

HISTORICAL DATA

Last Name: _____ First Init: ____ Middle Init: ____ Date: _____

1. Referring Physician: _____
2. Age: _____
3. Sex: Male
 Female
4. Race: White
 Black
 Hispanic
 Asian/Oriental
 Native American (Indian)
 Other: _____
5. Marital Status: Single / Never Married
 Married
 Divorced / Separated
 Widowed
6. Number of Children: _____
7. Last Grade Completed: Elementary School
 High School
 Vocational/Technical School
 College
 Graduate School
8. Height: _____ feet, _____ inches
9. Weight: _____ pounds
10. Job: Heavy manual labor
 Light manual labor
 Non-manual labor
 Not working
11. How long have you worked for present employer?
 6 months or less
 6 months to 1 year
 1 year to 3 years
 More than 3 years
 Not Applicable
12. Are you still working? Yes
 No
13. If not, how long have you been off work?
 0-3 months
 3-6 months
 6-12 months
 1-2 years
 more than 2 years
14. Have you filed a **FIRST REPORT OF INJURY** with your employer for this injury?
 Yes
 No
 Don't Know
15. Do you have an attorney assisting you with this injury/claim? Yes
 No
 Don't know
16. How did you injure your back or neck?
 Unknown
 Twisting
 Lifting
 Bending
 Squatting
 Slipping
 Fall from height (_____)
 Direct blow
 Other: _____
17. Did your accident occur at work? Yes
 No
 Not certain
 Not applicable
18. How long have you had back pain?
 0-3 months
 3-6 months
 6-12 months
 1-2 years
 More than 2 years
 No pain

19. Which term best describes your pain?

(check all that apply)

- Constant
- Worse with activities
- Worse with rest
- Worse at night
- Unpredictable
- Intermittent
- No pain

20. Does your pain also occur in...?

(check all that apply)

- Buttock
- Thigh
- Calf
- Foot
- Toes
- Not applicable

21. Does the pain involve...?

- Back only
- Back and one lower extremity
- Back and both lower extremities
- Lower extremity only
- Not applicable

22. Have you had any change in urination associated with your pain?

- Yes
- No
- Don't know

23. Aside from your back or neck problem, are you in good general health?

- Yes
- No
- Don't know

24. Do you have, or have you ever had...?

- Cancer
- Diabetes
- High blood pressure requiring medication
- Neck pain
- Coronary bypass surgery

25. Do you exercise...?

- Never
- Less than 20 minutes per week
- 20 to 60 minutes per week
- At least 60 minutes per week
- More than 60 minutes per week

26. How many major surgeries have you had?

- None
- 1 - 2
- 2 - 4
- 5 or more

27. How many back or neck surgeries have you ever had?

28. Have you ever received a chymopapain or collagenase enzyme for pain?

- Yes
- No
- Don't know

29. How many visits to doctors or chiropractors have you had in the past year for any reason?

- none
- 1
- 2 - 4
- 4 - 8
- 8 - 12

30. Check all medications you have taken for your back or neck pain:

- Tylenol (plain)
- Aspirin
- Percodan
- Codeine
- Valium
- Demerol
- Talwin
- Other: _____

31. Do you have a drinking problem? Yes

- No
- Perhaps

32. Do you enjoy your job? Yes

- No
- Not applicable

33. Do you like your boss? Yes

- No
- Not applicable

34. Has anyone in your immediate family been disabled because of back pain?

- Yes
- No


BODY DIAGRAM - MALE

Mark the areas where you feel the described sensations on your body.

Please use the appropriate symbols.

Mark areas of radiation.

