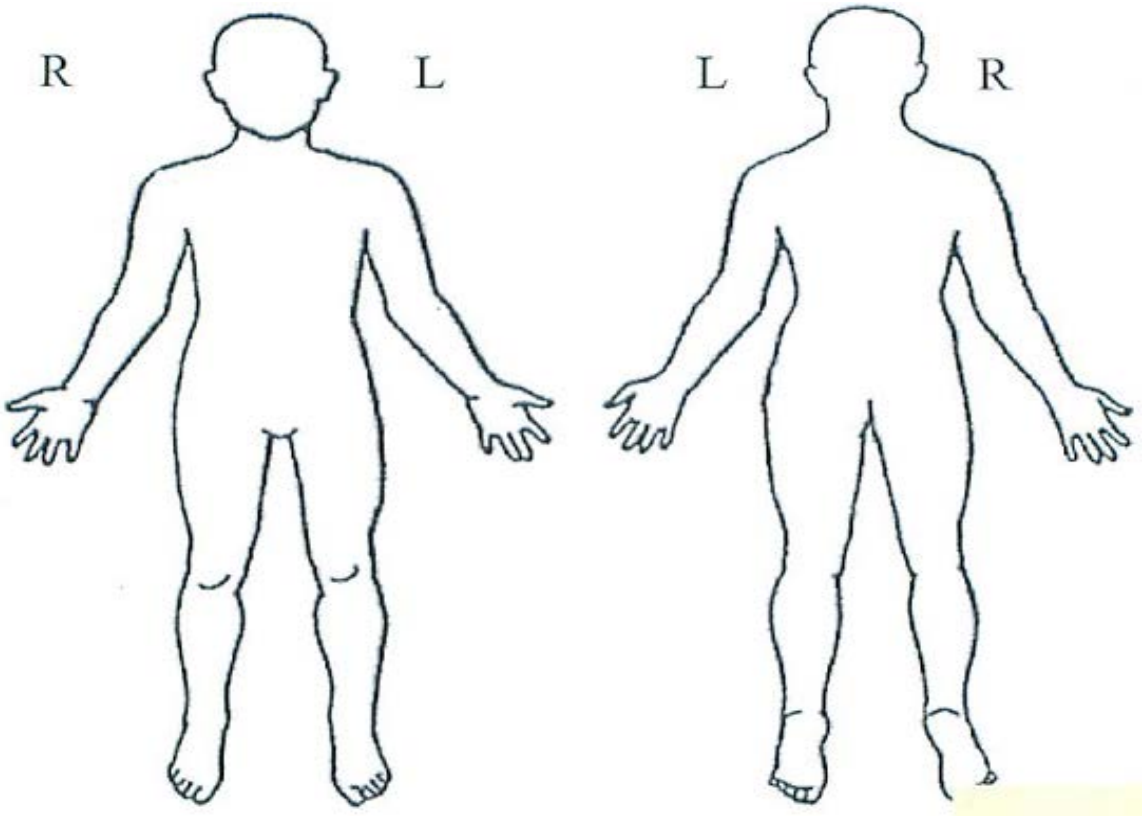
Physician Signature: _____ Date: _____

Ortho***Neuro***

Name: _____ Date: _____ Age: _____
SS#: _____ Sex: _____ DOB: _____
Referring Physician: _____
Referring Physician Address: _____

Mark the areas on the corresponding figures where you feel the described sensations. Mark areas of radiation using an arrow. Include all affected areas.

N *N* *N* *N** Dull Aching	*X* *X* *X* *X* Burning	=== === === === === Numbness
u u u u Stabbing	○ ○ ○ ○ ○ Pin and Needles	*s* *s* *s* *s* Muscular Cramp



Please circle or mark with an X on this line the level or intensity of pain, discomfort that you are currently experiencing.

/ _____

no pain pain as bad as it

A.) What is the nature of today's visit? _____

Date accident or symptoms occurred. _____ Is this work related? Yes No

Is this the first time you have had this problem? Yes No

Give a detailed description of the event: _____

List any physicians you have seen for this problem: _____

Do you have trouble with (please circle)

Weakness	Bladder	Bowels	Walking (how far) _____
Bending	Twisting	Dressing	Lifting (how much) _____
Sitting (how long) _____		Car Rides _____	
Sleep	Morning Stiffness	Changes in Weather	
Stairs (how many flights) _____	Laying Down	Numbness	Fever Chills
Rashes	Joint Swelling	Other _____	

Currently (today) how severe is the pain in your spine (neck or back)?

_____

no pain intolerable

Currently (today) how severe is the pain in your limb (arms or legs)?

_____

no pain intolerable

How often does the pain interrupt your sleep? _____ not at all _____ occasionally

_____ half of the time _____ often _____ always _____ never sleep well

Is your pain (please circle) CONSTANT INTERMITTENT VARIES

B.) Occupation _____ Date last worked _____

How long have you been with this job? _____

Exercise Habits: (please describe) _____

Hobbies: _____

C.) Treatment up to date: (please circle)

Osteopathic Chiropractic Physical Therapy Injections Bracing Traction Surgeries

Describe: _____

D.) PLEASE LIST BELOW

Allergies to medication: _____

CURRENT medications for this problem (name, dose, frequency)

Other CURRENT medications: (name, dose, frequency)

Prescription and non-prescription medications taken in the PAST (indicate if it is for the current problem):

Other medical problems:

_____ Heart Disease
_____ Lung Disease
_____ Cholesterol
_____ Dental Disease
_____ High Blood Pressure
_____ Brain Tumor
_____ Encephalitis/Meningitis
_____ Headaches

_____ Thyroid problems
_____ Panic Attacks
_____ Mental Illness
_____ Depression
_____ Cancer
_____ Stroke
_____ Diabetes/Hypoglycemia
_____ Glaucoma
_____ Kidney Disease

_____ Sinusitis
_____ Ear Infection
_____ Arthritis (osteo/rheumatoid)
_____ Ulcer/Stomach Disease
_____ Skin Disorder
_____ Sore Throat/Tonsillitis
_____ Mononucleosis
_____ Lumps/Cysts
_____ Deep venous Thrombosis/ Thrombophlebitis
_____ Bleeding Disorders/Anemia
_____ Hepatitis A or B / Liver Disease
_____ Aneurysm
_____ Bronchitis / Asthma
_____ Sleep Disorder
_____ Seizure/Epilepsy
_____ Tuberculosis
_____ Other: explain _____
_____ Other: explain _____

Surgeries and hospitalizations (where, hospital/city, type of surgery/treatment):

E.) Check any that apply

_____ Single _____ Married _____ Divorced _____ Widowed

How many children do you have and their ages: _____

_____

How much do you smoke per day? _____

How many years have you smoked? _____

Do you use smokeless tobacco? _____ Yes _____ No

Please indicate how much alcohol you consume:

_____ Beers per week

_____ Glasses of wine per week

_____ ounces (drinks) of liquor per week

Have you in the past or do you use recreational drugs? _____ Yes _____ No

Last year of school completed? _____

What is your support system? _____

F.) Indicate who among your **close relatives** may have any of the following ailments?

Heart Disease	_____	Seizure or Epilepsy	_____
Cancer	_____	Brain Tumor	_____
Lung Disease	_____	Headaches	_____
High Blood Pressure	_____	Thyroid	_____
Cholesterol	_____	Arthritis	_____
Stroke	_____	Muscular Disease	_____
Ulcer	_____	Spine Problems	_____
Diabetes	_____	Panic Attacks	_____
Hypoglycemia	_____	Mental Illness	_____

G.) Which test have you had in the past? (where, when and results)

MRI: _____

EEG: _____

Disc Injections: _____

X-Rays: _____

Bone Scan: _____

Cat Scan: _____

Myelogram: _____

EMG / Nerve Conduction Study: _____

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? _____

H.) What is your height? _____ Weight? _____

I.) Review of Systems

Yes	No	
____	____	Do you have a fever?
____	____	Do you have a skin rash?
____	____	Have you gained or lost weight in the last six months?
		How much ____
____	____	Are you intolerant of heat or cold?
____	____	Do you sweat heavily at night?
____	____	Any skin lumps, cysts, or lesions?
____	____	Any changes in skin, hair, nail or teeth?
____	____	Do you have eye pain, redness, or inflammation?
____	____	Has your vision been blurred or doubled?
____	____	Have you ever lost vision in one or both eyes?
____	____	Do you experience dizziness or lightheadedness?
____	____	Have you ever fainted, passed out or blacked out?
____	____	Do you have difficulties with balance or unsteadiness?
____	____	Do you have ear pain or fullness?
____	____	Do you have hearing difficulties or ringing in your ears?
____	____	Does your face become numb or lose sensations?
____	____	Is your sense of smell or taste disturbed?
____	____	Are your teeth sensitive to cold, hot, or other?
____	____	Do you have sinus discharge, blood or mucus?
____	____	Do you have chest pain?
____	____	Does your heart race or skip beats?
____	____	Do you become short or breath?
____	____	Do your feet or ankles swell?
____	____	Do you cough up phlegm or blood?
____	____	Do you have a persistent cough or wheeze?
____	____	Any pain or discomfort in your abdomen?
____	____	Has your appetite changed?
____	____	Have you had nausea or vomiting?
____	____	Do you suffer from constipation, diarrhea or excess gas?
____	____	Have there been any changes in your bowel movements?
____	____	Have you been jaundiced?
____	____	Do you have burning or pain with urination?
____	____	Do you have to get up often at night to urinate?
____	____	Do you experience weakness of the arms or legs?
____	____	Any numbness or tingling of the arms or legs?
____	____	Do you have headaches or facial pain?
____	____	Do you have neck or back pain?
____	____	Do you have muscle pain or swelling?
____	____	Do you have joint pain or swelling?
____	____	Do you have difficulty with concentration or memory?
____	____	Do you often feel depressed?
____	____	Do you often feel anxious or nervous?
____	____	Do you often feel tired or sleepy?
____	____	Do you have difficulty falling asleep or staying asleep?
____	____	Do you have suicidal thoughts?

Sign Here _____

All Finished! Thank You

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
☐ Prescriptions & Ancillary Equipment
☐ Other _____
☐ Test Results
☐ Copies of Medical Records

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: _____ Date of Birth: _____

Language: _____ Social Security Number: _____

Emergency Contact: _____ Phone 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