1. Patient Rights and Responsibilities Acknowledgement

I understand that as a patient, I have both rights and responsibilities. I have received a copy of this document for my reference.

Initial: _____

2. Notice of Privacy Practice Acknowledgement

My signature below indicates that I have been provided with a copy of the Spine Institute of Idaho Notice of Privacy Practice Pamphlet.

Initial: _____

3. Office and Billing Policy Acknowledgement

I understand that as a patient, I have been provided with a copy of the Spine Institute of Idaho Financial Policy and Patient Disclosure agreement.

Initial: _____

4. Photograph Acknowledgement

I, the patient/guardian, acknowledge that a photograph may be taken for identification purposes.

Initial: _____

5. Notice of Nondiscrimination and Accessibility Requirements

My signature below indicates that I have been provided with a copy of the Spine Institute of Idaho Nondiscrimination and Accessibility Requirements.

Initial: _____

6. Attendance and Cancellation/No Show Policy Acknowledgment

My signature below indicates that I have been provided with a copy of the Spine Institute of Idaho Attendance and Cancellation agreement.

Initial: _____

Signed:_____ Date:_____ Time:_____

Patient or Designated Representative

Relationship to Patient: [ ] Legal Guardian [ ] Other: _____

(check one)

Signed:_____ Date:_____ Time:_____

Spine Institute of Idaho Representative

Signature Acknowledgements

Patient ID

Patient Name: _____

DOB: _____

Physician Name:_____

SPINE INSTITUTE OF IDAHO

Patient Medical History Form

Name:	**Age:**	**Date of Visit:** / /
Height: **Feet** **Inches**	**Weight:** **pounds**	

Medical Illnesses

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Depression
- ☐ Anxiety
- ☐ Hepatitis C
- ☐ Cancer (Specify) _____
- ☐ Asthma
- ☐ COPD/ Emphysema
- ☐ Congestive Heart Failure
- ☐ Migraine Headaches
- ☐ Acid Reflux/ Ulcers
- ☐ HIV
- ☐ Arthritis
- ☐ Thyroid Disease
- ☐ Seizure Disorder
- ☐ Seasonal Allergies
- ☐ Kidney Disease
- ☐ MRSA

Surgical History

- ☐ Heart Surgery
- ☐ Cardiac Stent Placement
- ☐ Hysterectomy
- ☐ Gall Bladder removed
- ☐ Tonsils removed
- ☐ Shoulder Surgery
- ☐ Bowel Surgery
- ☐ Appendix removed
- ☐ Cataract surgery
- ☐ Joint Replacement

Spine Surgeries:	Surgeon:	Date:	Outcome:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Family History

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Cancer
- ☐ Stroke
- ☐ Asthma
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Blood Clots
- ☐ Mental Illness
- ☐ Spine Disorder
- ☐ Other: _____

Personal History

- ☐ Single
- ☐ Married
- ☐ Divorces
- ☐ Separated
- ☐ Widowed
- ☐ Employed
- ☐ Student
- ☐ Unemployed
- ☐ Disabled
- ☐ Retired
- ☐ Number of Children: _____
- ☐ Number of Children at Home: _____

Pregnant: Yes No

Social History: Please indicate how often you use the following Substances

Tobacco:

- ☐ Never Smoked
- ☐ Smoke __ pack(s) of cigarettes/day OR Chew 1 can every __ day(s)
- ☐ Quit Date:

SPINE INSTITUTE OF IDAHO

Patient Medical History Form

Alcohol:

☐ Never ☐ Rarely ☐ Moderately (3-5 days/week) ☐ Daily

Recreational Drugs:

☐ Never ☐ Rarely ☐ Moderately (3-5 days/week) ☐ Daily

What Medications do you take? (Please list all medications and dosages. Include over the counter medications and herbal supplements)

_____ _____
_____ _____
_____ _____
_____ _____

Are you allergic to any medication? (Please list medication and reaction)

_____ _____
_____ _____

Mark Only Symptoms you have had in the last 3 months:

GENERAL:
- ☐ Fatigue
- ☐ Fever
- ☐ Night Pain
- ☐ Weight Gain
- ☐ Unexplained Wight Loss

GASTROINTESTNAL
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Frequent Heartburn

EARS, NOSE, THROAT
- ☐ Hearing Loss
- ☐ Ringing in the ears
- ☐ Vertigo
- ☐ Nasal congestion
- ☐ Mouth/lip sores
- ☐ Tooth abscess
- ☐ Difficulty Swallowing
- ☐ Hoarse voice
- ☐ Throat lesions

NEUROLOGICAL
- ☐ Difficulty with balance
- ☐ Loss of coordination
- ☐ Gait abnormality
- ☐ Headaches
- ☐ Muscle weakness
- ☐ Seizures
- ☐ Sensory disturbance
- ☐ Speech difficulty
- ☐ Tremor

GENITOURINARY
- ☐ Erectile dysfunction
- ☐ Increased urination
- ☐ Decreased urination
- ☐ Loss of urine
- ☐ Burning/pain with urination

BLOOD/ LYMPHATIC:
- ☐ Bleed easily
- ☐ Prolonged bleeding after surgery
- ☐ Bruise Easily
- ☐ Painful/ swollen lymph node (s)

CARDIAC
- ☐ Chest Pain
- ☐ Shortness of breath w/activity
- ☐ Lower extremity swelling
- ☐ Heart Murmur
- ☐ Heart racing

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety

ALLERGY/IMMUNE
- ☐ Immune Disorder
- ☐ Seasonal allergies

RESPIRATORY
- ☐ Cough
- ☐ Vomiting blood
- ☐ Shortness of Breath
- ☐ Wheezing

EYES
- ☐ Discharge
- ☐ Cataracts
- ☐ Visual field loss

SKIN
- ☐ Abnormal growth
- ☐ Rash
- ☐ Non-healing sore

The Information provided in the form is true and complete to the best of my knowledge:

Patient Signature: _____

Form Reviewed by Provider: _____

SPINE INSTITUTE OF IDAHO

BACK/NECK FORM

TO BE COMPLETED BY PATIENT

Last Name **First Name** **Middle Name** **Today's Date**

Dominant Hand: **R**____**L**____Age:_____Sex:_____

CURRENT COMPLAINTS

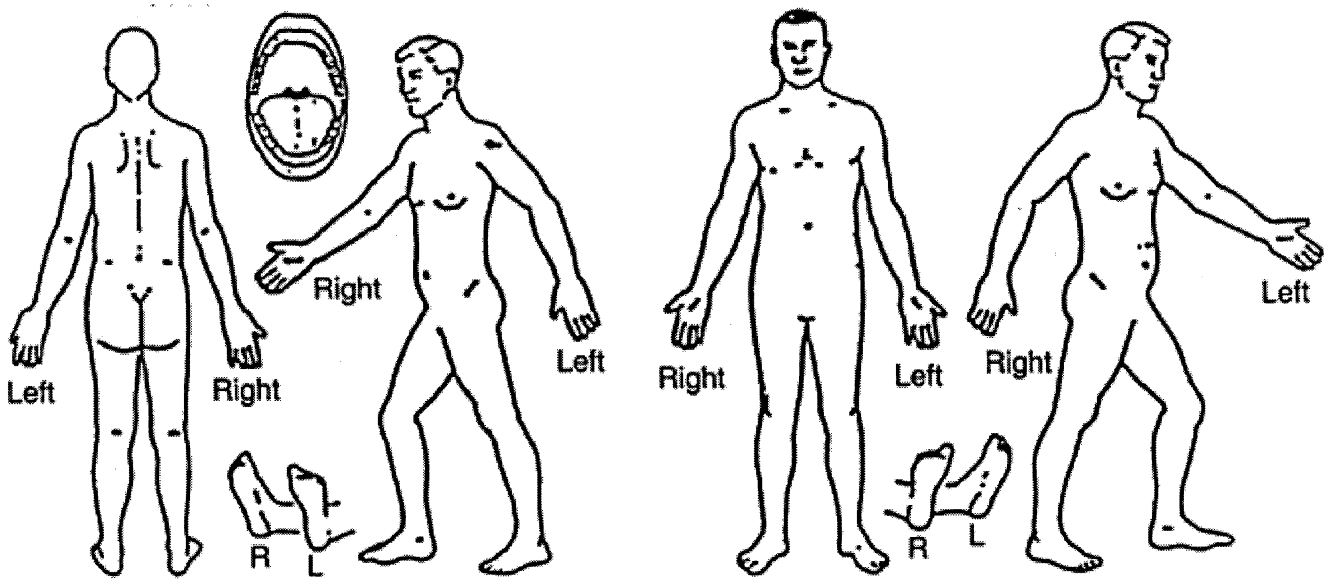
Please describe your current symptoms (for example back pain, leg pain, neck pain arm pain)

