Current Medical History

Today's Date _____ Name _____ Phone _____

Birth Date: _____ Sex: O Male O Female Handedness: O RH O LH Age: _____

Patient Address _____ S.S.N. _____

Patient City, State, Zip _____

Primary Care Doctor _____ Referring Doctor _____

Symptoms

What are your symptoms/ chief complaint? _____

_____

Is the pain mostly in the back, neck, elsewhere?

O neck only O neck and Rt. arm O neck and Lt. arm O neck and both arms

O back only O back and Rt. leg O back and Lt. leg O back and both legs

O Rt. Shoulder O Lt. Shoulder O Rt. Knee O Lt. Knee O Other: _____

Amount of pain in: neck _____ % arm(s) _____ % back _____ % leg(s) _____ %

How long ago did these symptoms begin?

Choose One *Choose One*

1-2	3-4	5-6	7-8	9-10	11-12	Days	Weeks	Months	Years
O	O	O	O	O	O	O	O	O	O

History of Present Condition

Date of onset? _____ Have you ever had this before? O No O Yes When? _____

Is your condition, the result of a... O fall O car accident O injury on the job O other _____

Is the pain O constant, or does it O come and go? explain: _____

How do your symptoms limit you? O working O walking O driving O sleeping O sitting O standing

What makes the pain better ? O sitting O standing O laying O walking O changing postion

O rest O ice O heat O medication O other _____

What makes the pain worse? (choose all that apply)

O Coughing O Sneezing O Lifting O Bending O Standing O Sitting

O Lying down O Other: _____

Does your pain radiate into your arm or leg? O No O Yes (describe) _____

Do you have weakness, numbness, or tingling in your arms or legs? O No O Yes (describe)

_____

Have you lost control over your bowel or bladder function? O No O Yes (describe)

_____

Name_____ DOB_____

How long can you ...

Walk	O <25 feet	O 26-100 feet	O 1 Block	O 1/2 Mile	O >1 mile
Stand	O 0-5 min	O 6-15 min	O 16-30 min	O 31min - 1 hr	O > 1 hour
Sit	O 0-5 min	O 6-15 min	O 16-30 min	O 31min - 1 hr	O > 1 hour
Sleep at night	O 1-2 hours	O 3-4 hours	O 5-6 hours	O 6-8 hours	O > 8 hours

Which of the following describes you currently? O working O not working because of back or neck problem

O not working because of another health problem O homemaker, retired or unemployed

How long have you been at your job? O 0-6 months O 6-12 months O 1-2 years O 2-5 years

O 5-10 years O 10-20 years O 20-30 years Last date you worked? _____

What is your occupation? _____

Does your job require? O bending O lifting O standing O sitting

Employer at the time of injury? _____ Is there a lawsuit pending or a problem? O No O Yes

Have you had a previous injury to this area? O No O Yes

Have you had a previous Workers' Compensation Claim? O No O Yes Explain: _____

Previous treatments/tests

Who first treated you for this problem? Dr. _____ City _____

What treatments did you have then? _____

What tests have you had? (pertinent to current complaint)

O CT Scan of the _____

O X-rays of the _____

O MRI of the_____

O EMG of the_____

O Other of the_____

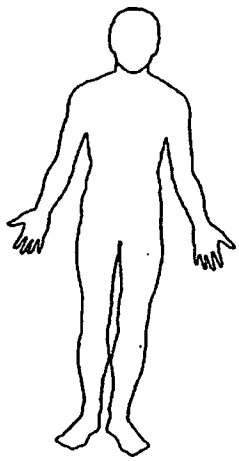
Please circle any of the following treatments you have had and note whether or not it helped. (Choose all that apply)

Physical Therapy:	O Helped	O No Help
Injections:	O Helped	O No Help
Chiropractor:	O Helped	O No Help
Other: _____	O Helped	O No Help

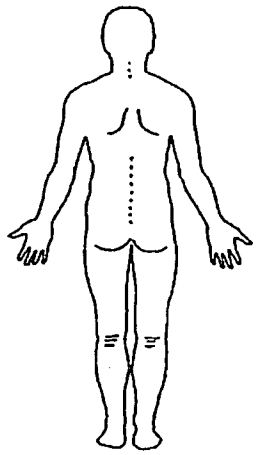
Name_____ DOB_____

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

Front



Back



Stabbing pain	/////
Burning pain	ooo
Aching pain	xxx
Numbness	= = =
Pins and needles	vvv

Rate your **current pain**: (No Pain) (Severe Pain)

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Rate your **worst pain**: (No Pain) (Severe Pain)

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Rate your **least pain**: (No Pain) (Severe Pain)

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Medical History

Please fill in the circles if you have a history of or currently have any of the following health problems?

