CENTRAL OREGON
SPINE & SPORTS

H: _____
W: _____
BP: _____
P: _____
BMI _____

Name: _____ Age:_____ Date of Appt: _____

PHARMACY PHONE: _____

E-MAIL ADDRESS: _____

Would you like to subscribe to our newsletter? ❑ Yes ❑ No

DOCTOR OR THERAPIST THAT REFERRED YOU TO US: _____

❑ SELF REFERRAL

PRIMARY CARE PHYSICIAN'S NAME: _____

Are you: ❑ Male ❑ Female ❑ Right handed ❑ Left handed ❑ Ambidextrous

Race/Ethnicity: _____

CHIEF COMPLAINT

Reason for visit: _____

Location of your pain: ❑ Head ❑ Shoulder ❑ Mid Back ❑ Leg ❑ Ankle/Foot ❑ Wrist/Hand ❑ Neck
❑ Headaches ❑ Low Back ❑ Knee ❑ Hips/Buttocks ❑ Arm

HISTORY OF PRESENT ILLNESS

Date of injury or symptom onset: _____

Type of injury: ❑ Sports Injury ❑ Job Accident

❑ Car Accident Driver? ❑ Yes ❑ No Passenger? ❑ Yes ❑ No Seatbelted? ❑ Yes ❑ No

Other (explain):_____

Please describe how you injured yourself: _____

_____

_____

Please describe your current symptoms: _____

_____

_____

Circle the number that corresponds to the severity of your pain on a scale of 0-10.

"0" means no pain and "10" is the worst pain you can imagine.

At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its best: : 0 1 2 3 4 5 6 7 8 9 10

Which of the following best describes the character of your pain?

Timing:

❑ Continuous, steady, constant

❑ Rhythmic, periodic, intermittent

❑ Brief, momentary, transient

Frequency: _____ Duration: _____

Quality:

❑ Throbbing ❑ Burning

❑ Aching ❑ Tingling/numbness

❑ Sharp ❑ Superficial

❑ Dull ❑ Deep

What makes your pain worse? _____

What makes your pain better? _____

How long/far can you: Sit _____ Stand _____ Walk _____

Since your injury is your pain: ❑ Better ❑ Same ❑ Worse

If your pain is changed, what percentage? (Please circle) 10 20 30 40 50 60 70 80 90 100%

Have you had any loss of bowel or bladder control? ❑ Yes ❑ No

PREVIOUS TREATMENT

Have you had treatment since your injury? ❑ Yes ❑ No

Have you been to the ER for this? ❑ Yes ❑ No

Have you had any of the following tests or procedures performed:

X-Rays? ❑ Yes ❑ No CT Scan? ❑ Yes ❑ No MRI? ❑ Yes ❑ No EMG? ❑ Yes ❑ No Epidurals? ❑ Yes ❑ No

Other (please explain): _____

Medical:

Dr. _____ Date of 1st visit_____ Last visit_____

Diagnosis given: _____

Medication given: _____

Treatment provided: _____

Chiropractic: ❑ No ❑ Yes

Dr. _____ Date of 1st visit_____ Last visit_____

Diagnosis given: _____

Frequency: ❑ Everyday ❑ Three times/week ❑ Two times/week ❑ Weekly

Has it helped? ❑ No ❑ Yes

Physical Therapy: ❑ No ❑ Yes

Therapist _____ Date of 1st visit_____ Last visit_____

Has it helped? ❑ No ❑ Yes Home exercise program given? ❑ No ❑ Yes

CURRENT MEDICATIONS & SUPPLEMENTS:

NAME	DOSAGE	HOW OFTEN DO YOU TAKE THIS PER DAY

MEDICATION ALLERGIES: ❑ No ❑ Yes

NAME	REACTION

Are you allergic or had any reaction to iodine, shellfish, IVP dye, or contrast media? ❑ No ❑ Yes

PAST MEDICAL HISTORY

❑ Anxiety ❑ Asthma ❑ Cancer ❑ Diabetes ❑ Heart Attack ❑ Heart Murmur ❑ Lung Disease

❑ Ulcers/PUD ❑ Polio ❑ Stroke ❑ Parkinson's ❑ Arthritis ❑ Thyroid Trouble ❑ High Cholesterol

