SPINE TECH BARRINGTON

PERSONAL AND FAMILY HEALTH HISTORY

Date:_____/_____/_____

Full Name:_____ I prefer to be called: _____

Spouse/Guardian:_____

Address:_____
STREET CITY STATE ZIP

_____
STREET CITY STATE ZIP

Date of Birth:____/____/____Age:_____Married_____Single_____Widow(er)_____

Home Tel :(___) _____Work Tel :(___)_____Cell:(___)_____

Last 4 of Soc. Sec. #:_____ (Used as PIN for check-in)

E-Mail Address: _____

(WE USE EMAIL ADDRESS FOR MRI/XRAY REPORT)

Preferred means of appointment reminders: TEXT / E-MAIL _____

Height: _____ Weight: _____ Most recent blood pressure (if known):_____ Pregnant? _____

Date of last physical exam:_____By whom:_____

Family doctor:_____

Have you ever been to a Naprapath, Chiropractor before? Yes/No When_____

Have you ever been to Massage Therapy? Yes?/No When_____

Occupation: _____Employer:_____
NAME PHONE

Employer Tel: (___) _____ Full Time / Part Time

Emergency Contact: _____

Other physicians consulted in past 12 months: _____

NAME **DIAGNOSIS**

_____

Accidents and/or injuries related to current symptoms:

_____

ACCIDENT OR INJURY DATE OTHER IMPORTANT INFO. REGARDING INJURY

Reason for Seeking Care: Please make us aware of all issues of concern today. (i.e. acute conditions, nagging sports injuries, headaches, stress, internal imbalances, arthritis, numbness, etc.)

Primary Complaint: _____

_____

- **Rate your discomfort 1-10: ____ (10 is worst) At its best 1-10:_____ At its worst: ___**
- **Frequency of discomfort 0%-100%: _____ Onset : Gradual / Sudden**
- **How long since you first noticed the discomfort? _____ Getting better/worse/no change**
- **Aggravated by:_____ Relieved by:_____**
- **Discomfort is sharp/achey/tingling/numb/other:_____**
- **Time of day when it is most noticeable:_____**
- **Have you ever had this discomfort before (if yes, explain):_____**

_____

Secondary Complaint: _____

_____

- **Rate your discomfort 1-10: ____ (10 is worst) At its best 1-10:_____ At its worst: ___**
- **Frequency of discomfort 0%-100%: _____ Onset : Gradual / Sudden**
- **How long since you first noticed the discomfort? _____Getting better/worse/no change**
- **Aggravated by:_____ Relieved by:_____**
- **Discomfort is sharp/achey/tingling/numb/other:_____**
- **Time of day when it is most noticeable:_____**
- **Have you ever had this discomfort before (if yes, explain):_____**

_____

Third Complaint: _____

_____

- **Rate your discomfort 1-10: ____ (10 is worst) At its best 1-10:_____ At its worst: ___**
- **Frequency of discomfort 0%-100%: _____ Onset : Gradual / Sudden**
- **How long since you first noticed the discomfort? _____ Getting better/worse/no change**
- **Aggravated by:_____ Relieved by:_____**
- **Discomfort is sharp/achey/tingling/numb/other:_____**
- **Time of day when it is most noticeable:_____**

Additional information you would like to share with the doctor:

_____

_____

_____

_____

Daily Activities: Effects of Current Condition on Performance: (1= No limitations , 5=Unable to Perform,even with help)

Carrying Groceries:	**1**	**2**	**3**	**4**	**5**
Changing Positions:	**1**	**2**	**3**	**4**	**5**
Climbing Stairs:	**1**	**2**	**3**	**4**	**5**
Computer Strain:	**1**	**2**	**3**	**4**	**5**
Driving:	**1**	**2**	**3**	**4**	**5**
Household Chores:	**1**	**2**	**3**	**4**	**5**
Lifting objects off the floor:	**1**	**2**	**3**	**4**	**5**
Tying Shoes:	**1**	**2**	**3**	**4**	**5**
Reading/Concentration:	**1**	**2**	**3**	**4**	**5**
Self-care: Bathing:	**1**	**2**	**3**	**4**	**5**
Self-care: Dressing	**1**	**2**	**3**	**4**	**5**
Self-care: Shaving	**1**	**2**	**3**	**4**	**5**
Exercising	1	2	3	4	5
Sitting Still:	**1**	**2**	**3**	**4**	**5**
Sleep:	**1**	**2**	**3**	**4**	**5**
Standing Still:	**1**	**2**	**3**	**4**	**5**
Walking:	**1**	**2**	**3**	**4**	**5**
Yard work:	**1**	**2**	**3**	**4**	**5**

Pertinent personal and family history: of illness, disease or chronic health conditions?

Mark :(S) For Self (F) for Family

____Alcoholism	**____Cancer**	**____Gastric Reflux**	**____High Cholesterol**	**____Pacemaker**
____Allergies	**____Constipation**	**____Gout**	**____Irregularity**	**____Parkinsons Disease**
____Anemia	**____Degenerative Discs**	**____Headaches**	**____Kidney Disease**	**____Pinched Nerve**
____Appendicitis	**____Depression**	**____Heart Disease**	**____Liver Disease**	**____Pneumonia**
____Arthritis	**____Diabetes**	**____Hepatitis**	**____Miscarriage**	**____Prostate Problems**
____Asthma	**____Emphysema**	**____Hernia**	**____Multiple Sclerosis**	**____Stroke**
____Auto Immune	**____Epilepsy**	**____Herpes**	**____Muscle Spasms**	**____Thyroid Problems**
____Backaches	**____Fractures**	**____Herniated Disc**	**____Osteoporosis**	**____Tumors**
____Bronchitis	**____Gallbladder**	**____High Blood Pressure**	**____Other: _____**	

Have you ever had any joint displacement/dislocation or procedure performed on any of the joints?(including shoulders,hands,elbows,hips,knees,feet)

_____

_____

List all Medications/Vitamins:

_____

_____

_____

List of all Surgeries and Dates:

_____

_____

_____

List of Any accidents:

_____

_____

_____

Have you been Hospitalized after accident:

_____

_____

_____

_____

Alcohol: □ Daily □ Weekly □ Occasional □ Never
Smoking: □ Daily □ Weekly □ Occasional □ Never
Caffeine: □ Daily □ Weekly □ Occasional □ Never
Exercise: □ Daily □ Weekly □ Occasional □ Never
Pain Meds: □ Daily □ Weekly □ Occasional □ Never
Diet: □ Good □ Fair □ Poor
Sleep: □ Back □ Side □ Stomach □ Firm mattress □ Soft mattress □ other: _____
Allergies (Food / Seasonal / Meds / Latex): _____ Breast Implants? □Yes □No

SIGNATURE OF PATIENT OR GUARDIAN_____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy or your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You many not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____Signature_____Date_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATI

To our valued patients:

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine inappropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent and inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Patient Name _____Date _____