Intake Form

Visit Information

Chief Complaint: **Additional comments:** **How did you hear about us?**

Patient Information

First Name: **Last Name:** **Nick Name:** **Date of Birth:**

Gender: **Marital Status:** **Primary Language:** **Occupation:**

Current Employer: **Employment Status:** **Race:** **Ethnicity:**

Social Security Number: **Driving License Number:**

Contact Information

Street Address: **Apt #:** **City:** **State:**

Zip: **Mobile Number:** **Home Phone Number:** **Work Phone Number:**

Email Address: **Primary Phone Number:** **Secondary Phone Number:** **Tertiary Phone Number:**

Responsible Party Information

First Name: **Last Name:** **Nick Name:** **Date of Birth:**

Gender: **Marital Status:** **Relationship To Patient:** **Primary Language:**

Occupation: **Current Employer:** **Employment Status:** **Race:**

Ethnicity: **Social Security Number:** **Driving License Number:**

Contact Information

Street Address: **Apt #:** **City:** **State:**

Zip: **Mobile Number:** **Home Phone Number:** **Work Phone Number:**

Email Address: **Primary Phone Number:** **Secondary Phone Number:**

Primary Insurance Information

Insurance Plan Information

Insurance Company Name: **Insurance ID:** **Insurance Group:**

Policyholder Information

First Name: **Last Name:** **SSN:** **Date of Birth:**

Relation to Patient: **Current Employer:**

Second Insurance Information

Insurance Plan Information

Insurance Company Name: **Insurance ID:** **Insurance Group:**

Policyholder Information

First Name: **Last Name:** **SSN:** **Date of Birth:**

Relation to Patient: **Current Employer:**

Family members & Emergency contacts

Name	Contact Information	Types of information about relationship		
		Also visits this location	Is an emergency contact	Has different address than patient
	Cell #: Home #: Work #: Email:	☐	☐	☐
	Cell #: Home #: Work #: Email:	☐	☐	☐
	Cell #: Home #: Work #: Email:	☐	☐	☐
	Cell #: Home #: Work #: Email:	☐	☐	☐
	Cell #: Home #: Work #: Email:	☐	☐	☐

Medical History Form

Visit Information

Chief Complaint:

Additional comments:

How did you hear about us?

Primary Complaint

Primary Complaint

History of Present Illness - symptoms related to Leg/Back pain

When did your leg/back symptoms start (month and year)?

What is the duration of your leg/back pain?
- O Constant
- O Intermittent (on/off)
- O Positional

What does your leg/back pain feel like?
- O Sharp
- O Dull
- O Burning
- O Pins and Needles
- O Radiating

If you are experiencing leg symptoms, which leg is affected?
- O Right Leg
- O Left Leg
- O Both Legs

How is your pain distributed between your back and legs?

Back				Leg
100% Back	75% Back 25% Leg	50% Leg 50% Back	75% Leg 25% Back	100% Leg

On a scale of 1 to 10 with 10 being the most severe, select the number that best describes the severity of your leg/back complaint.

No Pain										Worst Pain
0	1	2	3	4	5	6	7	8	9	10

What makes your leg/back symptoms better?
- ☐ Patient has none to report
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Physical activity
- ☐ Heat
- ☐ Cold
- ☐ Leaning Forward
- ☐ Medication

Other:

What makes your leg/back symptoms worse?
- ☐ Patient has none to report
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Lying down
- ☐ Physical activity
- ☐ Heat
- ☐ Cold
- ☐ Massage

Other:

Have you done any of the following in order to avoid pain?
- ☐ Patient has none to report
- ☐ Not standing for long periods
- ☐ Not walking long distances
- ☐ Not sitting for long
- ☐ Not lifting weight
- ☐ Not twisting
- ☐ Not bending
- ☐ Not driving
- ☐ Not working out
- ☐ Taking shorter showers
- ☐ Not working around the house
- ☐ Using a walker or cane

Other:

Questions Regarding Bladder And Bowel

Do you experience leaking urine?
- O Yes
- O No

Do you experience leaking stool?
- O Yes
- O No

Do you experience retaining urine?
- O Yes
- O No

Do you experience retaining stool?
- O Yes
- O No

Do you have loss of feeling in your genital area?
- O Yes
- O No

How long have you had these symptoms?

History of Present Illness - symptoms related to Neck/Arm pain

When did your neck/arm symptoms start (month and year)?

What is the duration of your neck/arm pain?
- O Constant
- O Intermittent (on/off)
- O Positional

What does your neck/arm pain feel like?
- O Sharp
- O Dull
- O Burning
- O Pins and Needles
- O Radiating

If you are experiencing arm symptoms, which arm is affected?
- O Right Arm
- O Left Arm
- O Both Arms

How is your pain distributed between your neck and arms?

Arm				Neck
100% Arm	75% Arm 25% Neck	50% Neck 50% Arm	75% Neck 25% Arm	100% Neck

On a scale of 1 to 10 with 10 being the most severe, select the number that best describes the severity of your neck/arm pain.

No Pain										Worst Pain
0	1	2	3	4	5	6	7	8	9	10

What makes your neck/arm symptoms better?
- ☐ Patient has none to report
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Physical activity
- ☐ Heat
- ☐ Cold
- ☐ Leaning Forward
- ☐ Medication

Other:

What makes your neck/arm symptoms worse?
- ☐ Patient has none to report
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Lying down
- ☐ Physical activity
- ☐ Heat
- ☐ Cold
- ☐ Massage

Other:

Have you done any of the following in order to avoid pain?
- ☐ Patient has none to report
- ☐ Not standing for long periods
- ☐ Not walking long distances
- ☐ Not sitting for long
- ☐ Not lifting weight
- ☐ Not twisting
- ☐ Not bending
- ☐ Not driving
- ☐ Not working out
- ☐ Taking shorter showers
- ☐ Not working around the house
- ☐ Using a walker or cane

Other:

History of Present Illness - symptoms related to other neurosurgical condition

Answer questions as they apply.

What is the primary reason for your visit today?
- O Brain hemorrhage/stroke
- O Head injury/trauma
- O Brain tumor
- O Pseudotumor Cerebri
- O Hydrocephalus
- O Shunts (VP and LP shunts)
- O Seizures
- O Chiari malformations
- O Trigeminal Neuralgia
- O Carpal tunnel syndrome
- O Ulnar nerve entrapment
- O Another Condition

When did your symptoms start (month/year)?

How often do you experience symptoms?
- O Constant
- O Intermittent

On a scale of 1 to 10 with 10 being the most severe, select the number that best describes the severity of your condition.

No Symptoms					Mild					Severe
0	1	2	3	4	5	6	7	8	9	10

Back Or Neck Related Treatment History

☐ Patient has no treatments to report.

Treatment	Date (month/year)	Duration	How long did it help?
Physical Therapy			
Chiropractic Manipulation			
Pain Management			
Epidural Injections			
Nerve Root Block Injections			
Nerve Ablations			

Have you taken NSAIDs such as ibuprofen (Motrin, Advil, Duexis) or naproxen (Aleve, Vimovo) for your pain?

- O Yes
- O No

Have they improved your pain?

- O Yes they have
- O No they have not

When did you start taking them (month and year)?

Back Or Neck Related Tests/Studies

NOTE: List any tests or studies you have received regarding your neck or back condition.

☐ Patient has no tests, screenings, or studies to report.

Type	Completed?	Date (month/year)
EMG of Arms (Nerve Conduction Study)	☐	
EMG of Legs (Nerve Conduction Study)	☐	
Discogram (Back)	☐	
Discogram (Neck)	☐	
	☐	
	☐	
	☐	
	☐	

Medication and Supplement Dosages

Report all medications and supplements you are currently taking and indicate when you started taking them.

