Intermountain Spine & Orthopaedics

PATIENT INFORMATION

PLEASE PRINT AND FILL OUT **ALL INFORMATION**

Primary Doctor:	**Referring Provider:**

PATIENT INFORMATION

Patient's First name:	Middle:	Last:

Marital status (circle one) Single / Mar / Div / Sep / Wid	Age:	Birth date:	Social Security No:

Street address:	Home phone no.:

City:	State:	ZIP Code:	Employer:

Email:

PARENT OR GUARDIAN INFORMATION (IF UNDER THE AGE OF 18)

First name:	Middle:	Last:

Marital status (circle one) Single / Mar / Div / Sep / Wid	Age:	Birth date:	Social Security No:

Street address (If different):	Home phone no.:

City:	State:	Zip Code:	Employer:

Email:

IN CASE OF EMERGENCY

Name :	**Relationship to patient:**	**Home phone no.:** ( )

INTERMOUNTAIN SPINE
AND ORTHOPAEDICS
COMPASSION EXCELLENCE INTEGRITY

Intermountain Spine & Orthopaedics

David M. Christensen, MD

1411 Falls Ave E Suite 1301 • Twin Falls, Idaho 83301
Phone: (208) 732-0067 • Fax: (208) 732-3195 • www.imspineortho.com

RESPONSIBILITY FOR PAYMENT / ASSIGNMENT OF BENEFITS / CONTRACT

In consideration of the treatment provided at ISO to me or my child or dependent, I agree to pay ISO for such treatment. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover the treatment, I authorize ISO to bill any such insurer for all charges incurred in connection with the diagnosis, care and treatment. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered by my health insurance, Medicare, Medicaid or any other programs for which I am eligible. I understand that certain payments may be required at the time of, or in advance of, services being provided. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them. I understand and acknowledge that:

- If I elect to pay for medical treatment in cash, in full, before services are provided, I can request that my health insurance, in any form, not be billed for that service or be notified that the service was provided.
- I am responsible for notification to my insurance company to obtain authorization before service is rendered, and if I do not pre-certify for such services, my benefits may be reduced or lost, but I will still be responsible for paying ISO for those services. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.
- If I do not consent, or later revoke my consent, to the release of my information to any insurer that I have identified, I will be responsible to pay all listed charges for the treatment and services received.

I hereby assign ISO and the professionals involved in my care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which benefits may be available to pay for the services provided to me, and authorize payment for such services to be made directly to ISO.

If I default or do not pay for treatment(s) provided, I acknowledge and agree that ISO is entitled to recover the full amount of the debt owed for medical services and is entitled to the right of recovery of all collection expenses, including litigation or arbitration costs, and the reasonable attorney's fees incurred for the purpose of securing payment. Collection expenses and/or attorney fees include the fee charged to ISO to complete the collection. For example, if a collection agency or law firm charges 20% of the amount collected as their fee, ISO will add 20% to my bill and the collection agency or law firm will then earn 20% of the amount collected.

I agree that in order for ISO to service my account or to collect any amounts I may owe, Bonneville Collections or a vendor acting on its behalf, may contact me by telephone at any telephone number associated with my account, including cellular telephone numbers, which could result in charges to me. I agree that ISO or a vendor acting on its behalf may also contact me by sending text messages or e-mails, using any e-mail address I have provided. I acknowledge and agree that methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I HAVE READ, UNDERSTOOD AND FULLY AGREE TO each of the above statements and sign below as my free and voluntary act. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ISO or insurance company to release any information required to process my claims.

Patient or Authorized Person Signature	Relationship & Printed name	Date

Staff Signature	Date

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PLEASE NOTE AT ANY GIVEN TIME YOUR APPOINTMENT CAN BE RESCHEDULED

CONSENT FOR TREATMENT

I consent to evaluation and treatment of the condition for which I, or my child or dependent, have presented to Intermountain Spine and Orthopaedics (ISO) for, and authorize the physicians and/or other health care providers affiliated with ISO to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelyhood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by ISO. I authorize ISO to examine, use, store and dispose of all tissue, fluids, or specimens removed from my body. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at ISO.

PATIENT RIGHTS AND RESPONSIBILITIES

I understand that I have the right, and the responsibility, to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting complaint, to agree upon a treatment plan, and to follow that plan. I understand that my health care providers will treat me with respect and I agree to do the same for them.

USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that ISO will use and disclose my health information for the purposes of treatment, payment, and healthcare operations, as permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me. I understand and acknowledge that ISO may record medical and other information related to my treatment in paper, electronic, photographic, video, and other formats; and such information will be used in the course of my treatment, for payment purposes and to support healthcare operations. I give ISO, its employees, and agents consent to exchange information with other health care professionals and providers (i.e. physicians, consultants, hospitals, nursing homes, home health agencies and pharmacies) about my prior and current health conditions to facilitate treatment, or to facilitate discharge planning.

I HAVE READ, UNDERSTOOD AND FULLY AGREE TO each of the above statements and sign below as my free and voluntary act.

Patient or Authorized Person Signature	Relationship & Printed Name	Date

Staff Signature	Date

INTERMOUNTAIN SPINE
AND ORTHOPAEDICS
COMPASSION EXCELLENCE INTEGRITY

Pain Medication and Prescription Policy

Intermountain Spine and Orthopaedics, ISO, can only provide pain medication for patients who require a surgical procedure. Our practice does not provide long term pain management services. The following outlines our pain medication prescription policy.

- Patients may be prescribed pain medication during our initial consultation and surgical preparation period, if it is felt that surgery will likely be required. If surgery is not required, the patient will be referred back to his or her primary care provider to manage pain or make additional referrals. However, should patient have a contractual pain management agreement with another provider this precludes ISO from prescribing any medications.

- If surgery is necessary, pain medication will be prescribed prior to surgery if needed. Pain medication may also be prescribed for a predetermined period of time after the procedure is performed. During the recovery process, the amount of medication will be gradually reduced to help the patient avoid dependence on the drug.

- Pain medications must be taken as prescribed. Patients are not to increase medication dosage without consulting ISO.

- Improper use of medications can lead to the termination of the physician-provider relationship.

- Once pain medications are prescribed by our providers, you agree that our office will solely manage those pain medications; in other words, you agree not to take pain medications prescribed by other physicians. You further agree to use only one pharmacy to fill your prescriptions. Failure to follow these guidelines will result in discharge from the practice.

- Pain medications and prescriptions should be kept in a safe place. No medication that is lost or stolen will be replaced. We do not accept police reports or any other reports as proof of theft.

- You agree not to drive motor vehicles or operate heavy machinery while taking narcotic pain medication.

- You agree not to use alcohol or recreational drugs while taking any prescription medication.

- As your providers may not always be available in the office, please call for a refill at least 48-72 hours prior to running out of your medication.

- **Requests for prescription refills can only be accepted during regular office hours on Monday through Thursday. Prescriptions cannot be filled in the evenings, on weekends, or holidays because we must have access to patient medical records. Refill requests received after noon on Friday will not be filled until the following week.**

- If long-term pain management is required, the patient will be referred to a pain management clinic or to his or her primary care provider. After you have been referred to a pain management clinic or other specialty, released to your primary, our office will no longer prescribe pain medications.

I have read and understand the above stated Pain Medication and Prescription Policy for Intermountain Spine and Orthopaedics.

Signature of Patient or Responsible Party	Staff Signature	Date

INTERMOUNTAIN SPINE
AND ORTHOPAEDICS
COMPASSION EXCELLENCE INTEGRITY

Date: ☐☐ / ☐☐ / ☐☐☐☐

Please PRINT and fill out completely.

Shade circles like this: ●

Name _____ Age _____ yrs. D.O.B. _____

Height ☐ ft ☐☐ in Weight ☐☐☐ lbs Sex ○ Male ○ Female Are you or could you be pregnant? ○ Yes ○ No

Your Occupation _____ Employer _____

Who referred you to this office? ○ Dr. _____ ○ PA/NP _____
If more than one, please note.

HISTORY OF CARE

Who is your primary care physician? _____ Location: _____
Address: _____ Phone: _____

Please list any other doctors, clinics, or hospitals you have seen for your current _____ problems:

Name	*City*	*Date of First Visit*	*Currently Continuing?*

HISTORY OF CURRENT _____ PROBLEMS

List your chief complaints or main problems with the most severe first:
1. _____
2. _____
3. _____

Describe all details of any accident, incident or the way these problems began:
_____
_____
_____
_____

CURRENT SYMPTOMS

What time of day is your pain at its worst? ○ Morning ○ Afternoon ○ Evening ○ Night ○ Not Applicable

Does the pain wake you up at night? ○ Yes ○ No

In the past six months have you experienced: ○ Fever ○ Weight Loss _____ lbs ○ Chills ○ Night Sweats

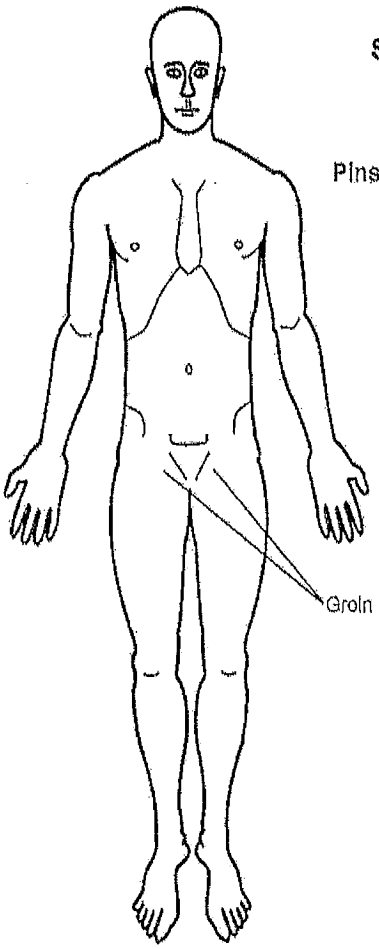
How would you describe your pain? ○ Constant ○ Constant, but worse with activity ○ Intermittent (comes and goes) ○ Intermittent, but worse with activity

Do you have full control of your bladder? ○ Yes ○ No

Do you have full control of your bowels? ○ Yes ○ No

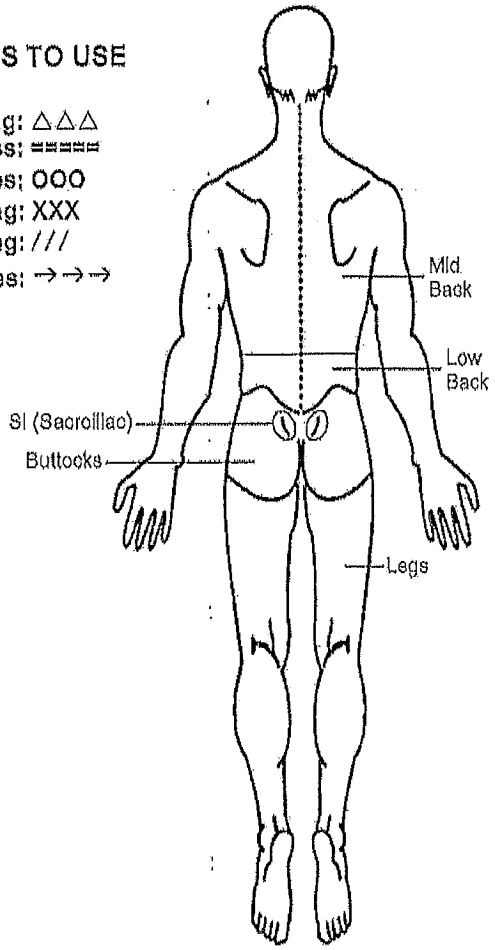
PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, include all affected areas.



SYMBOLS TO USE

Aching: △△△
Numbness: ======
Pins & Needles: OOO
Burning: XXX
Stabbing: ///
Radiates: →→→



Mark where any symptoms (pain, numbness, weakness, etc.) exist on average (most of the time) and at their worst.

		None										Unbearable
Current mid back pain	Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current low back pain	Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current SI pain	Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current buttock	Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current groin pain	Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current leg pain	Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

PAST MEDICAL HISTORY

Check if you currently are being treated for or have been diagnosed with:

	When?		When?
○ High Blood Pressure		○ Osteoporosis	
○ Diabetes		○ Kidney Disease/Problem	
○ Liver Disease		○ Seizures	
○ Heart Disease or Attack		○ Arthritis	
○ Stroke		○ Thyroid	
○ Cancer		○ Tuberculosis	
○ High Lipids (cholesterol, etc.)		○ Psoriasis	
○ Ulcer Disease		○ Polio	
○ Gastritis		○ Rheumatic Fever	
○ Reflux Disease (GERD)		○ Gout	
○ Asthma		○ Herpes Simplex	
○ Depression		○ **Other**	
○ Bipolar Disease			
○ Other Psychiatric			

Have you ever had a history of blood clots or pulmonary embolus? ○ Yes ○ No

SURGERIES

Please list all ***spine*** surgeries you have had in the past:

Type of Surgery	*Date*	*Surgeon*

Please list all ***other*** surgeries you have had in the past:

Type of Surgery	*Date*	*Surgeon*

MEDICATIONS

Please list ALL medications you are ***currently*** taking, including prescription and over the counter:

Medication	*Dosage*	*Frequency (how many pills in a 24 hours)*

ALLERGIES

Please list any ***allergies or adverse reactions*** you have to medications:

Medication	*What Happened?*

FAMILY HISTORY

Is your father alive? ○ Yes ○ No IF YES, age and any major medical problems? _____

IF NO, age at time of death? _____ What major medical problems did he have? _____

Is your mother alive? ○ Yes ○ No IF YES, age and any major medical problems? _____

IF NO, age at time of death? _____ What major medical problems did she have? _____

Any siblings? ○ Yes ○ No How many? _____

SOCIAL HISTORY

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Living with other

Education level achieved: ○ Grade School ○ Jr. High ○ High School ○ College ○ Post. Graduate

DO you currently smoke cigarettes? ○ Yes ○ No Number of Years Smoked: ☐☐

Packs per Day: *(Please choose the closest)* ○ < 1/2 ○ 1/2 ○ 1 ○ 2 ○ > 2

DID you smoke cigarettes in the past? ○ Yes ○ No Number of Years Smoked: ☐☐ Quit Date: ☐☐ / ☐☐ / ☐☐☐☐

Packs per Day: *(Please choose the closest)* ○ < 1/2 ○ 1/2 ○ 1 ○ 2 ○ > 2

Do you use any other tobacco products? ○ Yes ○ No What kind? _____ Quantity: _____

Do you use any recreational drugs? ○ Yes ○ No What kind? _____

Do you drink alcohol? ○ Yes ○ No Drinks per Day: ☐☐ Drinks per Week: ☐☐ Years:

DO YOU HAVE OR HAVE YOU HAD an unhealthy relationship with alcohol? ○ Yes ○ No

Type of alcohol consumption: ○ Beer ○ Wine ○ Mixed Drinks

WORK HISTORY

Are you currently: ○ employed ○ unemployed ○ retired ○ on sick leave ○ on disability ○ a stay at home parent

Has your job changed since your symptoms started? ○ Yes ○ No ○ Not Working

If you are at a different job or not working, did your symptoms play a role in your job change or decision not to work? ○ Yes ○ No

If you are working, are you on: ○ Normal duties ○ Light duties

If you are on light duty, did your current symptoms play a role? ○ Yes ○ No

Are you applying for disability? ○ Yes ○ No

Please describe your job _____

WORKMAN'S COMPENSATION HISTORY

IS THIS A WORKERS COMPENSATION CASE? ○ Yes ○ No

Have you had any PRIOR workers compensation injuries? ○ Yes ○ No If yes, how many? ☐☐

Please list any prior workers compensation cases/injuries:

Date	*Area Injured*	*Time off Work*	*Who Treated You?*

Were you at work when your symptoms began? ○ Yes ○ No

Did you have a specific accident or injury while at work to cause your symptoms? ○ Yes ○ No

What is the company name? _____

Prior to your WC injury, how long had you been employed by that company? ☐☐ months OR ☐☐ years

Do you currently have an attorney for this episode? ○ Yes ○ No

OSWESTRY LOW BACK PAIN DISABILITY INDEX

Please read instructions:
This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Shade circles like this: ●

Pain Intensity
- ○ I have no pain at the moment
- ○ The pain is very mild at the moment
- ○ The pain is moderate at the moment
- ○ The pain is fairly severe at the moment
- ○ The pain is very severe at the moment
- ○ The pain is the worst imaginable at the moment

Personal Care (Washing, Dressing, etc)
- ○ I can look after myself normally, without causing extra pain
- ○ I can look after myself normally, but it is very painful
- ○ It is painful to look after myself and I am slow and careful
- ○ I need some help, but manage most of my personal care
- ○ I need help every day in most aspects of self care
- ○ I do not get dressed, wash with difficulty and stay in bed

Lifting
- ○ I can lift heavy weights without extra pain
- ○ I can lift heavy weights, but it gives extra pain
- ○ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
- ○ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ○ I can lift only very light weights
- ○ I cannot lift or carry anything at all

Walking
- ○ Pain does not prevent me walking any distance
- ○ Pain prevents me walking more than 1 mile
- ○ Pain prevents me walking more than 1/4 of a mile
- ○ Pain prevents me walking more than 100 yards
- ○ I can only walk using a stick or crutches
- ○ I am in bed most of the time and have to crawl to the toilet

Sitting
- ○ I can sit in any chair as long as I like
- ○ I can sit in my favorite chair as long as I like
- ○ Pain prevents me from sitting for more than 1 hour
- ○ Pain prevents me from sitting for more than 1/2 hour
- ○ Pain prevents me from sitting for more than 10 minutes
- ○ Pain prevents me from sitting at all

Standing
- ○ I can stand as long as I want without extra pain
- ○ I can stand as long as I want but it gives me extra pain
- ○ Pain prevents me from standing for more than 1 hour
- ○ Pain prevents me from standing for more than 1/2 hour
- ○ Pain prevents me from standing for more than 10 minutes
- ○ Pain prevents me from standing at all

Sleeping
- ○ My sleep is never disturbed by pain
- ○ My sleep is occasionally disturbed by pain
- ○ Because of pain I have less than 6 hours of sleep
- ○ Because of pain I have less than 4 hours of sleep
- ○ Because of pain I have less than 2 hours of sleep
- ○ Pain prevents me from sleeping at all

Sex Life (if applicable)
- ○ My sex life is normal and causes no extra pain
- ○ My sex life is normal but causes some extra pain
- ○ My sex life is nearly normal but is very painful
- ○ My sex life is severely restricted by pain
- ○ My sex life is nearly absent because of pain
- ○ Pain prevents any sex life at all

Social Life
- ○ My social life is normal and causes me no extra pain
- ○ My social life is normal, but increases the degree of pain
- ○ Pain has no significant effect of my social life apart from limiting my more energetic interests, e.g., sports, etc.
- ○ Pain has restricted my social life and I do not go out as often
- ○ Pain has restricted my social life to my home
- ○ I have no social life because of pain

Traveling
- ○ I can travel anywhere without pain
- ○ I can travel anywhere but it gives extra pain
- ○ Pain is bad but I manage journeys over two hours
- ○ Pain restricts me to journeys of less than one hour
- ○ Pain restricts me to short necessary journeys under 30 minutes
- ○ Pain prevents me from traveling except to receive treatment

THE NECK DISABILITY INDEX

Please read instructions: Shade circles like this: ●

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 mark in each section only the ONE box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Pain Intensity

- ○ I have no pain at the moment
- ○ The pain is very mild at the moment
- ○ The pain is moderate at the moment
- ○ The pain is fairly severe at the moment
- ○ The pain is very severe at the moment
- ○ The pain is the worst imaginable at the moment

Personal Care (Washing, Dressing, etc)

- ○ I can look after myself normally, without causing extra pain
- ○ I can look after myself normally, but it is very painful
- ○ It is painful to look after myself and I am slow and careful
- ○ I need some help, but manage most of my personal care
- ○ I need help every day in most aspects of self care
- ○ I do not get dressed, wash with difficulty and stay in bed

Lifting

- ○ I can lift heavy weights without extra pain
- ○ I can lift heavy weights, but it gives extra pain
- ○ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
- ○ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ○ I can lift only very light weights
- ○ I cannot lift or carry anything at all

Reading

- ○ I can read as much as I want to, with no pain in my neck
- ○ I can read as much as I want to, with slight pain in my neck
- ○ I can read as much as I want to, with moderate pain in my neck
- ○ I can't read as much as I want, because of moderate pain in my neck
- ○ I can hardly read at all, because of severe pain in my neck
- ○ I cannot read at all

Headaches

- ○ I have no headaches at all
- ○ I have slight headaches that come infrequently
- ○ I have moderate headaches that come infrequently
- ○ I have moderate headaches that come frequently
- ○ I have severe headaches that come frequently
- ○ I have headaches almost all the time

Concentration

- ○ I can concentrate fully when I want to, with no difficulty
- ○ I can concentrate fully when I want to, with slight difficulty
- ○ I have a fair degree of difficulty in concentrating when I want to
- ○ I have a lot of difficulty in concentrating when I want to
- ○ I have a great deal of difficulty in concentrating when I want to
- ○ I cannot concentrate at all

Work

- ○ I can do as much work as I want to
- ○ I can do my usual work, but no more
- ○ I can do most of my usual work, but no more
- ○ I cannot do my usual work
- ○ I can hardly do any work at all
- ○ I cannot do any work at all

Driving

- ○ I can drive my car without any neck pain
- ○ I can drive my car as long as I want, with slight pain in my neck
- ○ I can drive my car as long as I want, with moderate pain in my neck
- ○ I can't drive my car as long as I want, because of moderate pain in my neck
- ○ I can hardly drive at all, because of severe pain in my neck
- ○ I cannot drive my car at all

Sleeping

- ○ My sleep is never disturbed by pain
- ○ My sleep is occasionally disturbed by pain
- ○ Because of pain, I have less than 6 hours of sleep
- ○ Because of pain, I have less than 4 hours of sleep
- ○ Because of pain, I have less than 2 hours of sleep
- ○ Pain prevents me from sleeping at all

Recreation

- ○ I am able to engage in all my recreation activities, with no neck pain at all
- ○ I am able to engage in all my recreation activities, with some neck pain
- ○ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck
- ○ I am able to engage in few of my recreation activities, because of pain in my neck
- ○ I can hardly do any recreation activities, because of pain in my neck
- ○ I can't do any recreation activities at all

Thank you for filling out this questionnaire. Even if you feel great, we would like you to complete the form.
If you would like to receive your questionnaires via e-mail please enter your e-mail address here: