Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out this form as complete as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

TODAY'S DATE: ______________ **REASON FOR TODAY'S VISIT:** ______________________________

Patient's Last Name______________________ **First:** ______________________ **MI:** _____

Address: ______________________ **City/State:** ______________________ **Zip:** ________

Primary Phone: ______________ (Cell, Work, Home) **Secondary:** ______________(Cell, Work, Home)

Date of Birth: ____________ **Age:** _____ **Sex:** ☐ Male ☐Female **Social Security:** ______________

Referring Physician: ____

Pharmacy: (name and location): ______________________________________

Emergency Contact: ______________________ **Relationship:**______________ **Phone:**__________

Race: __________ **Ethinicity:** Hispanic / Non-Hispanic / Decline to State **Preferred language:** English/Spanish/Other

Employer: ____________________________ **Employer's Phone number:** ______________________

Insurance Information

Primary Insurance Co.:______________________ **ID #** ____________________ **Group#**__________

Policy Holder Name: ______________________________ **Subscriber date of birth:** ______________

Secondary Insurance Co: ______________________ **ID #** ____________________ **Group #** __________

Policy Holder Name: ______________________________ **Subscriber date of birth:** ______________

If injury is work related; Work Comp carrier: ______________________ **Work Comp Claim #** __________

Date of Injury: ______________ **Adjuster's name and phone #:** ______________________________

If injury is MVA related, Insurance company: ______________________ **Claim #** ______________

Date of Injury: ______________ **Adjuster's name and phone #:** ______________________________

Person responsible for today's bill: ______________________________ **Method:** ☐Cash ☐Check ☐Charge

Release of Benefits

I HERBEY AUTHORIZE THE PHYSICIA TO OBTAIN AND/OR RELEASE MEDICAL RECORDS/XRAYS FROM PHYSICIANS OR OTHER MEDICAL CARE PROVIDERS AND INSURANCE COMPANITES IN ORDER TO FACILITATE MY HEALTHCARE. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE FOR MEDICAL SERVICES RENDERED.

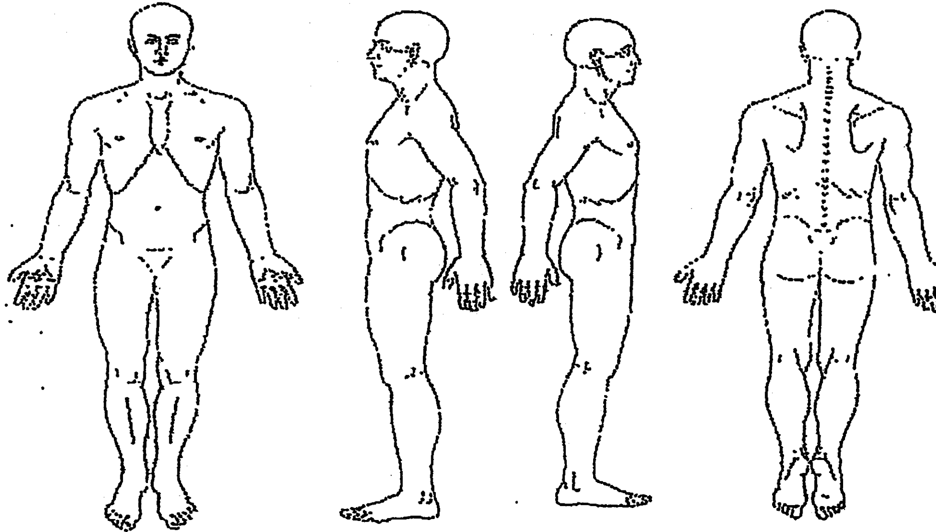
Signature: ____ **Date:** ______________________

Is the condition: ☐ Injury related ☐ MVA ☐ Fall Injury ☐ Illness ☐ Surgery ☐ No Reason

☐ Work Injury ☐ Non-work Injury ☐ Other ______________________________

Primary location of pain: ______________________ **Secondary pain:** ______________________

Pain located: mark as indicated



Pain described as: (check all that apply): ☐ aching ☐ burning ☐ pins and needles ☐ numbness ☐ stabbing

Pain intensity: Circle you pain score with '0' representing no pain and '10' the most severe pain imaginable

Current pain	1	2	3	4	5	6	7	8	9	10
Average last 7 days	1	2	3	4	5	6	7	8	9	10

Pain described as: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Date pain was first noticed: ______________________ **Is this a recurrent problem?** ☐ Yes ☐ No

Pain is worse: ☐ in the morning ☐ in the evening ☐ same all the time ☐ varies day to day

Please describe how your pain first started (i.e. accident, injury, please describe) ______________________

____

How long can you stand? __________ **How far can you walk?** __________ **How long can you sit?** __________

Things that make my pain worse: ______________________________

Things that make my pain better: ______________________________

Do you have? (check all that apply) ☐ bowel/bladder problems ☐ coldness ☐ decreased exercise tolerance

☐ increase in sweating ☐ numbness ☐ skin discoloration ☐ tingling ☐ walking problems ☐ weakness

Name: ______________________________ Date: ______________

Medical Review: Check any condition that applies to you

	Are Experiencing		Are Experiencing
General		**Musculoskeletal**	
Fever		Limitation of use of any joint (including back)	
Sleeping problems		Muscle pain	
Unintentional weight loss		Pain in back	
Unintentional weight gain		Pain in neck	
		Painful joints	
Eyes		Stiffness in joints	
Blurred vision		Swelling of joints	
Loss of vision		Weakness	
Ears, Nose, Throat		**Integumentary/Skin**	
Dizziness		Change in hair or nails	
Hearing loss		Change in skin color	
Ringing in ears			
Nasal congestion		**Neurological**	
Hoarseness or other voice changes		Headache	
Snoring		Severe face pain	
Sore throat		Seizures	
Cardiovascular		**Psychological**	
Blacking out or fainting		Anxiety	
Chest pain		Depression	
Heart murmer		Trouble sleeping	
Irregular heartbeats		Appetite is increased	
Leg cramps			
Swelling of ankles		**Endocrine**	
		Fatigue	
Respiratory		Neck has enlarged	
Non-productive cough		Increased thrist	
Productive cough			
Shortness of breath		**Hematologic**	
Wheezing		Bleeds excessively after injury	
		Bruises easily	
Gastrointestinal		Masses (lumps) in neck	
Abdominal pain			
Diarrhea		**Immunologic/Allergic**	
Heartburn		Rash after contact with specific substance	
Nausea			
Vomiting		**Weight**	
		Do you feel your weight is:	
Genitourinary		Within a healthy range	
Blood in urine		Close to a desired and healthy range	
Change in urinating pattern		Unhealthy	
Frequency in urination			
Loss of bladder control		**Patients 50 years of age and older**	
		Have you had a colonoscopy	Yes
		with in the last 5 years, or as	No
		recommended by your primary physician	

Name:______________________________ **Date:**______________

Contact Allergies: check all that apply

☐ Adhesive Tape ☐ Iodine ☐ Latex ☐ Contrast Dye

Past Medical History: check all that apply

☐ Bone Cancer ☐ Breast Cancer ☐ Lung Cancer ☐ Prostate Cancer

☐ Migraine headache ☐ Chronic sinusitis

☐ Angina ☐ Heart attack ☐ High blood pressure ☐ Asthma

☐ Gastroesophageal reflux ☐ Stomach ulcer ☐ Hepatitis

Are you pregnant? ______ ______ ☐ Kidney disease ☐ Kidney stones

☐ Arthritis ☐ Degenerative bone disease Osteoporosis

☐ Epilepsy ☐ Multiple sclerosis ☐ Stroke ☐ Depression

☐ Diabetes ☐ Thyroid dysfunction

☐ AIDS ☐ HIV

Family History:

☐ Heart disease ☐ High blood pressure ☐ Alcoholism ☐ Substance abuse ☐ Diabetes

Social History:

Retired? ☐ yes ☐ no

Tobacco Use: ☐ None ☐ Smokeless tobacco ☐ Cigarettes ☐ Cigars

If yes, average daily usage: ☐ ½ pack ☐ 1 pack ☐ 1 ½ packs ☐ 2 packs ☐ 3 packs

Alcoholic Beverages – a drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer

☐ Less than 12 drinks/yr ☐ 1-13 drinks/mo ☐ 4-14 drinks/wk ☐ >2 drinks/day

Do you use drugs recreationally? ☐ Yes ☐ No

Diagnostic Studies: (Dates and results)

MRI's	
CT's	
X-rays	
EMG's	
Discography	
Bone Scans	

Previous pain treatments: (check all that apply)

☐ Acupuncture ☐ Biofeedback ☐ Chiropractor ☐ Exercise ☐ Injections
☐ Nerve Blocks ☐ Physical Therapy ☐ Psychotherapy ☐ Surgery ☐ TENS
☐ Rx and OTC meds used previously: (not meds on current list) ____________________
☐ Other: ____________________

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Prescribed Medication and Dosage	How Often Taken	Reason for Taking
OTC and Herbal Medications		

Medication/Non-med Allergies: ____ **Yes** ____ **No** If yes, please list below:

Name of Medication	Type of Reaction
Contact Allergies	**Type of Reaction**

Surgical History:

Name of Surgery/Procedure	Date

SPINE & PHYSICAL MEDICINE
FINANCIAL POLICY
(Initial and Sign)

______**PAYMENT POLICY: PAYMENT IS EXPECTED AT THE TIME OF SERVICE:**
The patient or the guarantor is responsible for payment of medical charges incurred, regardless of insurance or third party liability. We accept most major insurances, cash, check, or VISA and Master Card. We also offer Care Credit.

______**LIABILITY CLAIMS:**
Patients that are seen as a result of a motor vehicle or other accident are required to pay in full for each date of service. Your MedPay policy will be billed after coverage is confirmed. Third party insurance will not be billed but other arrangements may be available.

______**PAYMENT ARRANGEMENTS:**
Payment arrangements will be made on a case by case basis. Short term internal payment plans can be arranged; but will require a signed authorization to automatically deduct payment from a major credit card. Any unresolved balances will be turned to a collection agency. If payment arrangements are made, they must be followed for continued care, including provider prescriptions etc.

______**CO-PAYS:**
Co-payments are expected at the time of service. *Spine and Physical Medicine has a contractual obligation with most insurance that we will ask and collect for your co-payment at the time of service. It is our contractual and legal obligation to ask you to pay.*

______**SERVICES NOT COVERED BY YOUR CO-PAY:**
For many policies, co-pay only applies to the office visit. Further treatment such as injections, electrodiagnostic studies, trigger point injections, joint aspirations, etc. are considered separate services, and will require additional payment.

______**PAYMENT OF DEDUCTIBLE:**
We will be required to ask for full payment of your deductible at the timeof service for office visits and procedures.
Again, cash, check, VISA, Master Card or money order can be utilized.

______**NO SHOW POLICY:**
Patient will be charged a $50.00 no-show fee if appointment is not kept. This must be paid prior to future appointments and also prior to refilling prescriptions, or other services. Recurrent cancellations may also be subject to this policy.

______**BILLING:**
Should the patient or guarantor have insurances that may assist with the cost of your services. We agree to submit your claim to the carrier, to receive payment directly from the carrier, and based on the Explanation of Benefits, bill the patient or guarantor for the remaining amount due. If you have any billing questions, please contact our billing service at 208-401-1000.

PATIENT SIGNATURE______________________________________ DATE_______________

MEDICATION POLICY

(Please initial and sign)

________ 1. Medication usage is only one component of the comprehensive rehabilitation program and generally the physical component is the most important. Prescription of medication is contingent on compliance with the complete rehabilitation program.

________ 2. All conditions of the Controlled Substance Agreement will be followed (ask questions if you have any concerns on these conditions).

________ 3. Prescriptions of controlled substances will not be provided if there is under-reporting of medication use or false information provided.

________ 4. Safeguard your medications. Medications will not be replaced if they are lost, taken by roommates, get wet, get destroyed, dropped down the sink, left on airplanes, left in motel rooms, etc., etc. If your medication has been stolen and you complete a police report, an exception may or may not be made.

________ 5. Narcotic medications will not be increased over the phone and if medication is taken in excess of what is prescribed, there will not be early refills. If pain relief is inadequate, you must follow up with your physician.

________ 6. The prescription of controlled substances requires monitoring. Therefore, the appropriate appointments will be scheduled. You must keep the scheduled appointments and meet your financial obligations for these appointments to continue with prescription of medication.

MEDICATION REFILLS:

1. Medications are refilled at appointments or Monday through Thursday, 8 a.m. to 5 p.m.
2. Refills of most medications, call your pharmacy and they will fax a request to our office.
3. For schedule 2 medications, a written prescription is required and you must contact the office.
4. Allow 24-48 hours for refills.
5. Prescriptions will not be refilled on weekends, holidays or after hours.

PATIENT SIGNATURE: ______________________________ DATE: ______________