❑ Rheumatic Fever ❑ Claustrophobia ❑ Depression ❑ Alcoholism ❑ Hepatitis ❑ Hypertension ❑ Liver Disease

❑ Chronic Pain ❑ Other _____

Have you ever had similar symptoms/injury before? ❑ No ❑ Yes

If yes, when: _____ Please describe briefly: _____

_____

PAST SURGICAL HISTORY

Have you had any surgeries? ❑ No ❑ Yes

If yes, please list type of surgery and approximate date:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

FAMILY HISTORY

Please check box for any medical condition that a blood relative has history of:

❑ Anxiety ❑ Asthma ❑ Cancer ❑ Diabetes ❑ Heart Attack ❑ Heart Murmur ❑ Lung Disease

❑ Ulcers/PUD ❑ Polio ❑ Stroke ❑ Parkinson's ❑ Arthritis ❑ Thyroid Trouble ❑ High Cholesterol

❑ Rheumatic Fever ❑ Claustrophobia ❑ Depression ❑ Alcoholism ❑ Hepatitis ❑ Hypertension ❑ Liver Disease

❑ Chronic Pain ❑ Psychiatric Illness

❑ Other _____

SOCIAL HISTORY:

Marital Status: (check one or more)

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ "Living Together" ❑ Separated

Number of children: _____ Ages: _____

Do you smoke? ❑ No ❑ Yes How much?_____

Previous Smoker? ❑ No ❑ Yes When stopped?_____

Do you drink alcohol? ❑ No ❑ Yes How Much? _____

Coffee, tea, cola beverages (cups/glasses/cans per day) _____

Do you use recreational drugs? ❑ No ❑ Yes What type/how often? _____

Are you currently employed? ❑ No ❑ Yes If yes, type of job: _____

REVIEW OF SYSTEMS: Please mark those items which you currently experience:

GENERAL

❑ Fever ❑ Weakness ❑ Weight gain ❑ Night sweats ❑ Weight Loss ❑ Fatigue ❑ Chills

DERMATOLOGIC

❑ Jaundice ❑ Itching/rash ❑ Lesions ❑ Easy bruising

HEAD/HEARING & VISION

❑ Trauma ❑ Ringing in ears ❑ Changes/loss ❑ Double vision ❑ Headaches ❑ Blindness ❑ Discharge

❑ Light Sensitivity ❑ Tenderness ❑ Blurred vision ❑ Rings around lights ❑ Glasses ❑ Dizziness

PULMONDARY

❑ Wheezing ❑ Shortness of breath ❑ Chronic Cough ❑ Coughing up blood

CARDIOVASCULAR

❑ Chest Pain ❑ Leg Swelling ❑ Shortness of breath with exertion ❑ Racing heart

GASTROINTESTINAL

❑ Nausea ❑ Vomiting ❑ Abdominal Pain ❑ Stool color changes ❑ Bloody stool ❑ Heartburn

❑ Constipation ❑ Incontinence of bowels ❑ Diarrhea

GENITOURINARY

❑ Blood in urine ❑ Incontinence ❑ Menopause ❑ Vaginal Discharge ❑ Venereal disease

❑ Urgency/frequency with urination ❑ Pregnancy ❑ Pain/burning on urination

❑ Sexual problems ❑ Painful menstruation ❑ Irregular menstruation

MUSCULOSKELETAL

❑ Arthritis ❑ Joint Swelling ❑ Trauma

NEUROLOGICAL

❑ Loss of Sensation ❑ Seizures ❑ Numbness and Tingling

PSYCHOLOGICAL

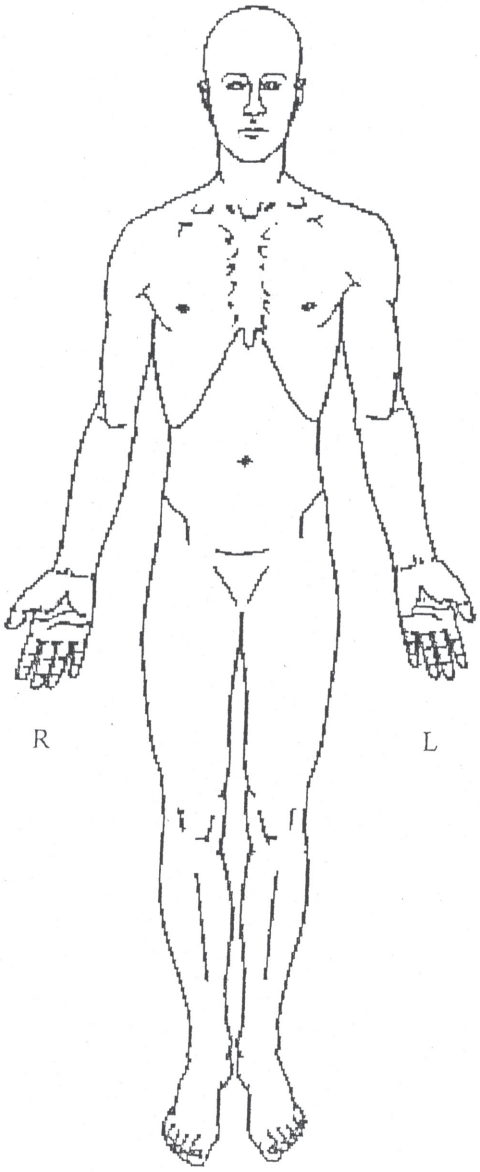
❑ Sadness ❑ Anxiety ❑ Depression

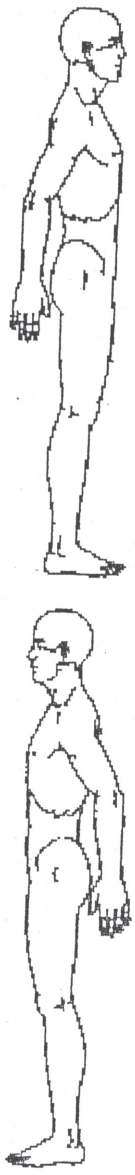
PLEASE LIST YOUR TOP 3 STRESSORS:

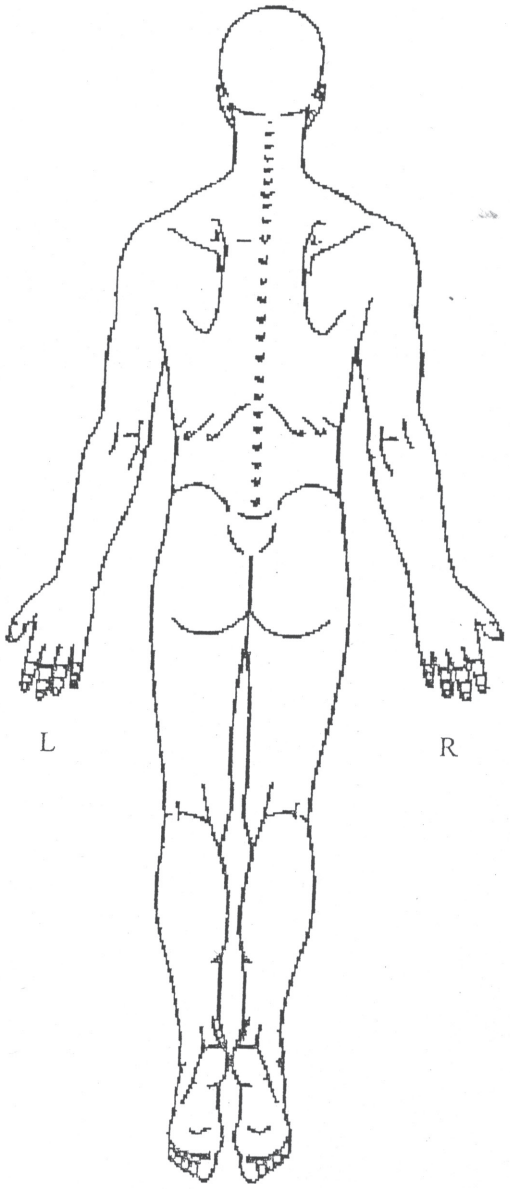
1. _____ **2.** _____ **3.** _____

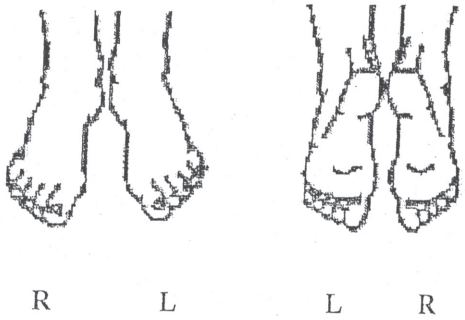
Mark on the areas on your body where you feel the described sensations. Use the symbols listed. Mark areas of radiating pain or numbness as well. Include all affected areas.