☐ Patient has no medications to report.

Medications	Start Date (month/year)

Past Medical History - Diagnosis & Conditions

NOTE: Please select diseases and conditions that you have been diagnosed with in the past.

Diseases and Conditions

☐ Patient has none to report
☐ Hearing Loss
☐ Memory Loss
☐ Meningitis
☐ Migraines
☐ Seizures
☐ Vertigo
☐ Vision Problems
☐ Bleeding Disorder
☐ Cancer (describe below)
☐ Depression/Anxiety
☐ Fibromyalgia
☐ Acid Reflux
☐ ADD/ADHD
☐ AIDS/HIV
☐ Angina
☐ Alcoholism
☐ Seasonal Allergies
☐ Arthritis
☐ Anemia
☐ Asthma
☐ Bipolar
☐ Birth Defects
☐ Congenital heart disease
☐ Congestive Heart Failure
☐ COPD (bronchitis/emphysema)
☐ Diabetes Type I or II
☐ Diverticulitis
☐ Ear Infections
☐ Eczema
☐ Enlarged Prostate
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ Heart Murmur
☐ Hepatitis A/B/C
☐ High blood pressure
☐ High Cholesterol
☐ Infective endocarditis
☐ Irritable Bowel
☐ Kidney Disease
☐ Mitral valve prolapse
☐ Pneumonia
☐ Rheumatic heart disease
☐ Sinusitis
☐ Sleep Apnea
☐ Tinnitus
☐ Thyroid Disease
☐ Tuberculosis Headaches
☐ Sexually Transmitted Infections
☐ Voice Hoarseness
☐ Earwax
Other:

Allergies

Allergies to Medications, Items, and Food

☐ Patient has none to report
☐ Aspirin
☐ Acetaminophen
☐ Codeine
☐ Erythromycin
☐ Ibuprofen
☐ Iodine
☐ IV constrast
☐ Latex
☐ Metals
☐ Penicillin
☐ Sulfa drugs
☐ Tape
Other:

Surgical History

Have you had ANY previous surgeries? If so, please list ALL previous surgeries.

☐ Patient has no surgeries to report.

Surgery	Year	Physician	How long did it help your pain?
Brain Surgery			
Back Surgery			
Neck Surgery			
Adenoid Surgery			
Appendectomy			
Cancer Surgery			
Cardiac Bypass Surgery			
Cesarean Delivery			
Colonoscopy			
Coronary Artery Stent			
Cosmetic Surgery			
Ear Surgery			
Ear Tube Placement			
Eye Surgery			
Gall bladder (cholecystectomy)			
Hernia repair			
Hysterectomy			
Kidney Stone Removal			
Neurosurgery			
Organ Transplant			
Orthopaedic Surgery			
Septoplasty			
Sinus Surgery			
Sleep Apnea Surgery			
Spine Surgery			
Thyroid Surgery			
Tonsillectomy			
Urologic Surgery			
Vascular Surgery			
Weight Loss Surgery			

Other Surgeries

Family History of Diseases

Report medical diseases or conditions in your family.

☐ Patient has no family history of diseases to report.

	Father	Mother	Sibling	Children	Other
Spine Conditions	☐	☐	☐	☐	☐
Brain Conditions	☐	☐	☐	☐	☐
Brain Tumor	☐	☐	☐	☐	☐
Neurological Disorders	☐	☐	☐	☐	☐
Spine Tumor	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Deceased	☐	☐	☐	☐	☐
Blood Diseases	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Psychiatric disorders	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Seasonal Allergies	☐	☐	☐	☐	☐
Aneurysm	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Digestive Problems	☐	☐	☐	☐	☐
Drug/Alcohol Abuse	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
HIV	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Lipids	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐
Memory Loss	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐
Muscle Weakness	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐

Patient Social History

Occupation

Employer

Marital Status

Who lives with you at home?

