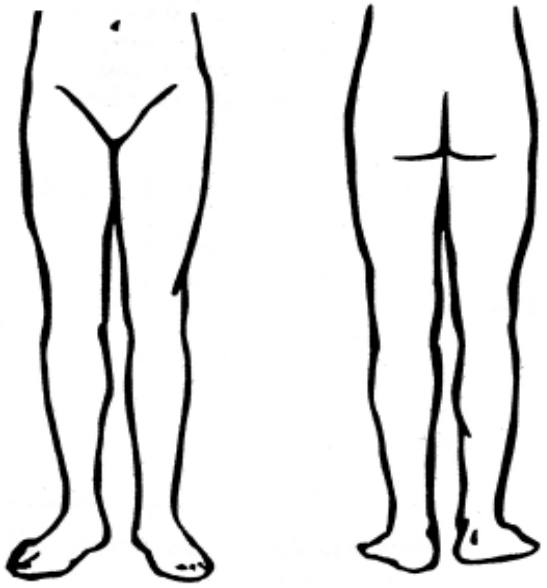
BACK FORM

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

- How long have you had your **BACK** or **LEG 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:____ Walking: ____
  Standing: ____ Coughing/Sneezing: ____ Everything: ____
- What position is the most comfortable to sleep in? Back: ____ Stomach: ____ Curled on side:____
- What SYMPTOMS do you feel in your **BUTTOCK** or **LEGS**? Pain:____
  Tingling / Numbness: ____
  Weakness / Loss of Strength: ____



On this picture, please draw where your ***Back, Buttocks or Legs*** *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**?

	Name	**Dose**			
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 <u>ALL OTHER MEDICATIONS</u> you are taking?**

_____ _____ _____

_____ _____ _____

_____ _____ _____

- **<u>MEDICINE ALLERGIES:</u>** _____

Is your <u>Mother</u> living?	**Yes**	**No**	**Is your <u>Father</u> living?**	**Yes**	**No**
Her Medical History			His Medical History		
- Heart Disease			- Heart Disease		
- Heart Attack			- Heart Attack		
- Blood Pressure			- Blood Pressure		
- Diabetes			- Diabetes		
- Stroke			- Stroke		
- Lung Disease			- Lung Disease		
- Cancer			- Cancer		
- Other _____			- 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
☐ 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