBER PHYSICIAN FAX NUMBER

from the above-named patient's medical record(s).

PATIENT INFORMATION IS NEEDED FOR:

- ◯ Continuing Medical Care
- ◯ Insurance
- ◯ School
- ◯ Military
- ◯ Personal Use
- ◯ Other: _____
- ◯ Social Security/Disability
- ◯ Legal Purposes

INFORMATION TO BE RELEASED OR ACCESSED:

- ◯ History & Physical
- ◯ Progress Notes
- ◯ Care Plan
- ◯ EKG Reports
- ◯ Operative Reports
- ◯ Lab/Pathology Reports
- ◯ Consultation Report
- ◯ Discharge Summary
- ◯ X-Ray Reports/Images
- ◯ Emergency Room Record
- ◯ Face Sheet
- ◯ Other:

The above information may be released to: **STRIDECARE**
12221 MERIT DRIVE, SUITE 620
DALLAS, TEXAS 75251
PHONE: (866) 552-4866
FAX: (866) 946-4085

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness or communicable disease, including Human Immunodeficiency Virus (HIV) and Acruired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned to my signing this authorization, except in certain circumstances such as for participation in research programs or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

This authorization will not expire unless I revoke the authorization in writing.

_____ _____
SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE

_____ _____
PRINTED NAME OF PATIENT OR LEGALLY AUTHROIZED REPRESENTATIVE DATE

Primary Care Doctor: _____ Referring Physician: _____
Primary Care Clinic Name: _____
Pharmacy: _____ Pharmacy Phone: (_____) _____- _____

Vascular History

Place an "x" if you have any of the following:

___ Red/purple spider veins
___ Abdominal veins
___ Leg ulcers/Open wounds
___ Skin discoloration below knee
___ Bulging veins
___ Diagnosed with vein disease
___Purple spots on feet
___Diagnosed w/ arterial disease
_____

Years with varicose veins/spider veins _____
Years with venous ulcers/open wounds _____

Place an "x" if you have any of the following:

___ Ache or hurt
___ Become restless
___ Ankle skin changes
___ Bleeding from veins
___ Swelling?
___ Heaviness
___ Cramping
___ Burning
___ Itching
___ Pelvic Pain
___ Cold Feet
___ Nail loss
___ Hair loss
___ Pain that wakes you
___ Dangle leg for relief
___ Tiredness/fatigue in leg
___ Other _____
_____

Please check any factors that **aggravate** your leg discomfort:

___ Prolonged standing
___ Prolonged sitting
___ Around/during Menstrual Cycle
___ Exercise
___ Tender to touch
___ Pregnancy
___ Sexual Intercourse
___ Other _____
_____

Please check any methods you have used to **relieve** your leg discomfort:

___ No discomfort
___ Compression hose/Leg wraps
___ Exercise
___ Leg elevation
___ Warm soaks/heating pad
___ Cold packs
___ Massage
___ Pain medications
___ Ibuprofen ___ Tylenol ___ Aspirin
___ Other _____

Have you ever worn compression stockings? Yes ☐ No ☐
If so, Stockings prescribed by: _____ When? _____ How long? _____

Have you been treated for your leg veins before? ☐ Yes ☐ No

By whom? _____ When? _____

- If so, By which of the following methods:

___ Cosmetic injections
___ Radiofrequency closure
___ Laser for spider vein
___ Stripping
___ Ambultory Phlebectomy
___ Ultrasound guided injections
___ Laser catheter ablation
___ Ligation:
___ Other: _____
___ Unknown

What was the outcome? _____

What would you like to correct most about your legs? _____

_____

Are you currently on or have been prescribed blood thinners? Yes ☐ No ☐

- **If yes, for how long?** _____

Current Medication(s) (no need to record dosage)

Allergies to medications: Yes ☐ No ☐ (if yes please cite below)	**Reaction**

Past Medical History

Place an "x" if you have any of the following medical illnesses:

___ COPD
___ HIV or AIDS
___ Arthritis
___ Asthma
___ Patent Foramen Ovale (Hole in heart)
___ Bleeding disorder
___ Cancer
___ Pace Maker
___ Atrial Fibrillation
___ Blood transfusions
___ Clog in lungs (PE)
___ Clog in legs (DVT)
___ Depression
___ Diabetes
___ Dialysis
___ Heart attack (MI)
___ High blood pressure
___ High cholesterol
___ Stroke
___ Kidney problems
___ Lupus
___ Hepatitis B
___ Hepatitis C
___ Thyroid disease
___ Migraines
___ Erectile dysfunction

Please list any surgeries that you have had:

Please indicate if you have a FAMILY history of varicose or spider veins or peripheral arterial disease?

___ Mother ___ Father ___ Maternal Grandmother ___ Maternal Grandfather
___ Brother ___ Sister ___ Children ___ Paternal Grandmother ___ Paternal Grandfather

FAMILY history of blood clots? Yes ☐ No ☐

Females Only

Are you pregnant or planning on becoming pregnant soon? Yes ☐ No ☐

Are you currently breastfeeding? Yes ☐ No ☐

Do you have more leg discomfort on or around your menstrual cycle? Yes ☐ No ☐

Number of children: _____ Number of miscarriages: _____

Social History

Occupation: _____

Do your daily activities require prolonged periods of standing/sitting? Yes ☐ No ☐

- If yes, what activity requires prolonged periods of standing/sitting? _____

_____

Do you now or have your ever used tobacco? Yes ☐ No ☐ Packs per week: _____

- Quit date, if applicable: _____

Average number of alcoholic beverages per week:

None ☐ 1-5 ☐ 6-10 ☐ 10+ ☐

StrideCare

Please check all that apply:

CONSTITUTIONAL ☐ Fever ☐ Chills ☐ Night Sweats ☐ Weight Gain – Weigh Loss	**MUSCULOSKELETAL** ☐ Muscle Weakness ☐ Arthralgias / Joint Pain ☐ Back Pain	**ENDOCRINE** ☐ Fatigue ☐ Cold Intolerance ☐ Heat Intolerance ☐ Erectile Dysfunction ☐ Changes in Menstrual Cycle
CARDIOVASCULAR ☐ Chest Pain ☐ Shortness of Breath – Walking ☐ Shortness of Breath – Lying Down ☐ Palpitations	**INTEGUMENTARY** ☐ Dry Skin ☐ Rashes ☐ Discoloration ☐ Growths/Lesions	**HEMATOLOGIC** ☐ Excessive Bleeding ☐ Bruising ☐ Swollen Glands
RESPIRATORY ☐ Cough ☐ Wheezing ☐ Shortness of Breath ☐ Coughing up Blood	**NEUROLOGIC** ☐ Numbness ☐ Tingling ☐ Tremors ☐ Dizziness ☐ Headaches	
GASTROINTESTINAL ☐ Nausea ☐ Vomiting ☐ Abdominal Pain ☐ Changes in Appetite ☐ Diarrhea ☐ Constipation ☐ Heartburn	**PSYCHIATRIC** ☐ Depression ☐ Depression ☐ Anxiety ☐ Sleep Disturbances ☐ Feeling Unsafe in Relationship ☐ Thoughts of Suicide	

StrideCare

Release of Information

I hereby authorize StrideCare to release any information acquired in the course of my examination or treatment.

Name: _____ Relationship: _____ Contact: _____

Name: _____ Relationship: _____ Contact _____

Signature (Patient): _____ Date: _____

Printed Name (Patient): _____

StrideCare

Revised Venous Clinical Severity Score

	RIGHT				LEFT			
	NONE (0)	MILD (1)	MODERATE (2)	SEVERE (3)	NONE (0)	MILD (1)	MODERATE (2)	SEVERE (3)
Pain (or heaviness, fatigue, soreness burning)								
None								
Occasional								
Daily								
Daily Limiting								
Vericose Veins Also includes corona phlebectatica (ankle flare)								
None								
Few								
Calf or thigh								
Calf AND thigh								
Edema								
None								
Foot and ankle								
Above ankle, below knee								
To knee or above								
Pigmentation								
None								
Perimallcolar only								
Diffuse, lower 1/3 calf								
Wider, above lower 1/3 calf								
Inflammation (erythema, cellulitis, eczema, dermatitis)								
None								
Perimallcolar only								
Diffuse, lower 1/3 calf								
Wider, above lower 1/3 calf								
No. active ulcers								
0								
1								
2								
3 or more								
Active ulcer duration								
N/A								
< 3 months								
3-12 months								
> 1 year								
Active ulcer size								
N/A								
< 2 cm								
2-6 cm								
> 6 cm								
Use of compression therapy								
Not used								
Occasional								
Most days								
Always								

TOTAL SCORE RIGHT: _____ **TOTAL SCORE LEFT:** _____