- ☐ Patient has none to report
- ☐ Spouse
- ☐ Adult Children
- ☐ Parents
- ☐ Significant Other
- ☐ Relative

Other:

How many alcoholic drinks do you consume in a week?

How many cigarettes do you have a day?

Years since you quit smoking:

Do you use recreational drugs?

- O Yes
- O No

Specifically, do you use any of the following?

- ☐ None to report
- ☐ Marijuana
- ☐ Cocaine
- ☐ Heroin
- ☐ Non-prescribed narcotics or pain killers

Other:

Review of Systems

General

- ☐ Patient has none to report
- ☐ Fever
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain

Other:

Allergic / Immunologic

- ☐ Patient has none to report
- ☐ Stuffy nose
- ☐ Recent Skin Rash
- ☐ Itchy eyes

Other:

Bladder / Kidney / Liver

- ☐ Patient has none to report
- ☐ Blood in Urine
- ☐ Difficulty urinating
- ☐ Urinary incontinence
- ☐ Incontinence of stool
- ☐ Hepatitis

Other:

Cardiovascular

- ☐ Patient has none to report
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Palpitations
- ☐ Swelling in extremities

Other:

Digestive

- ☐ Patient has none to report
- ☐ Heartburn
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black Stools

Other:

Head / Ears / Nose / Throat / Mouth

- ☐ Patient has none to report
- ☐ Ringing in Ears
- ☐ Hearing loss
- ☐ Sinus pain
- ☐ Sore throat
- ☐ Nose bleed
- ☐ Glaucoma

Other:

Hematologic

- ☐ Patient has none to report
- ☐ Blood Clots
- ☐ Unusual Bleeding
- ☐ Recent bruising

Other:

Musculoskeletal

- ☐ Patient has none to report
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Joint Swelling

Other:

Neurological

- ☐ Patient has none to report
- ☐ Dizziness
- ☐ Hallucinations
- ☐ Headaches
- ☐ Memory loss
- ☐ Tremor
- ☐ Nausea
- ☐ Psychiatric problems
- ☐ Seizures
- ☐ Loss of smell
- ☐ Stroke
- ☐ Tingling/numbness
- ☐ Vertigo
- ☐ Gait difficulties
- ☐ Weakness in Extremeties

Other:

Psychiatric

- ☐ Patient has none to report
- ☐ Depression
- ☐ Anxiety

Other:

Respiratory

- ☐ Patient has none to report
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Asthma
- ☐ Cold

Other:

Skin

- ☐ Patient has none to report
- ☐ Skin Cancer
- ☐ Lumps
- ☐ Moles

Other:

Height and Weight

Height (Feet)

Height (Inches)

Weight (In Pounds)

Body Mass Index

Allodynia Symptom Checklist - ASC-12

Question: How often do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage each of the following?

	Rarely, never, or does not apply to me	**Less than half the time**	**Half the time or more**
Combing your hair	0	1	2
Pulling your hair back (e.g., ponytail)	0	1	2
Shaving your face	0	1	2
Wearing eyeglasses	0	1	2
Wearing contact lenses	0	1	2
Wearing earrings	0	1	2
Wearing a necklace	0	1	2
Wearing tight clothing	0	1	2
Taking a shower (when shower water hits your face)	0	1	2
Resting your face or head on a pillow	0	1	2
Exposure to heat (e.g., cooking, washing your face with hot water)	0	1	2
Exposure to cold (e.g., using an ice pack, washing your face with cold water)	0	1	2

ATTRIBUTION: Lipton R. B., Bigal, M. E., Ashina, S., Burstein, R., Silberstein, S., Reed, M. L., Serrano, D., and Stewart, W. F., (2009)

Depression Assessment (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficulty at all	Somewhat difficult	Very difficult	Extremely difficult
1	2	3	4

ATTRIBUTION: Kurt Kroenke, Robert L. Spitzer, & Janet B. W. Williams (2001)

