

SPINE TECH BARRINGTON

PERSONAL AND FAMILY HEALTH HISTORY

Date: ____/____/____

Full Name: _____ I prefer to be called: _____

Spouse/Guardian: _____

Address: _____

Date of Birth: ____/____/____ Age: ____ Married ____ Single ____ Widow(er) ____

Home Tel : (____) _____ Work Tel : (____) _____ Cell: (____) _____

E-Mail Address: _____

Preferred means of appointment reminders: Text / Email

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

Family Doctor: _____ Phone _____

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

Have you ever been to Massage Therapy? Yes?/No When _____

Occupation: _____ Employer: _____

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

Emergency Contact: _____ Phone: _____

Other physicians consulted in past 12 months:

Name _____ Diagnosis _____

Accidents and/or injuries related to current symptoms:

Accident or Injury _____ Date _____

Other important information regarding your injury: _____

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): _____

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)

Activity	1	2	3	4	5		1	2	3	4	5
Changing Positions	☐	☐	☐	☐	☐	Self-Care: Dressing	☐	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐	☐	Sitting Still	☐	☐	☐	☐	☐
Computer Strain	☐	☐	☐	☐	☐	Sleep	☐	☐	☐	☐	☐
Exercising	☐	☐	☐	☐	☐	Standing Still	☐	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐	☐	Tying Shoes	☐	☐	☐	☐	☐
Lifting Objects Off the Floor	☐	☐	☐	☐	☐	Walking	☐	☐	☐	☐	☐
Reading / Concentration	☐	☐	☐	☐	☐	Yard Work	☐	☐	☐	☐	☐

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

- | | | | |
|--|--|---|--|
| ☐ Allergies | ☐ Arthritis | ☐ Asthma | ☐ Auto Immune |
| ☐ Backaches | ☐ Cancer | ☐ Degenerative Discs | ☐ Depression |
| ☐ Diabetes | ☐ Emphysema | ☐ Epilepsy | ☐ Fractures |
| ☐ Gallbladder | ☐ Gastric Reflux | ☐ Headaches | ☐ Heart Disease |
| ☐ Hepatitis | ☐ Hernia | ☐ Herniated Disc | ☐ Herpes |
| ☐ High Blood Pressure | ☐ High Cholesterol | ☐ Implants | ☐ Kidney Disease |
| ☐ Liver Disease | ☐ Multiple Sclerosis | ☐ Muscle Spasms | ☐ Osteoporosis |
| ☐ Pacemaker | ☐ Parkinson's Disease | ☐ Pinched Nerve | ☐ Prostate Problems |
| ☐ Stroke | ☐ Thyroid Problems | ☐ Tumors | ☐ 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 the accident (Yes / No)

SIGNATURE OF PATIENT OR GUARDIAN_____

Agreements and Authorizations

Authorization to use or Disclosure of Individual Medical Information

I hereby authorize SPINE TECH INC to release any information required in the processing of applications for financial coverage for services rendered this admission. This authorization provides that my physician, therapist, nurse, or any other healthcare personnel may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agents. This authorization also includes any medical records containing information related to HIV (AIDS) testing or writing Health Care Contracts Service and for the purpose of enabling that insurance company or health care service plan corporation to evaluate my claims or its liability under such policies or contracts or coordinating benefits pursuant to such policy or contract provisions. I authorize use of this form on all my claim submissions. I permit a copy of this authorization to be used in place of the original.

(Witness)

(Date)

(Patient's or Personal Representative Signature)

Assignment of Insurance Benefits / Payment Guarantee / Collection Fee

I hereby authorize payment to be made directly to SPINE TECH INC for insurance benefits payable to me. I understand that I am financially responsible to SPINE TECH INC for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer.

(Witness)

(Date)

(Signature of Person Insured)

Notice and Acknowledgement

I acknowledge that I have received SPINE TECH INC Notice of Health Information Practices.

(Witness)

(Date)

(Patient's or Personal Representative Signature)

No Show / Missed App Policy

I agree to give 24 hour notice for all cancellations of treatments to provider or call (773) 621-2255. If a situation arises where scheduled treatment needs to be cancelled less than 24 hours in advance I agree to notify the provider or SPINE TECH INC immediately. I agree to pay the fee of \$50 .00 if I do not cancel scheduled treatment. I understand that after 3 cancelled scheduled treatments with out notification I will be terminated from SPINE TECH INC services. I understand that if services are terminated I am still liable for the \$50.00 fee for each non-cancelled treatment.

Personal Representative Relationship to patient

Patient unable to sign. Reason _____

Patient Name _____ Date _____