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.

REASON FOR TODAY'S VISIT: _____ Date of Injury: _____

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: _____**

Employer: _____ Employer's Phone number: _____

Pharmacy: (name and location): _____

Referring Physician: _____Marital Status: Single/Married/Divorced/Widowed/Other

Emergency Contact: _____ Relationship:_____ Phone:_____

Race: _____ Ethnicity: Hispanic / Non-Hispanic / Decline to State **Preferred language:** English/Spanish/Other

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 PHYSICIAN TO OBTAIN AND/OR RELEASE MEDICAL RECORDS/XRAYS FROM PHYSICIANS OR OTHER MEDICAL CARE PROVIDERS AND INSURANCE COMPANIES 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.

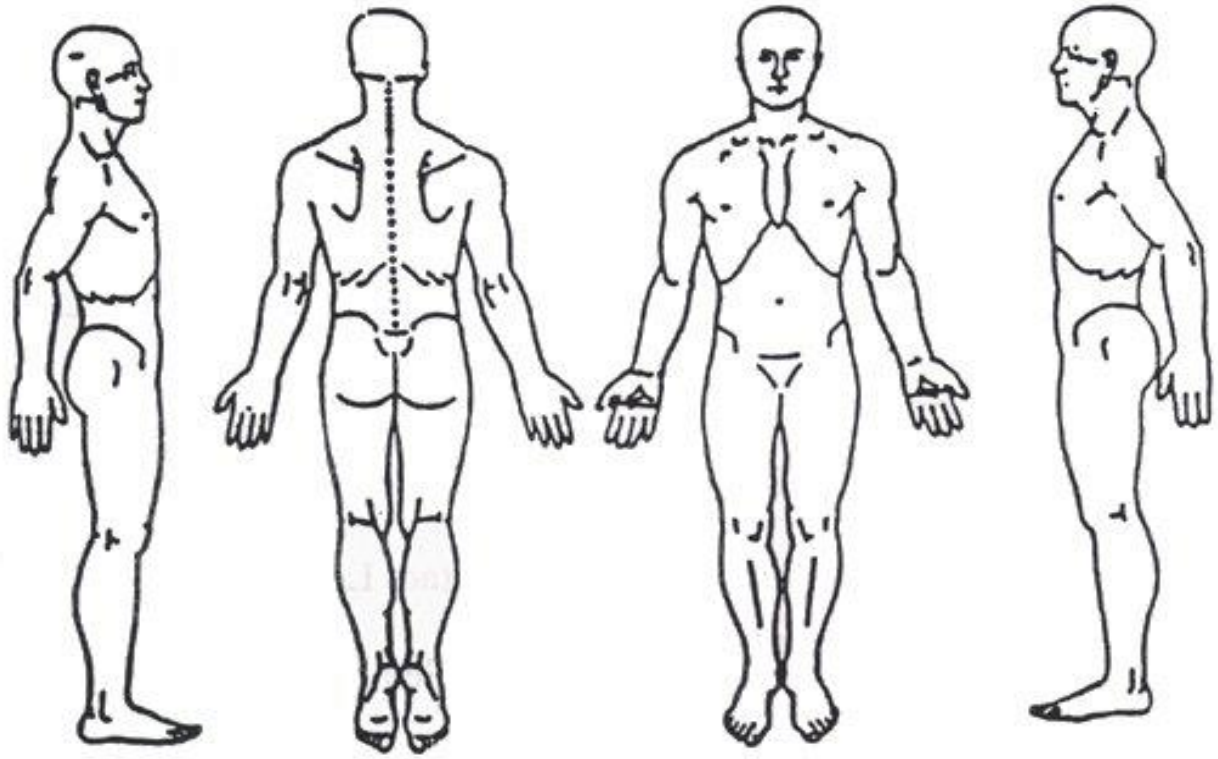
Signature: _____ Date: _____

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

☐ Work Injury ☐ Non-Work Injury ☐ Other _____

Primary Location of pain: _____ **Secondary Pain Location**: _____

Pain Location: Mark as indicated



Pain is described as: (check all that apply) ☐ Aching ☐ Burning ☐ Pins & Needles ☐ Numbness ☐ stabbing

Pain Intensity: Circle your 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, etc., please describe): _____

_____

_____

How long can you stand: _____ How far can you walk? _____ How long can you sit?_____

Things that make the pain worse? : _____

Things that make the 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

Diagnostic Studies: (Dates and results)

MRIs	
CTs	
X-Rays	
EMGs	
Discography	
Bone Scans	

Previous pain treatments: (check all that apply)

- ☐ Acupuncture
- ☐ Nerve Blocks
- ☐ Biofeedback
- ☐ Physical Therapy
- ☐ Chiropractor
- ☐ Exercise
- ☐ Injections
- ☐ Psychotherapy
- ☐ Surgery
- ☐ TENS
- ☐ Other _____
- ☐ RX and OTC meds (not on current med list) _____

Please list any medications you are currently taking:

Prescribed medication and dosage	How Often Taken	Reason for taking
OTC and Herbal Medications		

Medication/Non-medication Allergies: ____ YES ____ NO If yes please list below.

