Bone & Joint Specialists

PATIENT NAME: ________________________________ **Cellular#** ____________________
First Middle Last
Address: ____________________________________ **Apt./Sp.#:** ____________________
City: ________________________________ **State:** __________ **Zip:** ____________
Home Phone #: ( ) ________ - ________ **Work Phone #:** ( ) ________ - ________
Social Security #: ______ - ______ - ______ **Date of Birth:** __________ **Age:** ______ **Male Female**
Race and Ethnicity: __________ **Email:** ______________________________
Employer: ____________________________________ **How Long?** ____________
What type of work do you do? ______________________ **Marital Status: S M D W**

Who referred you to our office? ____________________ **Address:** ____________________

******_**Complete this section only if someone other than the patient is financially responsible**_*********

***Responsible Party:** ____________________ **Relationship to Patient** ____________________
***Home Address:** ____
***Telephone #:** ( ) ______________ **Birthdate:** __________
***Employer:** ______________________ ***Insured ID# or Social Security:** ________________

EMERGENCY CONTACT: (NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU).

Contact Name: ______________________ **Relationship to Patient:** ____________________
Home Phone: ( ) ________ - ________ **Cellular #:** ( ) ________ - ________

WHAT BODY PART ARE WE SEEING YOU FOR?: ______________________________
DATE OF INJURY/ONSET: ____________________

INSURANCE INFORMATION:

Primary Insurance: ____________________ **Policy ID#:** ____________ **Group#** __________
Address: ______________________________ **City/State/Zip** ______________________
Date of Birth: ______/______/______ **Insured Name:** ______________________________

Secondary Insurance: ____________________ **Policy ID#:** ____________ **Group#** __________
Address: ______________________________ **City/State/Zip** ______________________
Date of Birth: ______/______/______ **Insured Name:** ______________________________

Worker's Comp Name & Address: ____
Worker's Comp claim#: ______________________ **Date of Injury:** __________
Work Comp Adjusters Name: ____________________ **Tel#:** ____________ **Fax#:** ____________
Nurse Case Mgr Name: ____________________ **Tel#:** ____________ **Fax#:** ____________

I hereby assign all medical benefits to which I am entitled to Bone & Joint Specialists. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release any information needed to determine these benefits or the benefits for related services.

______________________________________ ____________________
Responsible Party Signature **Date**

Bone & Joint Specialists

Body part being treated for? ______________________________

How did the injury occur & where?

____

Any previous problems with this same body part in the past? ☐ **Yes** ☐ **No**
If yes, Please list: ______________________________

____

Have you been seen by any other doctor for your present problem? ☐ **Yes** ☐ **No**
If yes, which doctor and when? ______________________________

Have X-rays or any diagnostic studies been done? (ex: MRI's;CT;Bone Scan; and EMG studies)
If yes, Where, When and What body part? ______________________________

____

List all prescribed medications you are currently taking and the dosage:

____

____

******PLEASE LIST NAME OF PHARMACY SO THAT IT CAN BE ELECTRONICALLY SENT TO THE PHARMACY******

Pharmacy Name: ______________ **Pharmacy Number:** ______________
Pharmacy Cross Streets: ______________________________

Allergies to Medication: ☐ **Yes** ☐ **No**
If yes, please list which medication: ______________________________

List <u>All</u> Previous Surgeries: ______________________________

____

List <u>All</u> Medical Health Problems: ______________________________

____

What is your height? ________ **Weight?** ________

Do you currently smoke? ☐ **Yes** ☐ **No** **How many packs a day?** ________
If you do not currently smoke, have you ever smoked in the past? ☐ **Yes** ☐ **No**

Do you drink alcohol? ☐ **Yes** ☐ **No** **<u>Socially</u>:** ☐**Yes** ☐**No** **<u>Occasionally</u>:** ☐ **Yes** ☐**No**
Daily: ☐ **Yes** ☐ **No** **How often?** _______

PATIENT NAME: ______________________________ **DATE:** ______________

BONE & JOINT SPECIALISTS

DISCLOSURE:

Bone and Joint Specialists is a for-profit corporation solely owned by the physicians providing medical services to the community.