- O Heart disease/CAD
- O High blood pressure
- O Congestive Heart Failure
- O Stroke
- O Blood clots
- O Anemia
- O Lung disease
- O Kidney Disease/Stones
- O Asthma
- O Emphysema
- O Tuberculosis
- O Allergy to Anesthesia
- O Rheumatoid Arthritis
- O Diabetes
- O Bleeding Disorder
- O Neurological Problem
- O Hepatitis
- O Stomach Ulcers
- O Gastrointestinal Reflux
- O Thyroid disease
- O Prostate Disease
- O Liver Disease
- O Skin disease
- O Infections
- O Seizures
- O Cancer ... Type: ( )

O Osteoarthritis
O Obesity
O Rheumatic fever
O Heart Murmur
O Irregular heart beat
O Chest pain
O Heart attack
O Recent cold/fever
O Sleep Apnea/Snoring
O Osteoporosis
O Steroid medications
O Incontinence
O Depression/anxiety
O Psychiatric problems
O Sickle cell anemia
O Prior blood transfusions
O Dizziness/fainting
O Polio
O Drug/Alcohol Addiction
O HIV/Aids
O Ear Nose Throat Problem
O Other: _____

List all **surgeries/ hospitalizations/ serious illnesses**

_____

_____

_____

List all your **current medications** (include prescriptions, over-the-counter, and herbal medicines)

_____

_____

_____

_____

Allergies (drugs, food, seasonal and include type of reaction) O NKDA/NO O YES (If yes, what?)

_____

_____

Are you **allergic** to: O shellfish O iodine O x-ray dye O latex O steroids O aspirin

Are you taking currently taking any **blood thinners**: O aspirin O Plavix O Coumadin O vitamin E

Do you have any... O metal implants O infusion catheters O surgical clips O pacemaker

Have you ever had **complications** from surgery or anesthesia? O No O Yes Please describe:

_____

Please indicate any **family history** of **medical conditions**

O Arthritis
O Osteoporosis
O Diabetes
O Heart Disease
O Vascular Disease
O Stroke
O Neurological
O Seizures
O Psychiatric Disease
O Kidney Disease
O Kidney Stones
O Drug/Alcohol Abuse
O Cancer
O Bleeding Disorder
O Tuberculosis
O Other _____

Name_____ DOB_____

Social History

Marital Status:	O Single	O Married	O Divorced	O Separated	O Widowed
Number of Children:	O 1	O 2	O 3	O 4	O 5 or more
Education:	O Some HS	O HS Grad	O College	O Post Grad	
Exercise:	O Sedentary	O Mild	O Moderate	O Vigorous	
Tobacco:	O Never Used	O Former Smoker	O I Chew	O I Smoke	Amount/Day: _____
Alcohol:	O Never Used	O Occasional	O Frequently	Type and amount/wk:_____	
Caffeine	O Never Used	O Occasional	O Frequently	Type and amount/wk:_____	
Pregnant:	O No _ N/A	O Yes	O Planning	O Sterile	

Review of Systems (Mark yes or no for symptoms since last visit)

O No O Yes **Chills/fever**	O No O Yes **Leg cramp**	O No O Yes **Seizures**
O No O Yes **Nausea/Fever**	O No O Yes **Heart/Chest pain**	O No O Yes **Arm weakness**
O No O Yes **Night sweats**	O No O Yes **Shortness of breath**	O No O Yes **Arm numbness**
O No O Yes **Rash/ Skin Changes**	O No O Yes **Difficulty swallowing**	O No O Yes **Leg weakness**
O No O Yes **Easy Bruising**	O No O Yes **Heartburn**	O No O Yes **Leg numbness**
O No O Yes **Cold Symptoms**	O No O Yes **Loss of bowel control**	O No O Yes **Cold Intolerance**
O No O Yes **Visual change**	O No O Yes **Loss of bladder control**	O No O Yes **Depression**
O No O Yes **Joint swelling**	O No O Yes **Headache**	O No O Yes **Anxiety**

Height: _____ Usual weight: _____ Ideal weight: _____ Temperature:_____

To the best of my knowledge, the questions on this form have been answered correctly. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary healthcare services I may need.