Name of Medication	Type of Reaction
Contact Allergies (i.e tape, iodine, latex, contrast dye etc.)	**Type of Reaction**

Surgical History:

Type of Surgery/Procedure	Date of Surgery/Procedure

Past Medical History: (check all that apply)

☐ Mumps ☐ Measles

☐ Cancer (Specify type) _____

☐ Migraine headache ☐ Chronic sinitus ☐ Sleep apnea

☐ Angina ☐ Heart Attack ☐ High blood pressure ☐ Asthma

☐ Gastro esophageal reflux ☐ Stomach ulcer ☐ Hepatitis ☐Hernia

Are you pregnant? **YES** **NO** ☐ Kidney disease ☐ Kidney stones

☐Arthritis (osteo / rheumatoid) ☐Degenerative bone disease ☐Osteoporosis ☐ Scoliosis ☐Spinal stenosis

☐ Lupus ☐Shingles ☐ Neuropathy ☐ Epilepsy ☐ Multiple sclerosis ☐ Stroke ☐ Depression

☐ Diabetes (Type: I or II) ☐ Thyroid dysfunction ☐ Anemia

☐ AIDS ☐ HIV

☐ Other previously diagnosed conditions not listed above:

_____

_____

Family History: (check all that apply, please note which family member for each that apply)

☐ Heart Disease ☐ High Blood Pressure ☐ Alcoholism ☐ Substance abuse ☐ Diabetes

☐ Cancer (Specify type: _____)

Social History:
Dominant hand (circle one): Left Right Neither **Marital Status:** ___M/___S/___W/___D

Retired? ☐**YES** ☐**NO** Employed? ☐**YES** ☐**NO** if so, ☐**full time** ☐**part time**

Tobacco use: ☐ None ☐ Smokeless tobacco ☐ Cigarettes ☐ Cigars ☐Electronic/Vapor cigarettes

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.

☐ None ☐ Less than 12 drinks/year ☐ 1-13 drinks/mo ☐ 4-14 drinks/wk ☐ More than 2 drinks/day

Do you use drugs recreationally? ☐ **YES** ☐ **NO**

- If you are a patient 6 months and older, when was your most recent influenza immunization? N/A or date? _____
- If you are a patient 65yo or older, when was your most recent pneumonia vaccination administered? N/A or date? _____
- If you are a patient between the ages of 50-75yo, when was your most recent Colorectal CA screening (colonoscopy, sigmoidoscopy, or FOBT)? N/A or date? _____
- If you are a female between the ages of 24-64 yo, when was your most recent Cervical CA screening (pap test)? N/A or date: _____

- If you are a female patient between the ages of 42-69yo, when was your most recent Breast CA screening (mammogram) N/A or 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)	
Generalized aching		Loss of muscle strength	
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	
Wears corrective glasses			
Wears corrective contacts		**Integumentary/Skin**	
		Change in hair	
Ears, Nose, Throat		Change in nails	
Dizziness		Change in skin color	
Hearing loss		Sores	
Ringing in ears			
Nasal congestion		**Neurological**	
Hoarseness or other voice changes		Headache	
Snoring		Severe face pain	
Sore throat		Seizures	
		Tingling “pins & needles”	
Cardiovascular		Paralysis	
Blacking out or fainting			
Chest pain		**Psychological**	
Heart murmur		Anxiety	
Irregular heartbeats		Depression	
Leg cramps		Trouble sleeping	
Swelling of ankles			
		Endocrine	
Respiratory		Fatigue	
Non-productive cough		Neck has enlarged	
Productive cough		Increased thirst	
Pain or tightness in chest		Increased appetite	
Shortness of breath			
Wheezing		**Hematologic**	
		Bleeds excessively after injury	
Gastrointestinal		Bruises easily	
Abdominal pain		Masses (lumps) in neck	
Diarrhea		Persistent swelling in legs	
Constipation			
Heartburn		**Immunologic/Allergic**	
Nausea		Rash after contact with specific substance	
Vomiting			
		Weight	

Genitourinary		Do you feel your weight is:	
Blood in urine		Within a healthy range	
Change in urinating pattern		Close to a desired and healthy range	
Frequency in urination		Unhealthy	
Loss of bladder control			
Loss of bladder control			
		Patients 50 years of age and older	
		Have you had a colonoscopy	Yes
		within the last 5 years, or as	No
		recommended by your primary physician	

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 time of 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_____

Turn Over →

SPINE & PHYSICAL MEDICINE
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 to continue with prescription of medication.

_____ 7. You may be subject to have urine, saliva, or blood testing to determine compliance with the pain medicine regimen. Your physician has the right to order random drug screen testing.

_____ 8. Unannounced “call-ins” may be required, where you may be called and asked to come into the office, bringing all of your medications, with only 24 hours notice. You will inform the office of all medications you are currently taking.

_____ 9. Should any other provider, including dentists, prescribe any other or additional pain medication, for any reason, you will notify this office by calling and speaking to one of the office staff, or leaving a message, by the next business day.

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 Fridays, weekends, holidays or after hours.

PATIENT SIGNATURE: _____ DATE: _____