FINANCIAL POLICY:

PAYMENT FOR MEDICAL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Our office does verify eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your eligibility status. We will do all we can to assist you with your health insurance claims however, insurance is a contract between the insurance company and the insured. Final responsibility for payment of your account rests with you. Our office will bill a secondary insurance only once as a courtesy to the patient. If the insurance does not pay, then the balance becomes the responsibility of the insured.

If you are scheduled for surgery, we require any deductible's as well as coinsurance amounts paid prior to your date of surgery. In addition to the surgeon's fee, there is a need for an assistant at the time of your surgery. The assistant's fee is in addition to the surgeon's fee.

Any prior authorizations obtained by this office on behalf of you, the patient, are not a guarantee of payment, but are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company has received the claim. If you have any questions regarding our medical fees or questions regarding your insurance benefits, please speak with a billing specialist.

A returned check charge of $35.00 will be charged to the account for each returned check.

DELINQUENT AND COLLECTION ACCOUNTS:

- An account becomes delinquent when the minimal monthly payment has not been received within 30 days of the statement date.
- An account that has become delinquent for 60 days, may become a collections account and may be charged a collections handling fee, court cost's and attorney's fee's.
- Exemptions from the above are allowed charges under Medicare and Title XIX (Nevada Medicaid) contracts.
- There may be exceptions to all or any part of the account.
- Balances not paid by your insurance plan within 30 days, will automatically become the responsibility of the responsible party.

CANCELLATION, NO SHOW AND RESCHEDULING POLICY: If you fail to provide us with a 24 hour notice of cancellation or rescheduling, or fail to keep your scheduled appointment, there will be a $50 no-show fee.

I understand that Bone & Joint Specialists may not be a provider on my health plan, and I will be fully responsible for any outstanding charges that my insurance plan does not cover. A photocopy of this assignment is considered as valid as the original.

In the event that my account becomes a delinquent account or a collection account, I agree to pay Bone & Joint Specialists all incurred Finance Charges, Delinquent Account Handling Fee's, Collection Account Handling Fee's and incurred Collection cost's as set forth above in section 3 of the financial policy.

If it is necessary to forward your account to our Collection Agency, a Collection Fee markup of 35 to 50% will be added to the amount owing. Interest will accrue daily at the rate of 1.5% per month or 18% per year.

The mark-up reflects Bone & Joint Specialists receiving only it's billed charges. The additional money will go to the collection agency.

Signature of Responsible Party: ______________________ Date: ____________

BILLING INFORMATION

********ONLY COMPLETE THIS SECTION IF MOTOR VEHICLE ACCIDENT *************

What is the name of the insurance company? ______________________________

Insurance company address: ______________________________

Claims adjusters name: ____________________ **Phone#: (   )** ____________________

DO YOU HAVE AN ATTORNEY FOR YOUR INJURY? **YES** **NO**

Attorney's Name: ____________________ **Phone#: (   )** _________ - ___________

Attorney's Address: ______________________________

IF THERE IS A LIEN SIGNED WITH YOUR ATTORNEY, THERE WILL BE A $250 DEPOSIT REQUIRED

********ONLY COMPLETE THIS SECTION IF INJURED ON THE JOB****************

Did the injury occur at work? **YES** **NO**

If yes, please explain the injury details: ______________________________

____

Date the injury occurred: ____________________

Did you report the injury to a supervisor? **YES** **NO** **Supervisor's Name:** ____________________

Have you had any previous Worker's Compensation injuries in the past? **YES** **NO**

If yes, please explain: ______________________________

PATIENTS NAME: ______________________________ **DATE:** ____________________

Bone and Joint Specialists

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact ANNA HOLLAND, OFFICE MANAGER at (702) 474-7200.