Out of a 100%, what percent of pain do you have in your:

Neck Pain versus Arm Pain	_____**% Neck Pain**	+	_____**% Arm Pain**	=	**100%**
Back Pain versus Leg Pain	_____**% Back Pain**	+	_____**% Leg pain**	=	**100%**

PAIN DIAGRAM

Mark the areas on your body where you now feel your typical pain. Include all affected areas. Use the appropriate symptoms indicated below.
ACHE >>>> BURNING XXXX NUMBNESS ====PINS & NEEDLES OOOO STABBING /////



What do the following activities do to your neck/back and arm/leg pain? (Please check all that apply)

	No Change	Relieves Pain	Increases Pain
Sitting			
Walking			
Standing			
Lying Down			
Bending Forward			
Bending Backwards			
Lifting			
Straining			
Sneezing			
Coughing			

INTENSITY OF PAIN

0 = No Pain and
10 = Most severe pain imaginable

		Circle the number that applies
BACK	At Worse	0 1 2 3 4 5 6 7 8 9 10
	At Best	0 1 2 3 4 5 6 7 8 9 10
LEGS	At Worse	0 1 2 3 4 5 6 7 8 9 10
	At Best	0 1 2 3 4 5 6 7 8 9 10
NECK	At Worse	0 1 2 3 4 5 6 7 8 9 10
	At Best	0 1 2 3 4 5 6 7 8 9 10
ARMS	At Worse	0 1 2 3 4 5 6 7 8 9 10
	At Best	0 1 2 3 4 5 6 7 8 9 10

ONSET

Approximate date when your back/neck pain began? _____

How did this most current episode of back/neck pain occur? Check all that apply.

- ❑ Gradual Onset
- ❑ Fall
- ❑ Direct Blow
- ❑ Reaching
- ❑ Twisting
- ❑ Bending
- ❑ Lifting
- ❑ Pushing
- ❑ Pulling
- ❑ Don't Know
- ❑ Other

Was your injury the result of one of the following?

- ❑ Vehicle Accident
- ❑ On the Job Injury
- ❑ Recreational Accident
- ❑ Non- Work Related Incident
- ❑ No Known Cause

Please briefly describe the onset of your back/neck pain.

_____

_____

_____

_____

_____

_____

_____

PROGRESSION

How has your pain changed since its onset?

	Much Improved	**Somewhat Improved**	**No Change**	**A Little Worse**	**Much Worse**
BACK					
NECK					
LEGS					
ARMS					

How would you describe your overall severity of pain?

- ❑ **Mild** Nuisance Pain
- ❑ **Mild to Moderate**, but I can live with it
- ☐ **Moderate**; I am having difficulty dealing with it
- ☐ **Severe**; it is ruining my quality of life

PREVIOUS TREATMENT

MEDICATION PRESCRIBED

Indicate what medications have been prescribed and what kind of relief they provided.

