KEIPER SPINE

PATIENT HEALTH HISTORY FORM

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PATIENT INFORMATION

Primary reason for your visit? _____

Name: _____DOB: _____SSN: _____

Home Phone: _____Cell Phone: _____Pharmacy: _____

Occupation: _____Employer: _____

Email Address: _____Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic

Referring Doctor: _____ Primary Doctor: _____

Emergency Contact: _____Phone: _____

Disability? Y / N Since: _____ Disability Provider: _____

MOST RECENT IMAGING

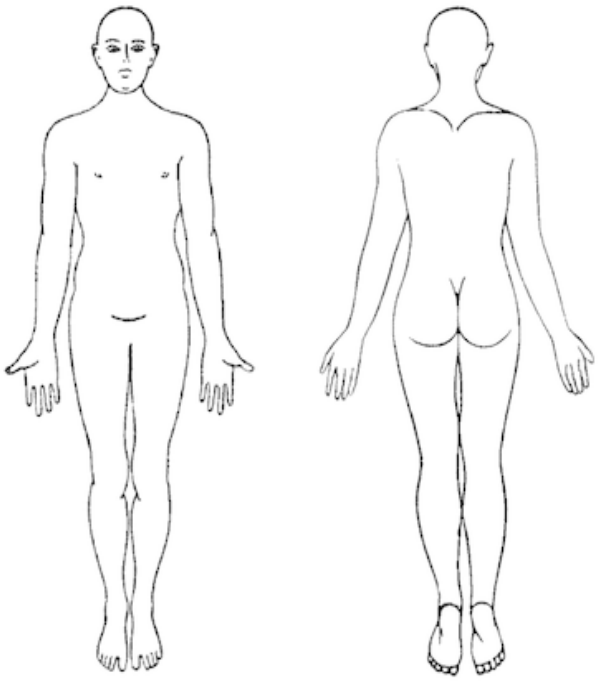
When: _____Where: _____What: _____

When: _____Where: _____ What: _____

SYMPTOMS Describe your symptoms. Please fill out and use the diagram below to assist you in your description.

*Mark on the drawing according to where you hurt. Please indicate on the drawing where you feel any of the following symptoms by placing the marks shown here on the **DIAGRAM KEY**.*

Numbness=**N** Ache=**A** Weakness=**W**
Burning=**B** Stabbing=**S** Pins & Needles=**P**



How long have you had these symptoms? _____

Average pain score (0=no pain to 10=worst)? _____

Do you have any weakness? ☐ Yes ☐ No

Where: _____

Do you have numbness/tingling? ☐ Yes ☐ No

Where: _____

What makes your pain better?

☐ Laying ☐ Sitting ☐ Standing ☐ Walking ☐ Rest ☐ Heat
☐ Ice ☐ Position change ☐ NSAIDs (ibuprofen, Celebrex, etc.)
☐ Narcotics (name): _____

What makes your pain worse?

☐ Laying ☐ Sitting ☐ Standing ☐ Walking ☐ Twisting ☐ Lifting
☐ Pushing/pulling ☐ Sit to stand ☐ Getting out of bed ☐ Carrying

Previously tried treatment(s):

☐ Physical therapy ☐ Helped? Yes (how long?) _____ ☐No
☐ Steroid injections ☐ Helped? Yes (how long?) _____ ☐No
☐ Chiropractic/massage ☐ Helped? Yes (how long?) _____ ☐No
☐ Home Exercise ☐ Helped? Yes (how long?) _____ ☐No
☐ Aquatic ☐ Helped? Yes (how long?) _____ ☐No
☐ Acupuncture ☐ Helped? Yes (how long?) _____ ☐No

Is this the result of a specific injury or accident? ☐ Yes ☐ No **Date of accident**_____ WC? _____ MVA? _____

Describe Injury _____ Are you involved in litigation regarding this condition? ☐ Yes ☐ No

MEDICAL HISTORY (Check all that apply)

☐Atrial Fibrillation	☐Cancer	☐Hepatitis B/C	☐Neuropathy
☐Anemia	☐Depression	☐Hernia	☐Obesity
☐Brain Aneurysm	☐Diabetes	☐High Cholesterol	☐Osteoporosis
☐Anxiety Disorder	☐GERD	☐Hypertension	☐Pacemaker
☐Arthritis	☐HIV or AIDS	☐Kidney Disease	☐Peripheral Vascular Disease
☐Asthma	☐Head Trauma/Injury	☐Liver Disease	☐Pulmonary Embolism
☐Back Problems	☐Headaches/Migraines	☐Lung Disease	☐Seizure/Epilepsy
☐Bleeding Disorder	☐Heart Attack (MI)	☐Multiple Sclerosis	☐Sleep Apnea
☐CAD	☐Aortic Aneurysm	☐Muscle/Joint/Bone Pain	☐Stroke
☐COPD		☐Neck Injury	☐Thyroid Problems

Past Neck/Back Surgical History:

Neck: Date: _____ Procedure: _____ Doctor: _____

Back: Date: _____ Procedure: _____ Doctor: _____

Other:_____

Family Health History: Place the letter of your family member relationship that has a condition listed below.
M-mother, **F**-father, **B**-brother, **S**-sister, **MGM**-maternal grandmother, **MGF**-maternal grandfather, **PGM**-paternal grandmother, **PGF**-paternal grandfather

Diabetes _____	Heart Attack _____	Back Problems _____
Cancer _____	Osteoporosis _____	Bleeding Disorder _____
Hypertension _____	Stroke _____	Rheumatoid Arthritis_____
Multiple Sclerosis _____		

Do you presently have any problems or symptoms in the following areas?

☐Numbness/tingling sensation	☐Chronic cough	☐Lack of bladder control
☐Muscle weakness	☐Shortness of breath	☐Change in sexual function
☐Difficulty walking	☐Coughing up blood	----------
☐Seizures	☐Voice changes	☐Recurrent fever, chills, sweats
☐Headaches	☐Chronic sinus problems	☐Recent weight loss
☐Change of Vision	----------	☐Enlarged lymph nodes
☐Depression	☐Abdominal pain	☐Extreme fatigue
☐Nervousness	☐Vomiting blood	☐Excessive thirst
----------	☐Frequent diarrhea	☐Easy bruising
☐Chest pain	☐Severe heart burn	☐Frequent bleeding
☐Irregular heart beat	☐Constipation	☐Abnormal mole
----------	----------	☐Skin rash
☐Environmental allergies	☐Excessive urination	
☐Heat or cold intolerance	☐Burning with urination	

SOCIAL HISTORY

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Tobacco Use: ☐Yes ☐No _____# packs per day Since_____

Former smoker? ☐Yes ☐No Year quit? _____

Alcohol Use: ☐Yes ☐No _____# drinks per day week month

Recreational Drug Use: ☐Yes ☐No

How often and what substance? _____

Exercise: ☐Yes ☐No ☐Occasional ☐Frequent ☐not at all

LIVING SITUATION

Do you live alone? ☐Yes ☐No

If you need surgery, do you have someone who can assist you in your recovery?
☐Yes ☐No

I attest that all information I provided is true and correct to the best of my knowledge:

Patient's signature: _____Date: _____

Patient Name: _____ **DOB:** _____

Allergies And Sensitivities

(Please list all including drugs, foods, environmental, inhalants, insects, and plants)

☐None

Allergy or Sensitivity	Reaction

Medication List:

☐ None ☐ List attached

Medication	Dosage	SIG (how you take it)	Why You Are Taking

KEIPERSPINE PC

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

(A NOTICE OF PRIVACY PRACTICE WILL BE OFFERED TO YOU DURING YOUR VISIT: OR YOU MAY REQUEST A COPY AT ANY TIME)

I have received a copy of this office's notice of privacy practices.

Please Print Name:_____

Patient Signature/Guardian:_____Date: _____

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I/We authorize medical service providers to release to KeiperSpine, PC, any medical, clinical or financial records required for my care. I/We also authorize KeiperSpine, PC release medical or financial records that may be required to ensure continuity of care to the other health providers, insurers, or contracted service providers. This includes but is not limited to my insurance company, rehabilitations services, Social Security Administration, and Workers Compensation.

Patient Signature/Guardian:_____Date:_____

If you would like us to be able to discuss your care with a friend or family member, please complete the below.

I authorize KeiperSpine, PC to discuss my care in person and over the phone with:

_____ (NAME), who is my _____ (RELATIONSHIP)

☐ They may also obtain my records or request that KeiperSpine, PC release clinical and/or financial records to a designated third party.

Patient Signature/Guardian:_____Date:_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

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Financial Agreement

It is your responsibility to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current photo ID and insurance cards should be presented at each office visit. As a courtesy, we will file your insurance claim(s) for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance.

Financial Agreement:

I understand that I am responsible for the payment of services rendered if the services are not covered by my insurance for any reason. KeiperSpine is a participating provider with most health plans, however, participation is subject to change. I understand it will be my responsibility to verify with my insurance carrier the plan participation status of KeiperSpine prior to services being rendered. Insurance will be according to the billing/payment guidelines of my primary insurance contract. If a referral is required by my plan, I understand it is my responsibility to obtain, or my insurance may not pay my claims.

Payment Agreement:

Co-payment, deductibles, co-insurance, non-covered services (including pre-existing conditions) and services denied due to lack of referral are my responsibility.

Assignment of Insurance Benefits:

I assign medical benefits paid by my insurance carrier(s) to be sent to KeiperSpine, PC. I acknowledge that I will be billed for charges not covered under my insurance policy as well as those portions indicated as my responsibility.

Additional Charges:

There may be additional medical services ordered by us, such as laboratory or radiology, for which you will be referred out of this clinic. If this occurs, you will receive a separate billing from that provider, for which you will be responsible. If surgery occurs, anesthesia and facility charges will bill separately from KeiperSpine as well.

Release of Information:

I authorize KeiperSpine, PC to furnish my insurance company(s), employer, other payer(s) or their representative's any and all information required to process my claim. Special permission is necessary to release the following information: drug/alcohol abuse, mental health or HIV related conditions.

Patient Balance:

I agree to pay any balance remaining on my account upon receipt of a statement. I understand that if I fail to pay the balance on my account this may result in KeiperSpine, PC pursuing any collection means possible. If my account becomes delinquent, it will most likely be forwarded to an outside collection agency (Quick Collect, Inc., phone: 800 252-6322). If this happens, I will be responsible for all costs of collection, including but not limited to, interest, rebilling fees, court costs, attorney fees and collection agency costs. At minimum, a $20.00 fee is added when an account is more than 2 months delinquent and if referred to collections, interest will begin accruing. If it becomes necessary, court costs and attorney fees typically start at $210.00.

I have read and I understand KeiperSpine's financial policies, and I accept responsibility for the payment of any fees associated with my care.

Patient Name:_____DOB:_____

Signature of Patient/Guardian:_____Date:_____