WHO WILL FOLLOW THIS NOTICE:

- Bone and Joint Specialists

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Research**
- **To Provide Information About Organ and Tissue Donation**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or**

Safety
The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.
You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from ANNA HOLLAND, OFFICE MANAGER at (702) 474-7200.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact ANNA HOLLAND, OFFICE MANAGER. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION.
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of this Notice
We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgement will be filed with your records.

Acknowledgement of Receipt of Notice of Privacy Practices for Bone & Joint Specialists

I hereby acknowledge that I have received the Notice of Privacy Practices from Bone & Joint Specialists.

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name: ______________________________ Relationship: _____________________

Name: ______________________________ Relationship: _____________________

Name: ______________________________ Relationship: _____________________

Name: ______________________________ Relationship: _____________________

Signature: ____ Date: _____________

Print Name: ____

Bone & Joint Specialists

2020 Palomino Lane, Suite #220, Las Vegas, NV 89106
2680 Crimson Canyon Dr., Las Vegas, NV 89128
(702) 474-7200 Central office (702) 228-7355 Northwest office

CONTRACT FOR CONTROLLED SUBSTANCES

Controlled substance medication (narcotics-opioids, tranquilizers, barbiturates, i.e. any drug which induces sleep or stupor) can be very useful but have high potential for misuse and abuse and are, therefore, closely controlled by government agencies. Used properly, some of them can be very effective pain medication. If used excessively, however, they can cause adverse effects, such as impaired judgment, vomiting, constipation, lethargy, organ damage, or even death. To ensure these medications are used properly, I agree to the following conditions.

1. I am RESPONSIBLE for my controlled substance medication. IF THE PRESCRIPTION OR MEDICATION IS LOST, STOLEN OR MISPLACED OR IF I USE IT UP SOONER THAN PRESCRIBED, I UNDERSTAND THAT IT MAY NOT BE REPLACED.

2. I will not request or accept narcotic medications from any other physician or individual while I am receiving such medications from my doctor at Bone & Joint Specialists (except if I am in the hospital). Besides being illegal to do so (NRS 453.391), it may endanger my health.

3. **I understand that there will be a 48 hour turnaround time (business hours) for non-narcotic medication refills; therefore, I will not wait until my medication is gone to request more medication. Controlled substances may be obtained only during a scheduled office visit. Refills will not be made at night, on holidays or on weekends.**

4. I understand that if I violate ANY of the above conditions, my controlled substance medication will be **discontinued immediately.**

I am aware of "narcotic effects", including physiological effects of tolerance (need for more medication to achieve the same pain relief) and dependence (withdrawal may occur if I stop my medications abruptly) and the effects of addiction (psychological dependence), which is less common in patients with true pain. I also understand that narcotics can adversely affect my judgment in making business decisions and in operating equipment, such as automobile. I must use special care while involved in activities requiring clear thought and concentration.

Effective October 1, 2015, Senate Bill 459 requires when prescribing narcotics, a pharmacy search is made regarding your medication history. By signing this form, I acknowledge and consent to this state mandated inquiry.

______________________________ ____________________
Signature of Patient/Guardian Date

______________________________ ____________________
Witness Signature Date

*******PATIENTS OF DR. MICHAEL ELKANICH UNDERSTAND THAT I WILL BE SUBJECT TO RANDOM DRUG TESTING******

Bone & Joint Specialists

L U M B A R

Name: ______________________ Age: ________ Date: ____________

Please read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE just circle the one which most closely describes your problem *right now*.**

SECTION 1 – **Pain Intensity**
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 – **Personal Care**
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of pain, I am unable to do any washing or dressing without help.

SECTION 3 – **Lifting**
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very little weights, at the most.