	NO HELP	SOME RELIEF	MUCH RELIEF
Anti-inflammatory: (Example Advil, Ibuprofen, Naprosyn, etc.)	☐	☐	☐
Muscle Relaxers: (Soma, etc.)	☐	☐	☐
Pain Medications: (Percocet, Lortab, Norco, Vicodin, etc.)	☐	☐	☐

THERAPY PRESCRIBED

	WORSENED	NO HELP	SOME RELIEF	MUCH RELIEF
PHYSICAL THERAPY	☐	☐	☐	☐
BEDREST	☐	☐	☐	☐
TRACTION	☐	☐	☐	☐
TENS UNIT	☐	☐	☐	☐
EXERCISE	☐	☐	☐	☐
INJECTIONS	☐	☐	☐	☐
ACCUPUNCTURE	☐	☐	☐	☐
BRACING	☐	☐	☐	☐
ICE PACK	☐	☐	☐	☐
HEAT PACK	☐			
ULTRASOUND	☐	☐	☐	☐
CHIROPRACTIC (NAME)	☐	☐	☐	☐

STUDIES

Indicate which of the following tests or treatments you have had for this problem.

TESTS			DATE	LOCATION
X-RAYS	YES	NO		
MRI	YES	NO		
CT SCAN	YES	NO		
DISCOGRAM	YES	NO		
BONE SCAN	YES	NO		
NERVE BLOCK	YES	NO		
EPIDERAL/STEROID	YES	NO		
EMG	YES	NO		

OTHER_____

SPINE SURGERY

	PROCEDURE	SURGEON	DATE	OUTCOME
1.				
2.				
3.				

OCCUPATIONAL HISTORY

Employer: _____ **Date of Hire**_____

Usual Occupation:

_____

Briefly describe your job:

_____

Prior Occupation: _____ **Date of Hire:** _____

Reason for leaving:

_____

How physically demanding is your job? Check one

_____ **Very Heavy (frequently lifting > 100#)**
_____ **Heavy (frequently lifting > 75#)**
_____ **Moderate (frequently lifting > 50#)**
_____ **Light (frequently lifting < 20#)**
_____ **Sedentary (essentially no lifting)**

Does an attorney assist you with your injury claim? ☐ **YES** ☐ **NO** ☐ **N/A**

If yes, please give name and address of attorney:

_____

_____

_____

Circle a number to indicate how much of a problem you are having with each of the following:

Anxiety	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Depression	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Irritability	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Insomnia	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Please sign and date this form

_____

Signature **Date**

********** Physical Findings, (M.D. use only) **********

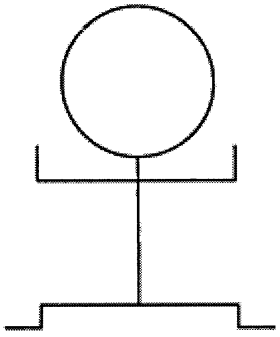
MOTOR

ABN MUSCLE	R	L

SENSORY

ABN LEVEL	R	L

FLEXION	SLR	R L
EXTENSION	DEGREES POSITIVE	
ROTATION L R	SITTING	
SIDE R L		

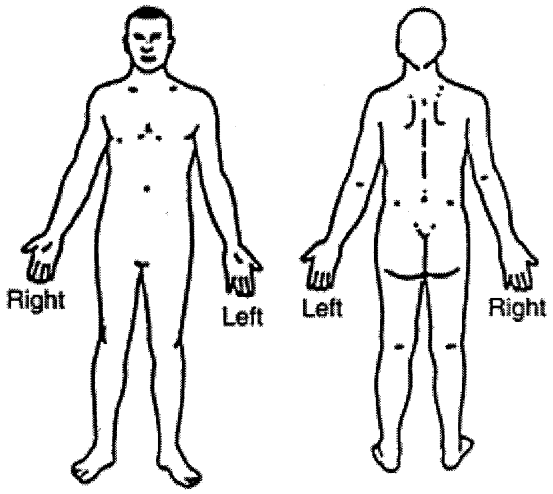


X-Ray
MRI / CT

Other

Impression

Plan



CC Dr.