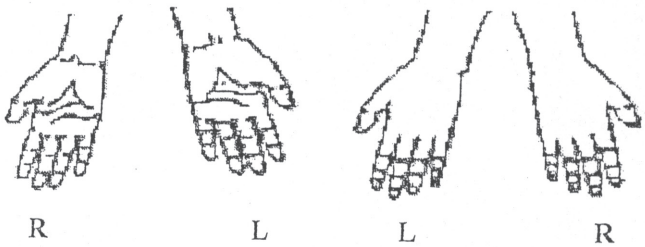
Numbness	Tingling	Burning	Stabbing/Sharp	Aching	Cramping
000	::::	XXX	////	^^^	□ □ □











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Dr. Philip Wallace

2115 NE Wyatt Court, Suite 101
Bend, Oregon 97701

PATIENT INFORMATION

Do you have medical insurance? YES ☐ NO ☐ Social Security #: _____

Last: _____ First: _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Birth Date: _____

Marital Status: ☐ M ☐ W ☐ S ☐ D ☐ OTHER Gender: ☐ Male ☐ Female Ht: _____ Wt: _____

Employer Name: _____ Employer Phone: (___) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Referring Physician: _____

Pharmacy: _____ Primary Care Physician: _____

Emergency Contact: _____ Phone: (___) _____ Relationship: _____

RESPONSIBLE PARTY INFORMATION

(IF PATIENT IS A MINOR OR IF POWER OF ATTORNEY IS INVOLVED)

Last: _____ First: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Birth Date: _____

Marital Status: ☐ M ☐ W ☐ S ☐ D ☐ OTHER Gender: ☐ Male ☐ Female

Social Security Number: _____ Relationship to Patient: _____

Employer Name: _____ Employer Phone: (___) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

MEDICAL INSURANCE

PRIMARY

Insurance Company Name: _____ Social Security Number: _____

Subscriber Last Name: _____ First Name: _____ Middle: _____

Subscriber Phone: ( ) _____ Subscriber Birth Date: _____ Gender: _____

Policy #: _____ Group #: _____

Copayment amount: _____ (Copayments are due at time of visit)

SECONDARY

Insurance Company Name: _____ Social Security Number: _____

Subscriber Last Name: _____ First Name: _____ Middle: _____

Subscriber Phone: ( ) _____ Subscriber Birth Date: _____ Gender: _____

Policy #: _____ Group #: _____

Is this appointment due to an on-the-job accident? ☐ YES ☐ NO Date of injury: _____
If yes, an 827 form will need to be filled out at your first visit.

Is this appointment due to a motor vehicle accident? ☐ YES ☐ NO Date of injury: _____
If yes, an MVA form will need to be filled out at your first visit.

AGREEMENT AND CONSENT

I have read and understand the following regarding my services at Central Oregon Spine & Sport:

- I authorize the release of information necessary for my treatment and insurance requirements
- I assign my insurance company benefit payments for services received
- To pay for services received that my insurance company considers a non-covered benefit
- To pay for services deemed by my insurance company as medically unnecessary
- Insurance Copayments at the time of service. Appointments will be rescheduled until copayment can be made at the time of service.
- Insurance Deductibles determined by my insurance company as patient responsibility
- Payment plan arrangements
- Forms and paperwork requests regarding care
- Clinic cost of obtaining payment if the Payment for Services above are not fulfilled
- Cancellation/No Show Policy: If there is no cancellation within 48 hours of the appointment, you will be billed a$50 charge. (If it is an emergency situation, this can be written off).

_____

Print Name Signature Date

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The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

A copy of the HIPAA Privacy Policy has been offered.

Print Name: _____

Signature: _____ Date: _____

Including your spouse, do you have any family / friends you would like us to be able to disclose your medical information to? If so, list their names here:

_____

_____