SECTION 4 - **Walking**
A. Pain does not prevent me from walking any distance.
B. I have some pain with walking but it does not increase with distance.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from waling more than ½ mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – **Sitting**
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 – **Standing**
A. I can stand as long as I want without pain.
B. I have some pain while standing but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7 – **Sleeping**
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – **Social Life**
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from social life at all.

SECTION 9 – **Traveling**
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – **Changing Degree of Pain**
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

LUMBAR index score: ________%

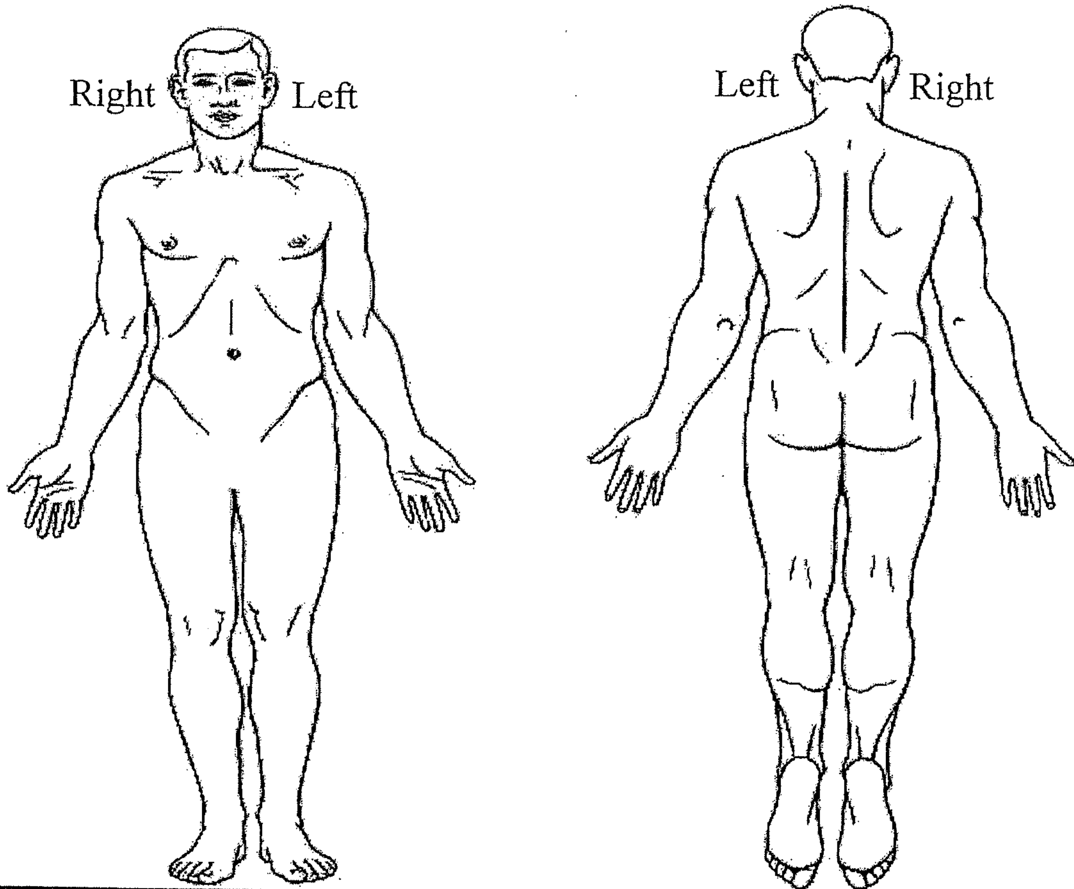
PATIENT SIGNATURE: ____________________

Bone & Joint Specialists

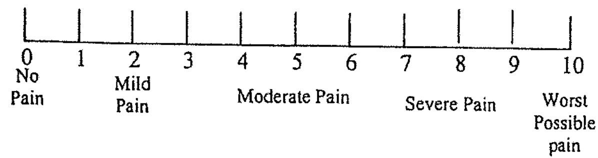
Patient Name: ______________________________

Date: ______________________________

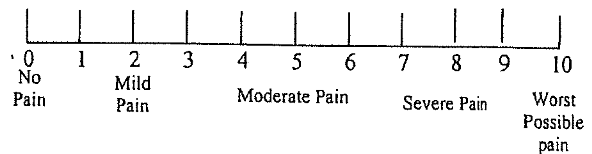
Please mark an "X" on the body part(s) where you have pain.
Mark a "0" on the body parts where you have numbness.



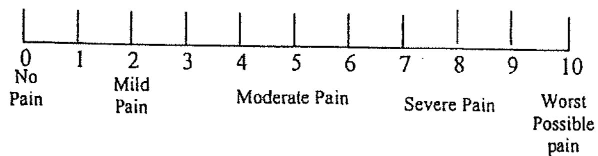
NECK



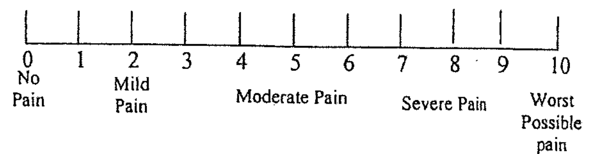
BACK



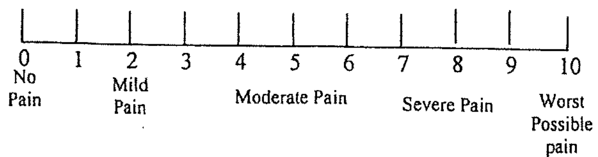
RIGHT ARM



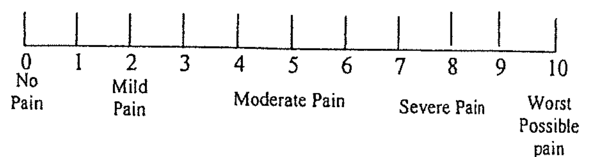
RIGHT LEG



LEFT ARM



LEFT LEG



Bone & Joint
Specialists

REVIEW OF SYMPTOMS

In the past month, have you experienced any of the following?
Please put a check mark in front of any/all of the following that you have experienced.
If you have experienced any of the symptoms, please be sure to notify your family doctor

H.E.E.N.T.

- ☐ Blurred vision
- ☐ Dry Eyes
- ☐ Hard of hearing
- ☐ Nasal Congestion
- ☐ Sore Throat
- ☐ Cough
- ☐ Other________

INTEGUMENTARY

- ☐ Moles
- ☐ Skin Rash
- ☐ Other:______

NEUROLOGIC

- ☐ Tremors
- ☐ Other:______

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Stress
- ☐ Poor sleep
- ☐ Swelling of feet
- ☐ Swollen glands
- ☐ Problems with blood clots
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other________

PULMONARY

- ☐ Shortness of breath
- ☐ Other________

GASTROINTESTNAL

- ☐ Abdominal Pain
- ☐ Other

ABDOMINAL

- ☐ Abdominal Pain
- ☐ Other________

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Other________

WORK STATUS

- ☐ Full Time
- ☐ Regular Duty
- ☐ Other________________________________
- ☐ Restrictions: ____

Bone & Joint Specialists

Patient Name: ______________________

Date: ______________________

This form must be filled out at each office visit.
We are required to have documentation of medications and allergies for each office visit; because of this we are unable to accept "no change" or "same as before" answers on this form.

Medications currently taking | **Dosage** | **Frequency**

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________

Allergies:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________

Pharmacy:

Name: ______________________

Address: ______________________

Phone: ______________________

Bone & Joint Specialists

PATIENT MEDICAL HISTORY

Name: ______________________________ Date: ______________

Height: __________ Weight: ______________ Birthplace: ______________

Reason you are being seen here: ☐ Pain ☐ Disability ☐ Medication

☐ Other: ______________________________

Have you been seen here within the past 3 years? ☐ YES ☐ NO

Hand Dominance: ☐ Left ☐ Right

PAST MEDICAL HISTORY: (Please circle any/all of the following that you have experienced.)

