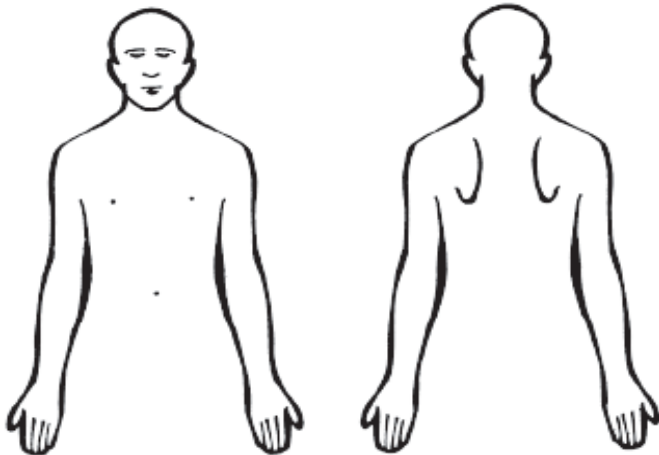


NECK FORM

Name: _____ Today's Date: _____
 Age: _____

- How long have you had your **NECK** and **ARM PROBLEM**? Weeks: _____ Months: _____ Years: _____
- Is your **PROBLEM** related to: Work Injury _____ Bending _____ Lifting _____
 Auto Accident _____ Slip / Fall _____ None of these _____
- Have you ever had this kind of **PROBLEM** before? No: _____ Yes (How many times): _____
- Since your **PROBLEM** began, has it gotten: Better: _____ Worse: _____ Unchanged: _____
- Which activities make your **PROBLEM** worse? Sitting: _____ Driving: _____ Using Arms: _____
 Working at a computer/or at a desk: _____ Everything: _____
- What position is the most comfortable to sleep in? Back: _____ Stomach: _____ Curled on side: _____
- What SYMPTOMS do you feel in your **SHOULDERS** and **ARMS**? Pain: _____
 Tingling / Numbness: _____
 Weakness / Loss of Strength: _____



*On this picture, please draw where your **Neck, Shoulder or Arms** hurt or where you have numbness/tingling.*

- Which of the following treatments have you had for your **PROBLEM**? Did it help your **PROBLEM**?
- Physical Therapy _____ Please name the Facility _____ Yes No
- Chiropractic treatments _____ Name of Chiropractor _____ Yes No
- Pain Management / Injections _____ Name of Doctor or Facility _____ Yes No

● **What medications are you PRESENTLY taking for your PROBLEM?**

| | <u>Name</u> | <u>Dose</u> |
|-------------------------------|-------------------------|-------------|
| Tylenol / acetaminophen _____ | Pain Pill _____ | _____ |
| Motrin / ibuprofen _____ | Muscle Relaxer _____ | _____ |
| Aspirin _____ | Anti-Inflammatory _____ | _____ |

ADDITIONAL INFORMATION

- Are you: Married: _____ Single: _____ Divorced: _____
- What is your present job? _____
- If you are **NOT** presently working, when did you last work? _____
- Do you smoke cigarettes/use tobacco? Yes/how much: _____ No: _____
- Do you drink alcohol/beer? Yes/how much: _____ No: _____

MEDICAL HISTORY

● **Are you presently experiencing any of these general medical symptoms? Circle all that apply.**

| | | | | |
|---------|-----------------|--------------|---------------------|--------------|
| Fever | Headache | Nausea | Chest Pain | Other: _____ |
| Chills | Ringing in Ears | Vomiting | Shortness of Breath | _____ |
| Rash | Blurred Vision | Constipation | Abdominal Pain | _____ |
| Fatigue | Fainting | Diarrhea | Urinary Problems | _____ |

● **Do YOU have a CURRENT or PAST medical history for the following illnesses:**

| | | |
|----------------------|--------------------------------|--------------------------|
| Blood pressure _____ | Emotional/Mental _____ | Stomach/colon _____ |
| Heart Disease _____ | Eye (glaucoma/cataracts) _____ | Skin Cancer/Rashes _____ |
| Lung Problems _____ | Ear/Hearing _____ | Diabetes _____ |
| Kidney/Bladder _____ | Nose/Sinus _____ | Cancer _____ |
| Thyroid _____ | Arthritis _____ | Other _____ |

● **If you are a women age 65 or older...**

- Have you been screened (DXA scan) for osteoporosis since you turned 60 years old? Y N
 If yes, what was the result of the testing? _____
- Have you been prescribed medication to prevent or treat osteoporosis? Y N
 If yes, what medication are you taking? _____

● **What Surgery or Operations have you had?**

- | | | | |
|------------|----------------|------------|---------------|
| - Tonsils | - Hernia | - Prostate | - Neck |
| - Appendix | - Gall Bladder | - Hip | - Breast |
| - Back | - Hysterectomy | - Knee | - Other _____ |

● **What are ALL OTHER MEDICATIONS you are taking?**

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

● **MEDICINE ALLERGIES:** _____

● **Is your Mother living?**

Yes No

- Her Medical History
- Heart Disease
 - Heart Attack
 - Blood Pressure
 - Diabetes
 - Stroke
 - Lung Disease
 - Cancer
 - Other

Is your Father living?

Yes No

- His Medical History
- Heart Disease
 - Heart Attack
 - Blood Pressure
 - Diabetes
 - Stroke
 - Lung Disease
 - Cancer
 - Other

Your current Weight _____ lbs. Height _____ ' _____ "

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

AUTHORIZATIONS

Section 1: Financial Policy

I have reviewed OrthoNeuro's Financial Policy and Authorizations (collectively, the "Financial Policy"), hereby

acknowledge my responsibilities set forth in the Financial Policy, and hereby make the authorizations set forth in the Financial Policy. Please initial: _____

Section 2: Appointment of Personal Representative to Receive Protected Health Information

You may rely upon your spouse, relatives or friends to be involved in your medical care. OrthoNeuro can Disclose your Protected Health Information to these people if you appoint them as your "personal representatives." To appoint an individual as your personal representative, complete this section:

I hereby appoint the following individual as my personal representative:

Name: _____ **Relationship to me:** _____

I hereby authorize OrthoNeuro to Disclose the following Protected Health Information to my personal representative:

All Protected Health Information

OR One or more of these choices:

Times of Appointments

Test Results

Prescriptions & Ancillary Equipment

Copies of Medical Records

Other _____

I may revoke my appointment of a personal representative at any time in writing. I understand that revocation of my appointment will NOT affect any action OrthoNeuro took in reliance on my appointment before it received written notice of my revocation. **Please initial:** _____

Section 3: Receipt of Notice of Privacy Practices

I hereby acknowledge receiving a copy of OrthoNeuro's Notice of Privacy Practices that outlines my privacy rights and explains how OrthoNeuro is permitted to Use and Disclose my Protected Health Information. I should call OrthoNeuro's Privacy Officer at (614) 890-6555 if I have a question or concern about my privacy rights. **Please initial:** _____

Section 4: Patient Information

Race: _____ Ethnicity: _____

Language: _____ Social Security Number: _____

By signing below, I am acknowledging that I have read and understand this form.

Patient Name (please print)

Patient Signature

Date

If applicable, Parent/Guardian Name
(Please Print)

If applicable, Parent/Guardian Signature

Date