

Office Use Only PT Acct # _____
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Health History Form

Name: _____ DOB: _____ Today's Date: _____

List all past medical problems:

List all current medical problems:

Are you currently pregnant or do you think you are pregnant? Yes No

List all current medications:(including over-the-counter and herbal/supplements) _____

What medications have you tried in the past: _____

List all DRUG ALLERGIES including adverse reactions: _____

Review of Systems

Are you currently having or have you had problems with your:

	Check	Describe all yes responses
Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Ears, Nose, Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lungs, Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Digestion/Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bowel movement	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart problems/Chest Pain (including rheumatic fever)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bleeding problems/Blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Balance problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Numbness/tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Blackout/fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Psychological problems/Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
AIDS/Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis/rheumatoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Weight loss/weight gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Migraines or headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Skin, e.g., rashes, lesions, moles	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

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Past Surgical History

Have you ever had any problems with anesthesia? Yes No Explain: _____

Surgery	Year	Complications

Family History

Do any of your grandparents, parents, siblings, or children have any of the following diseases? Please explain.

- Diabetes Yes No _____
- High blood pressure Yes No _____
- Heart attack Yes No _____
- Cancer Yes No _____
- Arthritis Yes No _____
- Rheumatoid arthritis Yes No _____
- Back or neck problems Yes No _____
- AIDS/HIV Yes No _____
- Bleeding disorders Yes No _____
- Epilepsy Yes No _____
- Hepatitis Yes No _____
- Migraines/headaches Yes No _____
- Psychiatric problems Yes No _____
- Stomach Yes No _____
- Thyroid problems Yes No _____

Social History

- Marital status: Single Married Divorced Separated Widowed
- Do you live alone? Yes No
- Employed (occupation _____) Student Retired
- Children? Yes No Number: _____
- Exercise? Never Rarely Weekly Daily
- What type of exercise? _____
- Smoking? Yes No _____ Packs per day for _____ years.
- Quit smoking? Yes No When? _____
- Previously smoked? Yes No _____ Packs per day for _____ years.
- Chew tobacco? Yes No How much? _____
- Drink alcohol? Yes No How much and how often? _____
- Substance abuse? Yes No What? _____

Patient Signature _____ Date _____

Reviewed by _____ Date _____

MD Signature _____ Date _____

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Today's Date: _____ Referring Doctor: _____
First Name: _____ Last Name: _____
DOB: _____ Age: _____ Sex: M / F
Height: _____ Weight: _____ Marital Status: S M D W

CHART # _____

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

Tell us about your symptoms

Date of injury: _____

Is this a work related injury? Yes No

What are your symptoms? _____

Is this pain mostly in back, neck or elsewhere? _____

How long ago did the symptoms begin? _____

Is the pain constant, or does it come and go? _____

How do these symptoms limit you? _____

What things make the pain better (rest, ice, heat, pills)? _____

What makes the pain worse? _____

Do you have pain that radiates into the arm or leg?
 Yes No Describe: _____

Have you lost any control over bowel or bladder functions?
 Yes No Describe: _____