_____ _____
Patient Signature Date

_____ _____
Reviewed by Date

☐ I have reviewed the patient's information and have updated their information.

_____ _____
Reviewed by Date

Metro Spine & Rehab P.A.

PRECISION SPINE

PATIENTS RIGHTS AND RESPONSIBILITIES
Acknowledge Receipt of Privacy Practices
Consent to Treat

CONFIDENTIALITY
It is the policy of this practice to treat all patient information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. If you have any questions, please ask a front desk representative for information. This practice makes every effort to provide our patients with an environment, which is safe, private and respectful of our patient's needs. If you have a complaint about our services, facilities or staff, we want to hear from you. We will do everything we can to see that your experience with us is professional in every way.

ISSUES OF CARE
This practice, physicians and staff are committed to your participation in care decisions. As a client, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask.

CONSENT
I give authorization for my doctor/staff to check/verify my prescriptions on the prescriber external database.

PATIENT RIGHTS
1. The patient has the right to receive information from health providers and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.
2. The patient has the right to make decisions regarding the health care that is recommended by his or her health provider. Patients may accept or refuse any recommended medical treatment.
3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.
4. The patient has the right to confidentiality. The health provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
5. The patient has the right to continuity of health care. The health provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care provided they give the patient reasonable assistance and direction, and sufficient opportunity to make alternative arrangements.
6. Any patient having a complaint or grievance should contact the Compliance Officer, Amy Stehli, at 913-387-2800. Once a grievance or complaint is filed, the Compliance Officer will respond in writing within 30 days to address and resolve the issues. Patients may also direct any complaint to the Kansas Department of Health and Environment hotline at 1-800-842-0078.

PATIENT RESPONSIBILITIES
1. Good communication is essential to a successful health provider-patient relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their health providers.
2. Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health.
3. Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.

4. Once patients and health providers agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with health provider instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
5. Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk.

CONSENT TO TREAT

I understand that the decision to be treated is my choice, any doctor I see if up to my personal discretion. Even if a third party advises me that I must. I also understand that I do not have to remain under the care unless it is of my own choosing. I understand this practice or my physician within this practice may feel it deemed necessary to terminate the doctor/patient relationship; when medical care is no longer needed, when the patient specifically withdraws from the relationship or becomes non-compliant with treatment, or when care of the patient is transferred to another physician. All medical records and diagnostic studies will remain confidential and anonymous if used in research studies. A request of medical records will be charged to cover necessary time and materials to prepare.

FINANCIAL RESPONSIBILITY (Financial responsibility is not applicable if you are being seen under a Worker's Compensation Claim)

As a courtesy to patients and their families, the Practice submits claims to most insurance carriers. To insure proper and prompt processing of your claim, it is important that all current insurance information be presented at the time of pre-registration. It is necessary that you have a copy of your insurance card and your driver's license or other form of identification with you when you check-in.

Many insurance plans require a referral in order to access health. If your insurance plan has such a requirement, it is your responsibility to obtain a referral from your Primary Care Physician and/or Specialist Physician.

If your insurance plan requires the medical services scheduled to be pre-certified or pre-authorized, we will attempt to obtain such approval from the insurance plan or the entity responsible for utilization management. Failure to meet your insurance requirements may result in partial or complete claim denial or a higher co-payment/or deductible, and you may be responsible for the remaining balance.

We are available to assist you in understanding your physician and facility benefits, should you be referred for a surgical procedure or surgery. We attempt to verify your insurance benefits prior to medical services being completed. Estimates of your financial responsibility are based on the accuracy of this information. The insurance benefit information provided by your insurance plan is based on the latest information they have available. Please remember that your insurance plan benefits are a contract between you, your employer and your insurance company. It is in your best interest to know and understand your benefits.

In the event you do not have insurance coverage, or cannot pay the patient responsibility portion of your bill, you will be asked to speak with one of our financial counselors. We accept all major credit cards.

I understand I am financially responsible for the medical services provided to me and for any balances not covered by my insurance or worker's compensation coverage.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices. My signature authorizes and gives my consent to use and disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient Name/Legal Representative Printed Date

_____

Patient Signature/Legal Representative Signature

Updated 3-16-18