KEIPERSPINE

PATIENT HEALTH HISTORY FORM

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PATIENT INFORMATION

Primary reason for your visit? _____

Name: _____ DOB: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Pharmacy/Location: _____ 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: _____

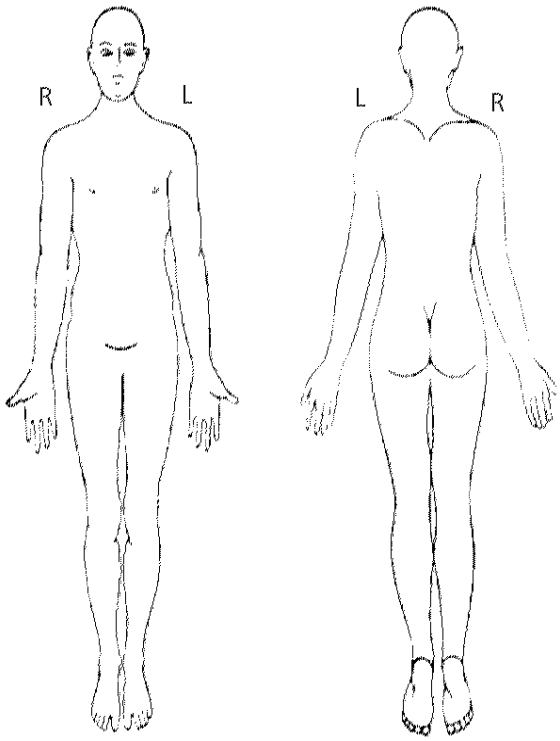
When: _____ Where: _____ What: _____

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

**Mark where you hurt and where you feel any of the following symptoms on the drawing :*

Numbness=**N** Ache=**A** Weakness=**W**

Stabbing=**S** Pins & Needles=**P** Burning=**B**



How long have you had these symptoms? _____

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

Back Pain #_____ Leg Pain #_____ Neck Pain #_____ Arm Pain #_____

Do you have numbness/tingling? ☐ No ☐ Yes 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?

☐Night Sweats _____	☐Impotence _____
☐Fever _____	☐Shortness of breath _____
☐Recent weight loss _____	☐Joint pain _____
☐Eye pain _____	☐History of skin cancer _____
☐Swallowing difficulties _____	☐Depression _____
☐Sleep apnea _____	☐Anxiety _____
☐Irregular heartbeat _____	☐Thyroid disorders _____
☐Chest pain _____	☐Diabetes _____
☐Use of blood thinners _____	☐ History of easy infections _____
☐Constipation _____	☐Easy bruising _____
☐Abdominal pain _____	☐Free bleeding (blood does not clot) _____
☐Bowel incontinence _____	☐History of bleeding disorder _____
☐Painful urination (dysuria) _____	
☐Urinary incontinence _____	

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, is there someone who can assist you after surgery? ☐Yes ☐No

_____

Do you feel safe in your home? ☐Yes ☐No

Do you need help with (circle all that apply):

Food Housing Transportation Utilities

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)

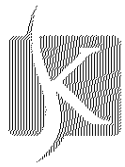
☐ None

Allergy or Sensitivity	Reaction

Medication List:

☐ None ☐ List attached

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



KEIPERSPINE

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Jonathan D. Sherman, MD | Zach Manning, NP
Carmina F. Angeles, MD, PhD| Linh Nguyen, PA-C
1410 Oak Street, Eugene, OR 97401
Phone: 541-485-2357 **Fax:** 541-485-2358

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.

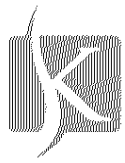
I authorize KeiperSpine, PC to discuss my care in person and over the phone with:

_____ (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:_____

ODI contact information and permission to use:
MAPI Research Trust, Lyon, France.
E-mail: PROinformation@mapi-trust.org
Internet: www.mapi-trust.org

Oswestry Disability Index 2.1a

This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark one box only in each section that most closely describes you today.

Section 1– Pain intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing additional pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of my personal care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without additional pain.
- ☐ I can lift heavy weights but it gives me additional pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than a quarter of a mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than half an hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without additional pain.
- ☐ I can stand as long as I want but it gives me additional pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than half an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never interrupted by pain.
- ☐ My sleep is occasionally interrupted by pain.
- ☐ Because of pain I have less than 6 hours sleep.
- ☐ Because of pain I have less than 4 hours sleep.
- ☐ Because of pain I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no additional pain.
- ☐ My sex life is normal but causes some additional pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly non existent because of pain.
- ☐ Pain prevents me from having any sex life at all.

Section 9 – Social life

- ☐ My social life is normal and causes me no additional pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to home.
- ☐ I have no social life because of pain.

Section 10 – Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me additional pain.
- ☐ Pain is bad but I am able to manage trips over two hours.
- ☐ Pain restricts me to trips of less than one hour.
- ☐ Pain restricts me to short necessary trips of under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Result: Your ODI = _____%

Signature of person filling out form: _____ *Date:* _____ *Time:* _____