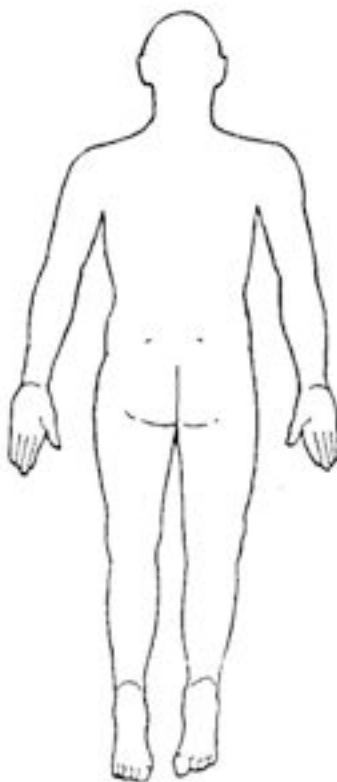
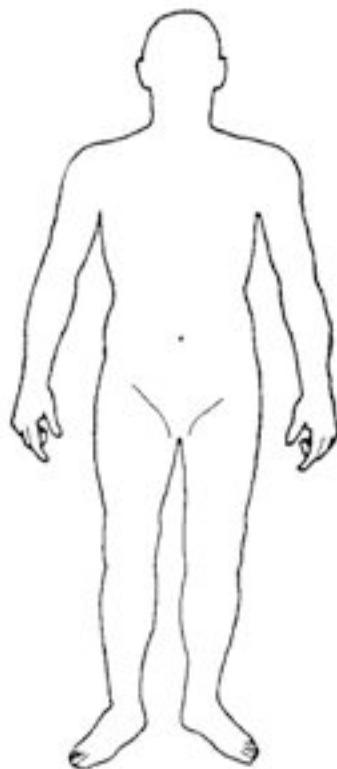
Include all affected areas.

Numbness: 

Pins & Needles: ○ ○ ○

Burning: X X X

Stabbing: /// /// ///





Patient Identification

Last Name: _____ Mr. Mrs. Miss SSN: _____ - _____ - _____
 First Name: _____ Other title _____ Date of Birth: ____/____/____
 Middle: _____ (Doctor, General, the III, etc...) Sex: Male ____ Female ____
 Marital Status: Married Single Separated Divorced Widowed Relationship to Guarantor: _____
 Student Status: Full Part N/A School: _____ Phone: () _____
 Employment: Full Part None Employer: _____ Phone: () _____
 Address: (This practice will send all correspondence to this address unless you provide us an alternate address below)
 Street: _____ City: _____ State: _____ Zip: _____
 Phone: () _____ (RSFH will contact you at this number unless you provide us an alternate number below)
 May we leave a general voice message for appointment reminders at this contact phone number? Yes _____ No _____
 May we leave a general voice message for normal test results at this contact phone number? Yes _____ No _____
 In Case of Emergency Contact Name _____
 Relationship _____ Home Phone () _____ Work Phone () _____

Guarantor/Responsible Party (if different from patient)

Last Name: _____ Mr. Mrs. Miss SSN: _____ - _____ - _____
 First Name: _____ Other title _____ Date of Birth: ____/____/____
 Middle: _____ (Doctor, General, the III, etc...) Sex: Male ____ Female ____
 Address: _____ Phone: Home () _____
 City: _____ State: _____ Zip: _____ Phone: Work () _____
 (Complete only if you want the Practice to communicate with you at an address/phone different than you provided above)
 Alternate Address: _____ Alternate Phone: () _____
 City: _____ State: _____ Zip: _____

Primary Insurance

Secondary Insurance

Member/Policyholder (if different from patient)		Member/Policyholder (if different from patient)	
_____	_____	_____	_____
Member/Policyholder ID#	Date of Birth	Member/Policyholder ID#	Date of Birth
_____	_____	_____	_____
Insurance Co. Phone Number	Group #	Insurance Co. Phone Number	Group #
(____) _____	_____	(____) _____	_____
Insurance Co. Address (Street Address/ P.O. Box)		Insurance Co. Address (Street Address/ P.O. Box)	
_____		_____	
City	State	Zip	
_____	_____	_____	_____

Ongoing Communication Regarding Your Healthcare

We may release/discuss your health information with following individuals/organizations for the following dates of service, range of time, or event(s): From (MM/DD/YY) _____ To (MM/DD/YY) _____

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate authorization must be completed if the information being release differs between the individuals/organizations listed above.

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Roper Saint Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

I have been provided a copy of the Roper Saint Francis Healthcare Notice of Information Practices.

Signed: _____ Date ____/____/____

Office Use Only:

Referred by: _____

ACCIDENT / INJURY INFORMATION

Are you being seen today as a result of an accident or injury? _____

If YES, please provide the following information. If NO, please sign and date at bottom.

Patient Name: _____

Insurance Co: _____

Subscriber: _____

Subscriber ID#: _____

Subscriber Employer: _____

Please describe the injury and how it occurred:

Date of Injury: _____ Involved body area: _____

Where did injury take place? _____

Did injury occur as a result of an accident that was caused by someone else? _____

If yes, name and address of person at fault: _____

Insurance company of person at fault: _____

Policy number or claim number: _____

Is this injury work-related? _____ If yes, has claim been filed for Workers Compensation? _____

Name of Workers Compensation Insurance Co. _____

SIGNATURE

DATE

PHONE NUMBER