AIDS	Depression	Heart Attack/Angina	Osteoporosis
Anemia	Diabetes	Hepatitis C	Peripheral Vascular Disease
Anxiety Problem	Diverticulosis	High Blood Pressure	Polio
Arthritis	Ear Trouble	HIV	Psychological/Psychiatric Problem
Asthma	Endometriosis	Irregular Heart Beat	Rheumatic Fever
Bipolar Disease	Enlarged Prostate	Irritable Bowel Syndrome	Scoliosis
Cancer	Fibromyalgia	Jaundice	Seizures
Colon Polyp	Gastritis	Kidney Disease	Sexually Transmitted Disease
Congestive Heart Failure	Glaucoma	Kidney Stones	Stroke
COPD/Emphysema	Gout	Liver Disease	Thyroid Disease
Deep Venous Thrombosis	Head Injury	Lupus	Tuberculosis
			Ulcers

Other Medical Problems: ______________________________

Allergies: ______________________________

Injuries: Please list all fractures, injuries, and motor vehicles accidents.

Year Injured	Nature of Injury	Year Injured	Nature of Injury

Hospitalizations/Surgeries:

Year	Reason for Hospitalization/Surgery	Year	Reason for Hospitalization/Surgery

Please continue on the other side ➡

Patient Signature: ______________________

Bone & Joint Specialists

Have you ever had a blood transfusion? ☐ YES ☐ NO

SOCIAL HISTORY:

Do you smoke now? ☐ NO ☐ YES _______ packs/day _______ # of yrs.

Did you smoke in the past? ☐ NO ☐ YES _______ packs/day _______ # of yrs.

Do you drink alcohol? ☐ NO ☐ YES _______ number of drinks/wk.

Do you have a history of drug/alcohol abuse? ☐ NO ☐ YES

Your level of education: ☐ Grade School ☐ High School ☐ Associate Degree ☐ Bachelor Degree ☐ Graduate School

FAMILY HISTORY:

Please check the box of any/all of the following problems that your blood relatives (e.g., parenls, Brothers, sisters, grandparents, aunts, uncles, children), have had:

Illness	Relative/Family Member (i.e., Mom, Grandfather)
☐ Arthritis	
☐ Back or Neck Surgery	
☐ Back Pain/Sciatica	
☐ Cancer	
☐ Diabetes	
☐ Heart Attack/Heart Disease	
☐ High Blood Pressure	
☐ Mental Illness	
☐ Muscle Disease	
☐ Neck Pain	
☐ Nerve Disease	
☐ Stroke	

Relation	Age	State Of Health/ Medical Problems	If Deceased, Cause Of Death	Age At Death
Father				
Mother				
Brothers and Sisters				
Spouse				
Children				

Patient Signature: ______________________

Bone & Joint Specialists

P A T I E N T   Q U E S T I O N N A I R E

Name: ______________________________ Age: __________ Date: __________

JOB DESCRIPTION

Occupation: ______________________ Number of years at this job: __________

Are you currently working? ☐ YES ☐ NO If so..: ☐ Part-time ☐ Full-time

☐ Regular Duty ☐ Modified Duty Working: ________ Hrs/Wk

What are your restrictions, if any? ______________________________

____

Does your job require you to: (please check all that apply)

☐ Lift or carry greater than 15 lbs. ☐ Bend or twist repetitively.

☐ Work overhead. ☐ Repetitive motion of the arms or legs.

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

Date Problem/Symptoms Started: ______________

Location of symptoms/pain when the problem started: ______________________

HOW DID THE PROBLEM START?

☐ Home/Leisure ☐ At Work ☐ Motor Vehicle Accident ☐ Fall ☐ Other: __________

Please briefly describe: ______________________________

Location of symptoms/pain now: ______________________________

Frequency of symptoms/pain: (please check one)

☐ CONSTANT ☐ INTERMITTENT ☐ RARE

Since the onset of symptoms, has the problem: (please check one)

☐ IMPROVED ☐ WORSENED ☐ STAYED THE SAME

Does coughing or sneezing cause any pain? ☐ YES ☐ NO

If so, where? ______________________________

Do any of the following activities make your symptoms worse? (please check all that apply)

☐ WALKING ☐ LYING ☐ BENDING/TWISTING ☐ WORKING OVERHEAD

☐ SITTING ☐ KNEELING ☐ LIFTING/CARRYING ☐ OTHER: __________

☐ STANDING ☐ TYPING ☐ PUSHING/PULLING

List anything (i.e. activities, positions, or treatments) that makes the pain better:

____

Do you have any weakness, if so, which arm, leg or muscle? ______________________

Have you had any new or recurrent problems with: Control of urination? ☐ YES ☐ NO

Bowel movements? ☐ YES ☐ NO

Have you experienced recent weight loss or fevers? ☐ YES ☐ NO

Please continue on the other side ←

PATIENT SIGNATURE: ______________________

Bone & Joint Specialists

HISTORY OF TREATMENT OF THIS PROBLEM

DIAGNOSTIC HISTORY

TEST	RECEIVED		DATE OF TEST/LOCATION
X-ray	☐ YES	☐ NO	______
MRI Scan	☐ YES	☐ NO	______
CT Scan	☐ YES	☐ NO	______
Bone Scan	☐ YES	☐ NO	______
EMG	☐ YES	☐ NO	______
Other: ______	☐ YES	☐ NO	______

MEDICATIONS *(If yes, please circle the medication below.)*	EXAMPLES	RECEIVED		DID THIS HELP?	
Anti-Inflammatories/ Cox-2 Inhibitors	Naprosyn, Ibuprofen, Vioxx Voltaren, Celebrex, Bextra	☐ YES	☐ NO	☐ YES	☐ NO
Muscle Relaxers	Soma, Flexeril, Skelaxin, Zanaflex	☐ YES	☐ NO	☐ YES	☐ NO
Pain Medication	Tylenol w/ Codeine, Vicodin, Darvocet, Percocet	☐ YES	☐ NO	☐ YES	☐ NO
Oral Steroid	Prednisone, Medrol Dose Pak	☐ YES	☐ NO	☐ YES	☐ NO
Neurontin, Zonegram, Paxil, Amitriptyline, Nortriptyline, Pamelor, Elavil, Prozac		☐ YES	☐ NO	☐ YES	☐ NO
Other	*Please list:* ______	☐ YES	☐ NO	☐ YES	☐ NO

TREATMENTS	RECEIVED		DID THIS HELP?	
Physical Therapy/ Exercise	☐ YES	☐ NO	☐ YES	☐ NO
Chiropractic Care	☐ YES	☐ NO	☐ YES	☐ NO
Injections in Muscle or other injections in office	☐ YES	☐ NO	☐ YES	☐ NO
Epidural Steroid Injections	☐ YES	☐ NO	☐ YES	☐ NO
Facet Blocks	☐ YES	☐ NO	☐ YES	☐ NO
Braces/Corsets	☐ YES	☐ NO	☐ YES	☐ NO

Back Surgery: ☐ Cervical ☐ Thoracic ☐ Lumbar When: ______

Prior to the onset of your current problem, did you ever visit a health care provider for problems with your spine? ☐ YES ☐ NO If yes, please list...

PHYSICIAN NAME	MONTH/YEAR OF TREATMENT

LEGAL ADVICE

Do you have an attorney regarding this injury/problem? ☐ YES ☐ NO

If yes, please list your attorney's name: ______

PATIENT SIGNATURE: ______