Anxiety Assessment (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at All	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

It you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
0	1	2	3

ATTRIBUTION: Robert L. Spitzer, Kurt Kroenke, Janet B. W. Williamns, Bernd Lowe (2006)

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. Use the following scale to choose the most appropriate number for each situation

	No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place, for example, a theater or a meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

ATTRIBUTION: Murray W. Johns (1991)

PTSD Checklist - PCL-C

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then fill in the circle of the response to indicate how much you have been bothered by that problem IN THE PAST MONTH. Please fill in ONE option only for each question.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	1	2	3	4	5
2. Repeated, disturbing dreams of a stressful experience from the past?	1	2	3	4	5
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5
6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	1	2	3	4	5
7. Avoid activities or situations because they remind you of a stressful experience from the past?	1	2	3	4	5
8. Trouble remembering important parts of a stressful experience from the past?	1	2	3	4	5
9. Loss of interest in things that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being “super alert” or watchful on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

ATTRIBUTION: Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993)

Back Pain Assessment (Modified ODI)

This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and select only one option in each section that best describes your condition today. We realize you may feel that two of the statements in any one section relate to you, but please select the option which most closely describes your current condition.

Section 1 - Pain Intensity

0. I can tolerate the pain I have without having to use pain medication
1. The pain is bad but I manage without having to take pain medication
2. Pain medication provides me complete relief from pain
3. Pain medication provides me moderate relief from pain
4. Pain medication provides me little relief from pain.
5. Pain medication has no effect on the pain

Section 2 - Personal care (Washing, Dressing etc.)

0. I can take care of myself normally without causing increased pain
1. I can take care of myself normally but it increases my pain
2. It is painful to take care of myself and I am slow and careful
3. I need help but I am able to manage most of my personal care
4. I need help every day in most aspects of my care
5. I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

0. I can lift heavy weights without increased pain
1. I can lift heavy weights but it causes increased pain
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
4. I can lift only very light weights
5. I cannot lift or carry anything at all

Section 4 - Walking

0. Pain does not prevent me walking any distance
1. Pain prevents me walking more than 1 mile
2. Pain prevents me walking more than 1/2 mile
3. Pain prevents me walking more than 1/4 mile
4. I can only walk using crutches or a cane
5. I am in bed most of the time and have to crawl to the toilet

Section 5 - Sitting

0. I can sit in any chair as long as I like
1. I can only sit in my favorite chair as long as I like
2. Pain prevents me from sitting more than 1 hour
3. Pain prevents me from sitting more than 1/2 hour
4. Pain prevents me from sitting more than 10 mins
5. Pain prevents me from sitting at all

Section 6 - Standing

0. I can stand as long as I want without increased pain
1. I can stand as long as I want but increases my pain
2. Pain prevents me from standing for more than 1 hour
3. Pain prevents me from standing for more than 1/2 hour
4. Pain prevents me from standing for more than 10 mins
5. Pain prevents me from standing at all

Section 7 - Sleeping

0. Pain does not prevent me from sleeping well
1. I can sleep well only by using pain medication
2. Even when I take pain medication, I sleep less than 6 hours
3. Even when I take pain medication, I sleep less than 4 hours
4. Even when I take pain medication, I sleep less than 2 hours
5. Pain prevents me from sleeping at all

Section 8 - Social Life

0. My social life is normal and does not increase my pain
1. My social life is normal, but it increases my level of pain
2. Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.)
3. Pain prevents me from going out very often
4. Pain has restricted my social life to my home
5. I have hardly any social life because of my pain

Section 9 - Traveling

0. I can travel anywhere without Increased pain
1. I can travel anywhere but it increases my pain
2. Pain restricts travel over 2 hours
3. Pain restricts travel over 1 hour
4. Pain restricts my travel to short necessary journeys under 1/2 hour
5. Pain prevents all travel except for visits to the doctor/therapist or hospital

Section 10 - Employment/Homemaking

0. My normal homemaking/job activities do not cause pain
1. My normal homemaking/job activities increase my pain, but I can still perform all that is required of me
2. I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming)
3. Pain prevents me from doing anything but light duties
4. Pain prevents me from doing even light duties
5. Pain prevents me from performing any job/homemaking chores

ATTRIBUTION: Julie M. Fritz, & James J. Irrgang (2001)

Neck Pain Assessment (NPI)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and select an option in each section which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please select the option which most closely describes your problem.

Section 1 - Pain Intensity

0. I have no pain at the moment
1. The pain is very mild at the moment
2. The pain is moderate at the moment
3. The pain is fairly severe at the moment
4. The pain is very severe at the moment
5. The pain is the worst imaginable at the moment

Section 2 - Personal care (Washing, Dressing etc.)

0. I can look after myself normally without causing extra pain
1. I can look after myself normally but it causes extra pain
2. It is painful to look after myself and Iam slow and careful
3. I need some help but manage most of my personal care
4. I need help every day in most aspects of self care
5. I do not get dressed, I wash with difficulty and stay in bed

Section 3 - Lifting

0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives extra pain
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
4. I can lift very light weights
5. I cannot lift or carry anything at all

Section 4 - Reading

0. I can read as much as I want to with no pain in my neck
1. I can read as much as I want to with slight pain in my neck
2. I can read as much as I want with moderate pain in my neck
3. I can't read as much as I want because of moderate pain in my neck
4. I can hardly read at all because of severe pain in my neck
5. I cannot read at all

Section 5 - Headaches

0. I have no headaches at all
1. I have slight headaches which come in-frequently
2. I have moderate headaches which come in-frequently
3. I have moderate headaches which come frequently
4. I have severe headaches which come frequently
5. I have headaches almost all the time

Section 6 - Concentration

0. I can concentrate fully when I want to with no difficulty
1. I can concentrate fully when I want to with slight difficulty
2. I have a fair degree of difficulty in concentrating when I want to
3. I have a lot of difficulty in concentrating when I want to
4. I have a great deal of difficulty in concentrating when I want to
5. I can't concentrate at all

Section 7 - Work

0. I can do as much work as I want to
1. I can only do my usual work, but no more
2. I can do most of my usual my work, but no more
3. I can not do my usual work
4. I can hardly do any work at all
5. I can't do any work at all

Section 8 - Driving

0. I can drive my car without any neck pain
1. I can drive my car as long as I want with slight pain in my neck
2. I can drive my car as long as I want with moderate pain in my neck
3. I can't drive my car as long as I want because of moderate pain in my neck
4. I can hardly drive at all because of severe pain in my neck
5. I can't drive my car at all

Section 9 - Sleeping

0. I have no trouble sleeping
1. My sleep is slightly disturbed (less then 1 hour sleepless)
2. My sleep is mildly disturbed (1-2 hour sleepless)
3. My sleep is moderately disturbed (2-3 hour sleepless)
4. My sleep is greatly disturbed (3-5 hour sleepless).
5. My sleep is completely disturbed (5-7 hour sleepless)

Section 10 - Recreation

0. I am able to engage in all my recreational activities with no neck pain at all
1. I am able to engage in all my recreational activities, with some pain in my neck
2. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
3. I am able to engage in few of my usual recreation activities because of pain in my neck
4. I can hardly do any recreation activities because of pain in my neck
5. I can't do any recreation activities at all

ATTRIBUTION: Howard Vernon & Silvano Mior (1991)

Legal Form

Permissions to Release Protected Data to Persons

Frisco Spine 8350 Dallas Parkway Suite 200, Frisco, TX, 75034

Enter details of related persons with whom we can exchange information with. For instance, a spouse or employee may be given scheduling permissions so they can book appointments on the patient's behalf.

Data permissions to give				
Health	**Scheduling**	**Financial**	**Person's Name (Relationship with Patient)**	**Contact Information**
☐	☐	☐		Cell #: Home #: Work #: Email:
☐	☐	☐		Cell #: Home #: Work #: Email:
☐	☐	☐		Cell #: Home #: Work #: Email:
☐	☐	☐		Cell #: Home #: Work #: Email:
☐	☐	☐		Cell #: Home #: Work #: Email:

Permissions for Staff to Leave Voice Messages

Frisco Spine 8350 Dallas Parkway Suite 200, Frisco, TX, 75034

Enter contact details of patient or related persons to whom we can leave voice messages on the patient's behalf.

Permission to leave voice messages	Person's Name (Relationship with Patient)	Phone Type	Phone Number
☐			
☐			
☐			
☐			
☐			

Notice of Privacy Practices

Frisco Spine

All Locations

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice, please contact our Privacy Officer, Brissa Palacios. We are committed to protecting the privacy of your **personal health information (PHI)**.

This Notice of Privacy Practices describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment, or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. We provide a copy of this Notice to you the first day you are treated.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.
We may change our Notice at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: friscospine.com

Uses and Disclosures of PHI

We may use and disclose, as needed, your PHI for certain health care operations, such as:

- To billing companies to obtain payment for services.
- To insurance companies and health plans to determine if the service will be paid for PRIOR to performing certain procedures.
- To government agencies in order to assist with qualification of benefits
- To collection agencies to collect payment for services
- To support business activities such as training personnel, quality improvement, and problem/complaint resolution.
- To health agencies that provide medical care to you, such as physical therapy and home health.

- To other providers involved in your care, such as to a referred physician or a health care provider assisting your physician in your treatment.
- To our office staff

We may use and disclose your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury, or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government programs, and civil rights laws.
- Legal processing: To assist in any legal proceedings or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical research: We may disclose your PHI to researcher when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.
- Business Associated: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription servies.
- Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
- Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications
- Treatment alternatives: We may provide you notice of treatment options or other health-related services that may improve your overall health.
- Appointment Reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose you PHI in the following situations UNLESS you object:

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post-procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death.
- We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures for any purposes which require the sale of your information.
- Release of psychotherapy notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or a group. These notes are kept separate from the rest of the medical record and do not include: medication and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require written authorization from you or your personal representative.Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or release information base on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your PHI. All requests to exercise your rights must be made in writing. You may obtain a request from the office.

You have the right to see and obtain a copy of your PHI.

This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. If requested, we will provide you a copy of your records and may charge you a reasonable fee. There are some exceptions to records which may be copied and the request may be denied.

You have the right to request a restriction of your PHI.

You may request for this practice not to use or disclose any part of you PHI for the purposes of treatment, payment, or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request, we will honor the restriction request unless the information is needed to provide emergency treatment. We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request an alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation to the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people and organizations who have received your health information from us.

The right applies to disclosures for purposes other than treatment, payment, or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12-month period, you may be charged a reasonable fee.

You have the right to received notification of any breach of your PHI.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices, you can contact:
Brissa Palacios, Privacy Officer at 972.377.9200

You may also lodge a complaint to the US Secretary of Health and Human Services if you believe you privacy rights have been violated by us. If you file a complaint, we will not retaliate against you.

This notice is published and becomes effective on April 13, 2003. Revised October 1, 2013. Revised September 21, 2015.

Acknowledgement, Consent, and Authorization

Frisco Spine

All Locations

Acknowledgement:
I acknowledge that I have been offered the opportunity to review and receive a copy of the Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Consent and Authorization:

- I do hereby consent and authorize Frisco Spine to release all information contained in my financial, medical, and contact records, including diagnoses and test results, to my insurance company or health plan, their agents and independent contractors, or to assist third parties business associates that supply goods or services to this office, where such goods/services require access to such information, or to any other person or entity that is responsible for paying or processing for payment any portion of my bill, for the purposes of administration, billing and quality and risk management. This consent applies to all records created in the course of and relating to my treatment and for the purpose of reimbursement for treatment.
- I will receive appointment reminders and other interactions on my email, text, and telephone answering system.
- Frisco Spine physicians may refer me to businesses and facilities where they may have vested interests. I have a right to choose my own provider and request a list of alternative providers within the area.

Right to Terminate or Revoke Authorization:

- I understand I have the right to revoke this authorization in writing at any time.
- I understand the revocation will NOT apply to information that has already been released.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated.

Assignment of Insurance Benefits

Frisco Spine

All Locations

I authorize payments from my insurance benefits to be made to Frisco Spine on my behalf for any services furnished to me by any healthcare providers associated with this group. I authorize release of my medical information to the Health Care Financing Administration or insurance company, if needed to determine these benefits.

I appoint Frisco Spine to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

Financial Responsibility

Frisco Spine

All Locations

It is important that we have a good understanding with our patients regarding financial responsibility. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through your Insurance Company.

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 90 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
  1. This is a pre-existing illness that is not covered by your plan
  2. You may have not met your full calendar year deductible
  3. The type of medical service required is not covered by your plan
  4. The health plan was not in effect at the time of service
  5. You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, it is your responsibility to pay the denied amounts in full.

We value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

I have read and understand my obligations and responsibilities. I have completed this form with accurate information. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

Office Policies

Frisco Spine

All Locations

Prescription Refills
Please have your pharmacy fax us a refill request at (972) 377-9300. Prescriptions will not be refilled on the weekends. Note: By signing this form, you are granting Frisco Spine permission to access your past medication history.

15 – Minute Late Policy
If you are over 15 minutes late to your appointment, you may be asked to reschedule.

Walk-In Appointments
Frisco Spine is an appointment only office. Examination by a physician cannot be guaranteed if you present to the office without an appointment.

Payments

Payment is expected at the time of service. Accepted methods of payment include cash, check, & credit card (American Express, Visa, Master Card, and Discover are accepted).

Form Completion

Please be aware that we legally have **7-10 business days** to complete forms. Patients are **required to pay a $25 completion fee** for disability/FMLA forms.

Copying of Medical Records

Patients requesting copies of their medical records will be assessed a $25 fee. If an abstract is sent to a continuing care provider, there is no charge. An authorization for release of information must be signed and submitted before any request for records will be processed.

No-Show Policy

Patients who schedule appointments but fail to show up are documented as “no-shows”. In addition, patients with multiple “no-shows” may be terminated from the practice.

Patient Termination Policy

Although it is an infrequent occurrence, a patient may be terminated from the office. Patient termination is at the discretion of the patient’s provider. Common reasons for terminations include, but are not limited to, noncompliance with medications (including the abuse of opioids/narcotics, by seeking these prescriptions from other providers while under our care), use of foul language, failure to comply with signed agreements, chronic noncompliance with recommended therapy, inappropriate behavior to staff, physicians, visitors or other patients.

Drug Screens

Drug screens are performed on a scheduled basis or may even be randomly requested at provider’s discretion.

Out Of Network Consent Form

NOTICE TO INSURED THAT AN OUT-OF-NETWORK PROVIDER MAY RENDER TREATMENT

If **Frisco Spine** refers you to a facility or another provider for further care, the possibility exists that an out-of-network provider may provide all or part of your care and services. While we extend courtesy assistance to you in order to minimize such occurrences of out-of-network care, you are solely responsible for determining which providers and facilities are preferred under your plan and we disclaim any liability for such of out-of-network care.

Should **Frisco Spine** refer you to a facility or another provider, we recommend that you contact your insurer for more information, and, to the extent possible, seek confirmation of the facility’s or provider’s network status.

Acknowledgement

REQUIRED **Initial Here*** I acknowledge receipt of the above notice.

____

Signature Page

Your Signature

Signature:

Date: