

YOUR MEDICAL HISTORY page 1

1 Patient information Chart # _____

Today's Date _____ Referring Doctor _____
Last Name _____ First Name _____ MI _____
Date of Birth (M/D/Y) _____ Age _____
Sex (M/F) _____ Height _____ Weight _____
Marital Status: Single Married Divorced Widowed

2 Your symptoms

Are your symptoms mostly in back, neck or elsewhere?

Date of Injury / when symptoms started: _____

How long have you had these symptoms?

≤ 6 weeks ≥ 7 - 12 weeks 4 months or more

Do you have pain radiating past your knee or elbow? Yes No

Does your leg or arm ever go numb? Yes No

Have you lost bowel or bladder control? Yes No

The pain is: Constant It comes & goes

Does your pain wake you up at night? Yes No

What things makes the pain better? (rest, ice, heat, pills)

What makes the pain worse? (sitting, standing, lifting)

Do you have pain that radiates into the arm or leg? Yes No

(If yes, describe) _____

Lost any control over bowel or bladder functions? Yes No

(If yes, describe) _____

Any weakness or numbness in an arm or leg? Yes No

(If yes, describe) _____

How long can you: _____ Sit _____ Stand _____ Walk

Is your pain the result of a: Fall Auto accident

Other (list) _____

3 Current status

Is there a law suit pending on problem? Yes No

Which of the following describes you currently?

Working; if yes: Full duties Limited

Not working because of back or neck problem

Not working because of another health problem

Homemaker, retired or unemployed

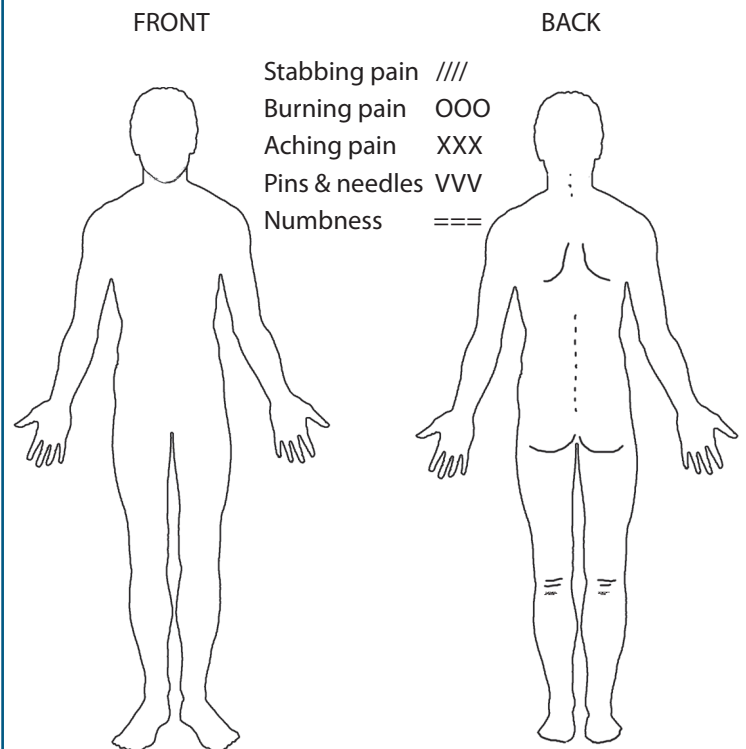
How long have you been at that job? _____

Does your job require lifting, standing, sitting? Yes No

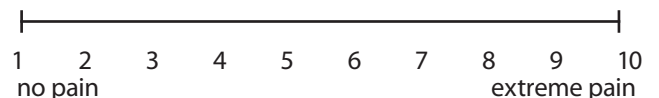
Employer at time of injury _____

4 Your pain

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



Circle your pain level on a scale of 1 to 10,
with 10 being unbearable pain.



YOUR MEDICAL HISTORY page 2

5 Previous treatments & tests

Name of the doctor that treated you FIRST
for this problem and the city.

What tests have you had? CT scan MRI X-ray EMG
 Other (list) _____

Did you have any injections for your problem? Yes No
(If yes, describe) _____

Did these injections help? Yes No
(If yes, describe) _____

Did you have previous back or neck surgery? Yes No
(If yes, describe) _____

List ANY OTHER SURGERIES you have had:

Have you ever had a blood transfusion? Yes No

Medications you currently take: _____

Past Medical History:

What problems have you been diagnosed with?

What doctors are you currently seeing?

What other concerns do you have?

6 Your health

List any ALLERGIES you have to medications, foods, etc.

Do you have any adverse reactions to anesthesia? Yes No
(If yes, describe) _____

Do you smoke? Yes No (How many packs a day?) _____

Do you drink alcohol? Yes No (How many days a week?) _____

Do you have any of the following medical problems:

AIDS/HIV Yes No Nerve problems Yes No

Arthritis or joint pain Yes No Psychiatric problems Yes No

Bleeding disorders Yes No Stomach problems Yes No

Cancer Yes No Thyroid problems Yes No

Diabetes Yes No Anxiety / Depression Yes No

Epilepsy Yes No Recently, have you had...

Heart problems Yes No Fever or chills Yes No

Hepatitis Yes No Weight loss Yes No

High blood pressure Yes No Chest pain Yes No

Migraines / headaches Yes No Shortness of breath Yes No

Muscle diseases Yes No Worse pain at night Yes No

Swollen ankles Yes No Night sweats Yes No

Other problems: _____

7 Your family history

Do any family members have a history of:

Back / neck problems Yes No Hepatitis Yes No

AIDS / HIV Yes No High blood pressure Yes No

Arthritis or joint pain Yes No Migraines / headaches Yes No

Bleeding disorders Yes No Muscle diseases Yes No

Cancer Yes No Nerve problems Yes No

Diabetes Yes No Psychiatric problems Yes No

Epilepsy Yes No Stomach problems Yes No

Heart problems Yes No Thyroid problems Yes No

Are your parents..... Living Deceased

1 Patient information

Last Name _____
 First Name _____ MI _____
 Address _____
 City _____ State _____ Zip _____
 Personal Phone # _____
 Social Security # _____
 Medicare # _____
 Marital Status: Single Married Divorced Widowed
 Date of Birth (M/D/Y) _____ Age _____ Sex (M/F) _____
 Occupation (If retired, list prior occupation)

 Employer's Address _____

 City _____ State _____ Zip _____
 Emergency Contact Name: _____
 Emergency Contact Phone # _____
 Name of Personal Doctor _____
 City _____ State _____
 Name of Pharmacy: _____
 Pharmacy Address: _____
 Pharmacy phone: _____

PERSONAL INFORMATION

2 Person responsible for payment

(Leave blank if same as patient)

Last Name _____
 First Name _____ MI _____
 Address _____
 City _____ State _____ Zip _____
 Personal Phone # _____
 Social Security # _____
 Date of Birth (M/D/Y) _____ Age _____ Sex (M/F) _____

 Occupation (If retired, list prior occupation)

 Employer's Address

 City _____ State _____ Zip _____

3 How did you hear of us?

Friend/Relative Newspaper/Magazine Internet Insurance directory Referral - Dr: _____

4 Insurance information

Primary Insurance _____	Secondary Insurance _____
Policy # _____ Group # _____	Policy # _____ Group # _____
Claims Address _____	Claims Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Insurance Telephone # _____	Insurance Telephone # _____
Name of Policy Holder _____	Name of Policy Holder _____
DOB: _____	DOB: _____

CONSENT FORM

1 Financial agreement

I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Insurance authorization must be obtained before a patient is seen. If I do not inform the physicians seen in this clinic of my current insurance and the insurance is denied because of no authorization, I will be responsible for payment. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to see the doctor, I will be responsible for the bill at the time of service.

Patient Name _____

Signature of responsible party _____

Today's Date _____

2 Consent for minor

I grant the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the patient.

Signature _____

Date _____

Relationship to patient _____

3 Notice of privacy practices

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. I will be offered a copy of any amended Notice or Privacy Practices.

Signature _____

Date _____

If not signed by the patient, please indicate the relationship between the signee and the patient:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

For office use only

Date received _____

Copayment _____

Authorization required Yes No

Processed by _____

Practice follow-up Yes No

Date of follow-up _____

Complete the following ONLY if the patient refuses to sign the acknowledgement. Efforts to obtain:

Reason for refusal

PRIVACY NOTICE | YOUR PERSONAL HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to ask us. We need to collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide via our website. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

HOW YOUR INFORMATION IS USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. We do not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related-benefits and services that may be of interest to you.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have that right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

I have received a copy of this Privacy Policy.

Patient Name (printed): _____ Signature: _____ Date: _____

OUR PAIN MEDICATION POLICY

In the course of your treatment, you may receive pain medications. However, all physicians are required by federal law to follow stringent policies related to the use of prescription drugs, especially narcotics.

Consequently, all patients need to make arrangements to obtain any necessary prescription refills prior to the weekend. We will not provide pain prescriptions or pain prescription refills during the weekend which begins each Friday at noon and ends the following Monday at 8:30 a.m.

The goal of our spine center is to help patients become less dependent on pain medications. Consequently, our policy is to NOT provide prescription refills by phone. So you may need to see the physician or the physician assistant to make these arrangements. Please call at least two days prior to your last dose. This will assure the most prompt response to your request. Do not wait until the day your medication runs out. Our clinical staff needs sufficient time to review your request for refill.

USE ONE PHARMACY

Using the same pharmacy helps assure that the pharmacy will stock your medication for refills and that the pharmacy will know that you have a legitimate need for pain medication. Consequently, it is in your best interest to use only ONE pharmacy for refills of your pain medication.

PROTECT YOUR MEDICATION FROM LOSS

You are personally responsible for the safekeeping of your medication. Please do not sell, trade or give it away. If your medication is damaged, stolen or lost you must notify us right away.

Please do not seek pain medication from any other doctor unless approved by our clinical staff. Let us know if at any time another doctor prescribes medication for you.

The above restrictions apply a variety of prescription drugs, including, but not limited to:

1. Narcotics. (Example include, Vicodin, Percocet, Oxycontin & Codeine)
2. Non-Steroidal Anti-Inflammatory drugs, "NSAIDS". (Example include, Motrin, Celebrex & Naprosyn)
3. Non-narcotic and other Pain Medicine. (Example include, Ultram or Darvocet)
4. Muscle Relaxants. (Example include, Flexeril or Soma)