TEXAS SPINE CLINIC

NEW PATIENT INTAKE

Name:_____ Date: _____

Address:_____ Employer: _____

City/State/Zip:_____ Occupation:_____

Home Ph:_____Work:_____ Insurance Co: _____

Cell Ph: _____ SS#_____ Policy Holder:_____

E-Mail:_____ Policy Holder Birthdate: _____

Sex: M/F Birthdate: _____ Age:_____ Policy Holder Employer:_____

Marital Status S/M/D/W Policy Holder Employer Address : _____

Family Physician: _____ Emergency Contact and Phone #:_____

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1. **Chief Complaint**:_____ When did it start?_____

How did the complaint begin(mechanism of injury)?_____

Please Circle the quality of the complaint/pain: Dull Aching Sharp Stabbing Radiating Sore Burning Throbbing Deep Nagging

Does the pain radiates or shoots to any part of the body? Where?_____

Severity of Complaint(1-10) with 0 being no pain/symptoms and 10 the worst pain imaginable: 0 1 2 3 4 5 6 7 8 9 10

Please Circle the frequency: Occasional(0-25% of day) Intermittent(25-50% of day) Frequent(50-75% of day) Constant(75-100% of day)

What makes the pain worse?_____ What makes it better?_____

2. **Second Complaint**:(Skip if not relevant)_____ When did it start?_____

How did the complaint begin(mechanism of injury)?_____

Please Circle the quality of the complaint/pain: Dull Aching Sharp Stabbing Radiating Sore Burning Throbbing Deep Nagging

Does the pain radiates or shoots to any part of the body? Where?_____

Severity of Complaint(1-10) with 0 being no pain/symptoms and 10 the worst pain imaginable: 0 1 2 3 4 5 6 7 8 9 10

Please Circle the frequency: Occasional(0-25% of day) Intermittent(25-50% of day) Frequent(50-75% of day) Constant(75-100% of day)

What makes the pain worse?_____ What makes it better?_____

3. **Previous treatments you have had for your current condition**:_____

4. **Past Medical History:**

   A. Major Illnesses:_____

   B. Previous Injury or Trauma:_____

   C. Allergies: _____

   D. Current Medications:_____ Reason for Taking:_____

_____ _____

_____ _____

_____ _____

E. Previous Surgeries:_____ Year_____ Surgeon:_____

_____ Year_____ Surgeon:_____

_____ Year_____ Surgeon:_____

_____ Year_____ Surgeon:_____

5. Family Health History:
Associated Health Problems of Relatives:_____

6. Social History:
Lifestyle(level of exercise, alcohol, tobacco usage)

Cigarettes: Yes ☐ No ☐ Alcohol: Yes ☐ No ☐ If Yes, how much:_____

Exercise Regularly: ☐ Yes ☐ No If Yes, State frequency:_____

REVIEW OF SYSTEMS

Allergic/Immunologic:

☐ Cancer
☐ Seasonal Allergies
☐ Immune Deficiency
☐ None of the above

Cardiovascular:

☐ Chest pain
☐ Palpitations
☐ Fainting
☐ Difficult breathing when laying
☐ Shortness of breathe on exertion
☐ Edema
☐ Shortness of breathe at night
☐ Heart murmurs
☐ None of the above

Endocrine:

☐ Excess thirst
☐ Cold intolerance
☐ Goiter
☐ Frequent urination
☐ Heat intolerance
☐ Excessive hunger
☐ None of the above

Ear/Nose/Throat:

☐ Nosebleed
☐ Hoarseness
☐ Bleeding gums
☐ Sinusitis
☐ Trouble hearing
☐ Thyroid mass
☐ Neck stiffness, pain or tenderness
☐ None of the above

Gastrointestinal:

☐ Loss of appetite
☐ Difficulty swallowing
☐ Abdominal pain after eating
☐ Heartburn
☐ Nausea/Vomiting
☐ Vomiting blood
☐ Jaundice (yellow skin/eyes
☐ Constipation
☐ Diarrhea
☐ Abnormal stool
☐ Hemorrhoids
☐ None of the above

Constitutional:

☐ Weight loss/gain
☐ Fever
☐ Loss of appetite
☐ Fatigue
☐ None of the above

Genitourinary:

☐ Urgency with urination
☐ Frequent urination
☐ Burning urination
☐ Blood in urine
☐ Trouble holding bladder
☐ Recurring infection
☐ Kidney stones
☐ Vaginal discharge
☐ Vaginal bleeding
☐ None of the above

Head/Eyes:

☐ Headache
☐ Dizziness
☐ Lightheadedness
☐ Excessive tearing
☐ Head injury
☐ Vision changes
☐ Double vision
☐ Eye pain
☐ None of the above

Hematologic/Lymphatic:

☐ Easy Bruising
☐ Blood clots
☐ Lymphedema
☐ Easy bleeding
☐ Swollen glands
☐ Blood transfusion
☐ None of the above

Musculoskeletal:

☐ Pain
☐ Swelling
☐ Joint stiffness / limited motion
☐ Joint pain
☐ Weakness
☐ Muscle wasting
☐ Cramps
☐ None of the above

Neurological:

☐ Seizures
☐ Paralysis
☐ Incoordination
☐ Tremors
☐ Numbness/Tingling
☐ Loss memory
☐ Motor loss
☐ Standing/Balance difficult
☐ None of the above

Psychiatric:

☐ Depression
☐ Hallucinations
☐ Suicidal thoughts
☐ Anxiety
☐ None of the above

Respiratory:

☐ Pain with breathing
☐ Shortness of breath
☐ Wheezing
☐ Cough
☐ Coughing blood
☐ Recurring infection
☐ Tuberculosis
☐ Night sweats
☐ None of the above

Integumentary:

☐ Rash
☐ Itching
☐ Skin color change
☐ Dry skin
☐ None of the above

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to perform any necessary examinations and/or treatment in accordance with Texas statutes and laws.

Patient Signature_____ Date_____

Guardian Signature_____ Date_____

TEXAS SPINE CLINIC

Patient Information:

Full Name: _____

Address: _____

Date of Birth: _____ Soc. Sec. # _____

Medical Records Release

Facility Information is Requested From

_____
_____
_____

Requesting Organization

Texas Spine Clinic
19016 Stone Oak Parkway, Ste. 280
San Antonio, TX 78258

Date and Type of Information Requested

_____/_____/_____ _____

_____/_____/_____ _____

_____/_____/_____ _____

I, _____, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1.) I do hereby authorize Texas Spine Clinic to obtain and release the following types of medical information: MRI/CT/Radiograph reports, History/Physical examination reports, Progress reports, Surgical reports and/or any information that could be relevant to my medical condition.
2.) I have the right to revoke this authorization at any time by writing to the health care provider listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3.) I understand that signing this authorization in voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be condition upon my authorization of this disclosure.
4.) Information disclosed under this authorization may be subject to redisclosure by the recipient.
5.) Date of authorization and expiration _____/_____/_____ thru _____/_____/_____

_____ _____

Patient Signature *Date*

New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, the Texas Spine Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that the Texas Spine Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Texas Spine Clinic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Texas Spine Clinic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including but not limited to disclosures via fax, email, telephone, and by mail.

I fully understand and accept / decline the terms of this consent.

Dated: _____

_____

Patient's Signature