Do you have any weakness or numbness in an arm or leg?
 Yes No Describe: _____

How long can you: sit _____ stand _____ walk _____

Is your pain the result of a: Fall Auto accident Injury on the job
 Other: _____

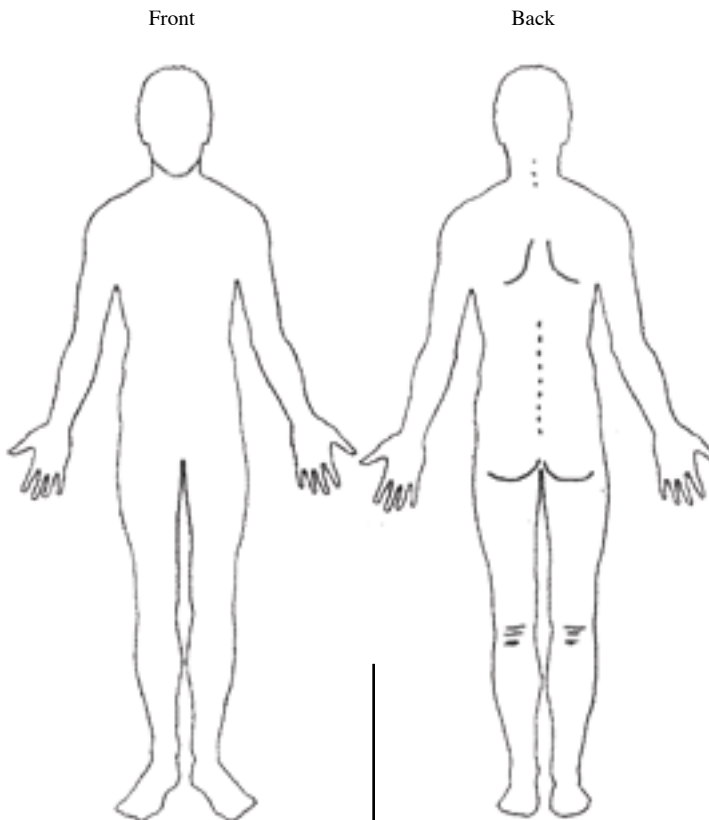
- Which of the following describes you currently?
- Working
 - Not working because of back or neck problem
 - Not working because of another health problem
 - Homemaker, retired or unemployed

How long have you been at that job? _____

Does your job require lifting, standing, sitting? _____

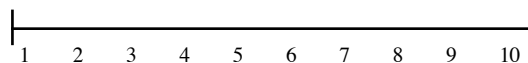
Employer at time of injury _____

Is there a law suit pending on problem? Yes No



Stabbing pain	////	Stabbing pain	////
Burning pain	oooo	Burning pain	oooo
Aching pain	xxxx	Aching pain	xxxx
Numbness	====	Numbness	====

Circle your pain level on a scale of 1 to 10, with 10 being unbearable, or worst imaginable, pain.



No Pain

Extreme Pain

Reviewed by: _____, MD Date: _____

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Who treated you first for this problem? Dr. _____ City: _____

What treatment did you have then? _____

What tests have you had? CT Scan MRI X-ray EMG

Other _____

Did you have any injections for your problem?

Yes No Describe _____

Did these injections help?

Yes No Describe _____

Did you have previous back or neck surgery?

Yes No Describe _____

List any **previous surgeries** you've had and the dates: _____

Did you have physical therapy before your problem?

Yes No Describe _____

Did this therapy help?

Yes No Describe _____

Do you do any special exercises for your back or neck? _____

What makes your pain better? _____

What makes your pain worse? _____

What are the hobbies/sports that you participate in

Does your pain limit your participation in these? Yes No How? _____

Do you have pain at rest? Yes No

Do you have pain at night? Yes No

Have you taken any medication for the pain? Yes No List, _____

Have you tried anything else for the pain? No Ice Brace Therapy Other

What do you hope we can accomplish today? _____

Patient Signature _____

Date _____



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Durango Orthopedics Associates, P.C.
Patient Registration and Consent for Medical Treatment

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Durango Orthopedic Associates, P.C.

2. **Authorization for Release or Information:** Durango Orthopedic Associates, P.C. and my physician may release information from my medical records to any health care provider involved in my care and treatment, including Mercy Medical Center. Durango Orthopedic Associates, P.C. and my physician may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare/Medicaid programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Durango Orthopedic Associates, P.C. is no longer responsible for the confidentiality of any information known or possessed by the payer.

3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Durango Orthopedic Associates, P.C. and of my physician, which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from Durango Orthopedic Associates, P.C., I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Durango Orthopedic Associates, P.C.

4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Durango Orthopedic Associates, P.C. charges.

5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Durango Orthopedic Associates, P.C. and my physician for charges not paid.

I acknowledge that:

I have read this form and understand its contents

I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms

I am responsible for the payment and/or co-payment that is due at the time of service

Signature of Patient or Legally Responsible Person

Name (Print)

Relationship/Reason Why Patient is Unable to Sign

Date