Orthopaedic Specialists of Charleston
ROPER ST. FRANCIS PHYSICIANS

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 doctos ro 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 ☐

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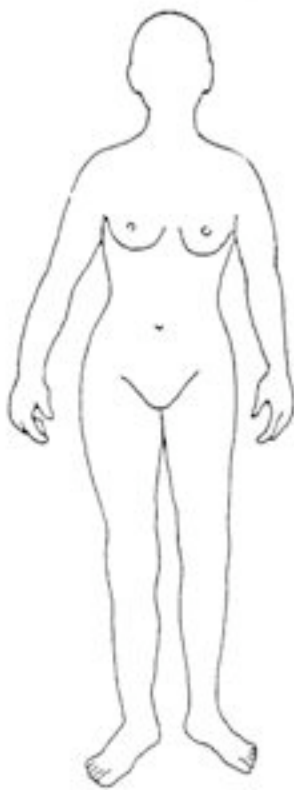
BODY DIAGRAM - FEMALE

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:** O O O	**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

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	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: _______________________________

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chart#________________

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**