



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
- Aching
- Sharp
- Dull
- Burning
- Tingling/numbness
- Superficial
- 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  
000

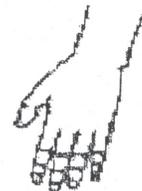
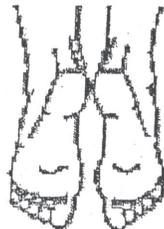
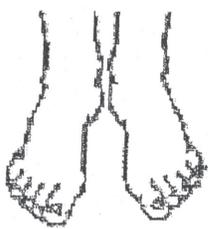
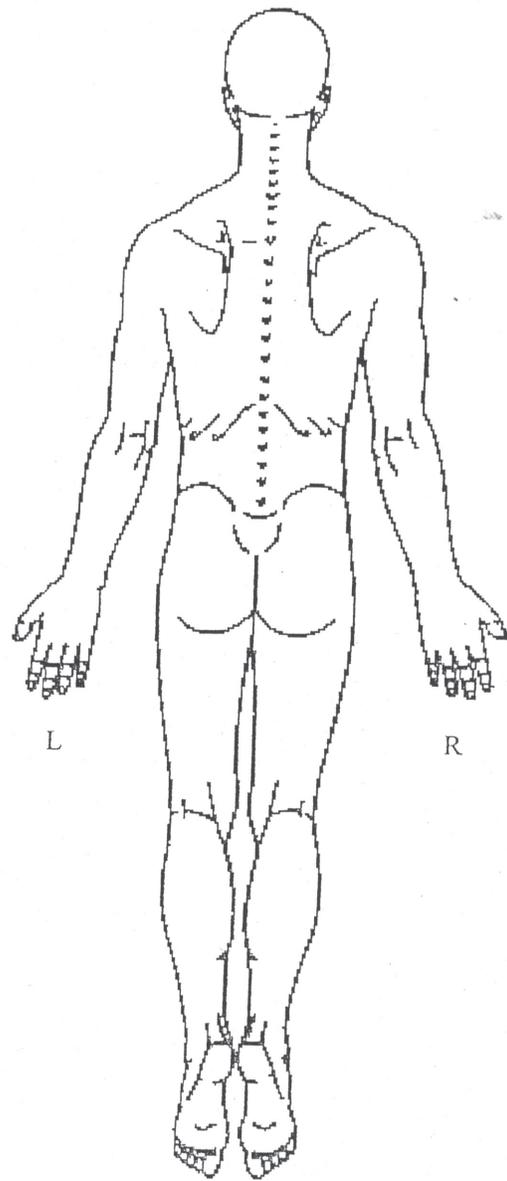
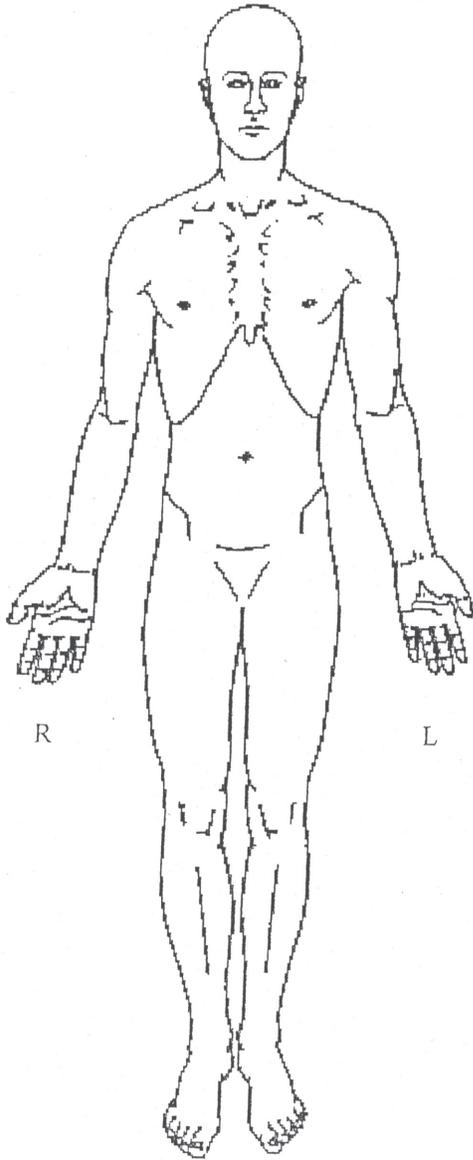
Tingling  
:::

Burning  
XXX

Stabbing/Sharp  
////

Aching  
^^^

Cramping  
□ □ □





CENTRAL OREGON  
SPINE & SPORTS

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

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:

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