Cornerstone Integrated HEALTHCARE
A Collaborative Approach to Orthopedic Medicine

Comprehensive Health History Forms

Patient Information

Patient Name: _____
(last) *(first)* *(middle initial)*

Address: _____

City: _____ State _____ Zip _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Work Ph: (_____) _____ Best Contact: Phone Text Email

Email: _____ Sex: M or F

DOB: _____ Age: _____

Status: □ Single □ Married □Widowed □Divorced □Separated □Minor

Occupation: _____

If retired what did you do? _____

Employer: _____

In Case of Emergency

Name: _____ Relationship _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

How Did You Hear About Us?

□ Referral: _____ □ Direct Mail
□ Internet □ Magazine
□ TV □ Other: _____

Informed Consent

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinical services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

Patient Signature (Date)

HIPAA Consent

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Patient Signature (Date)

Insurance Information

Who is responsible for this account? □ Self □ Other: _____

If other, what is the relationship to patient: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Is the patient covered by additional Insurance? □ Yes □ No

Subscribers Name: _____

DOB: _____ SS#: _____

Relationship to Patient: _____

Insurance Company: _____

Policy # _____ Group # _____

Assignment and Release

I understand and agree that (regardless of whatever health or medical benefits I have), **I am ultimately responsible to pay CORNERSTONE INTEGRATED HEALTHCARE, LLC, the balance due on my account for any professional services rendered and for any supplies, tests or medications provided**.

I hereby authorize payment of any health insurance or medical plan benefits directly to CORNERSTONE INTEGRATED HEALTHCARE, LLC, for medical services rendered and for any supplies, tests or medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to CORNERSTONE INTEGRATED HEALTHCARE, LLC, all rights to payments and benefits and all legal and other health plan that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies).

This assignment includes, but not limited to, a designation that CORNERSTONE INTEGRATED HEALTHCARE, LLC, can act on my/our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to CORNERSTONE INTEGRATED HEALTHCARE, LLC, as a result of services rendered by CORNERSTONE INTEGRATED HEALTHCARE, LLC, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer.

This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print Name of Patient, Parent, Guardian or Personal Representative

_____ _____
Relationship to Patient Date

Sig

Current Medications

Medication	Dosage	Frequency

Allergies: _____

Reaction? _____

Do you have any surgical devices in your body? (*i.e. screws, pins, plates, etc.)*

□ Yes □ No If yes, where located _____

Demographics:

Race: □ White □ African American □ Asian □ Other
□ American Indian □ Pacific Islander

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Surgical history: (procedure and year)_____

_____

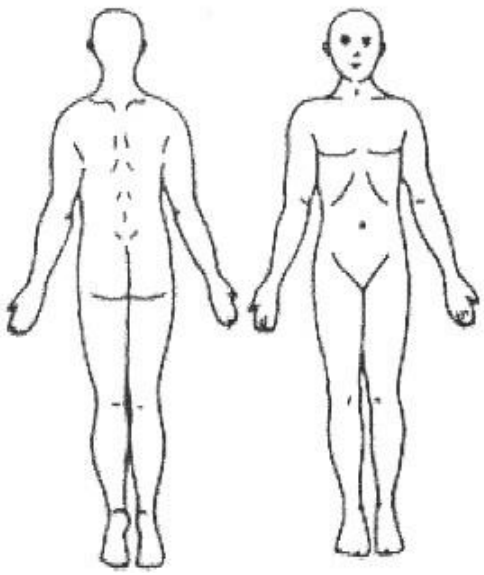
_____

_____

_____

_____

_____



Label on the Diagram the CURRENT Areas of Discomfort:

A= Aching
B= Burning
C= Cramps
D= Dull
N= Numbness
P= Pins&Needles
S= Stabbing
SH= Sharp
ST= Stiffness
SW= Swelling
T= Tingling

Current Condition

What Brought you in today?_____

_____

Has it occurred before? □ Yes □ No When? _____

Description (circle): Pain, Stiffness, Soreness Tightness, Numbness, Tingling Aching Other_____

How did it occur (circle): Unknown, Falling, Lifting a heavy object, Awakening, Bending, Sports, Other_____

When did this episode begin? _____

Type of onset (circle): Unknown, Gradual, Spontaneous, Sudden, Traumatic, Insidious, Other_____

Frequency (circle): 25%, 50%, 75%, 100%

What makes it worse_____

What makes it better_____

Is it radiating anywhere? _____Where?

_____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

Are you seeing another physician for this problem? _____

Who?_____

Do you wear a brace for this problem? _____

What treatment have you received for your condition?
□ Medication □ Surgery □ Physical Therapy □ Chiropractic Services
□ None □ Other

_____

Please list Current and Ongoing Problems in Order of Severity:

1. Problem _____
   □ Mild □ Moderate □ Severe

   Treatment/Approach _____
   Success: □ Excellent □ Good □ Fair

2. Problem _____
   □ Mild □ Moderate □ Severe

   Treatment/Approach _____
   Success: □ Excellent □ Good □ Fair

Primary Care Physician

Primary Care Physician's Name _____

Clinic Name _____

Phone Number _____

I allow my health progression to be shared with my primary care physician:

□ Yes □ No

Patient Name _____ Patient Signature _____ Date_____

Lifestyle History

Check Your Exercise Levels:

□ **Inactive** □ **Light Activity** □ **Moderate Activity**

□ **Heavy Activity** □ **Vigorous Activity**

Please check all that apply:

Do you currently used Tobacco – □ Yes □ No

Type _____ Amt/Day: _____

Have you previously used tobacco? _____Year Quit_____

Alcohol Drinks/Week: _____

Coffee/Caffeine Drinks Cups/Day: _____

Do you currently or have previously used recreational drugs? □ Yes □ No

If yes, what types/method (IV, inhaled, smoked, etc.) _____

_____

Work Activity

Labor Activity:

□ Light □ Moderate □ Heavy □ Sedentary

Work Activity Postures:

□ Bending □ Climbing □ Kneeling □ Pulling

□ Pushing □ Reaching □ Sitting □ Standing

□ Twisting □ Walking □ Computer □ Repetitive

Work Activity Level:

□ Full-Time □ Part-Time □ Homemaker □ Student □ Unemployed

Hours per week _____ Mostly □ Sitting □ Walking □ Standing

Work Environment:

□ Difficult □ Enjoyable □ Relaxed □ Stressful

Daily Activities

Effects of Current Condition on Daily Performance

Circle Each area of life that is affected

None
Almost any movement
Performing personal care
Turning head side to side
Reading
Looking over shoulder
Lifting arm over head
Computer work
Concentrating
Driving
Lifting
First thing in the morning
Walking
Sitting to standing
Sitting
Bending
Sleeping
Gardening
Carrying
Doing chores
Walking up stairs
Walking downstairs
Standing
Getting in and out of vehicle
Laying on affected side
Other_____

Health History Please check all that apply (past or present)

___ Arthritis
___ Rheumatic Arthritis
___ Bursitis
___ Osteoporosis
___Osteopenia
___ Fractures, Which bones?_____
_____
___ Herniated Disc
___ Pinched nerve
___Scoliosis
___Posthesis
___ Cancer, Of what?_____
_____
___ Headaches
___ Migraine Headaches
___ ADD
___ Alcoholism
___ Addiction
___ Eating Disorder
___ Depression
___ Alzheimer's
___ CVA (stroke)
___ Parkinson's Disease
___ Herpes/Lesions/Shingles
___ Constipation
___ CVA (Stroke)
___ Suicide Attempt(s)
___ Seizure Disorder
___ Multiple Sclerosis
___ Psychiatric Care
___ Eye problems
___ Cataracts
___Glaucoma
___Ear Infections
___Vertigo
___Anemia
___Hypothyroid
___Hyperthyroid

___**Lung Disease**
Describe_____
___Allergies
___Asthma
___COPD
___Pneumonia
___Sinusitis
___Sleep Apnea
___Tuberculosis
___Breast Lump
___**Heart Disease**
Describe_____
___Heart Failure
___High Blood Pressure
___High Cholesterol
___Blood Clots
___Blood Transfusion
___Pacemaker
___Atopic Dermatitis
___Psoriasis
___Eczema
___Lupus
___**Gastrointestinal Disease**
Describe_____
___Constipation
___Crohn's Disease
___Colitis
___Hepatitis
___Ulcer
___Diabetes
___Hernia
___Gallbladder Disease
___ Pacemaker
___ Parkinson's Disease
___ Pinched Nerve
___ Pleurisy
___ Polio
___ Prostate Problems
___ Prosthesis

Review of Systems: (please circle all that apply):

GENERAL:
fever chills fatigue
MUSCULOSKELETAL:
Other than stated above
_____
NEUROLOGICAL:
Dizziness fainting seizures
HEENT:
eye pain blurry/double vision discharge ear pain
discharge ringing, denies bleeding gums, sore throat and sore tongue, denies nose bleeds, stuffiness and drainage, denies swollen glands, lumps and goiter, eye pain, sore throat.
- CARDIOVASCULAR:
chest pain, palpitations, shortness of breath
- RESPIRATORY:
coughing, wheezing, production of phlegm
- GI: nausea, vomiting, diarrhea, abdominal pain.
- GU: urgency, frequency and pain.
- ENDOCRINE: polyuria, heat/cold intolerance, polydipsia.
- DERM/HEME: rashes, itching and redness.

Patient Name _____ Patient Signature _____ Date_____

Cornerstone Integrated HEALTHCARE
A Collaborative Approach to Orthopedic Medicine

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The Notice contains a patient's rights section describing your rights under law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how you protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

May we phone, email, or send a text to you to confirm your appointments? ◯YES ◯ NO

If yes, please CIRCLE your phone provider:

VERIZON AT&T T-MOBILE SPRINT CRICKET OTHER: _____

May we leave a message on your answering machine or on your cell phone? ◯YES ◯ NO

May we discuss your medical condition with any member of your family? ◯YES ◯ NO

If YES, please name the members allowed: _____

This consent was signed by: _____

Signature: _____ Date: _____