

NeuroSpine

20755 Greenfield Road, Suite 803
Southfield, MI 48075

Your symptoms are worse in the: morning after night

Same all day

What are your goals for treatment? _____

Please list past surgeries/conditions/hospitalizations (or you may attach a separate list):

_____/_____/_____
_____/_____/_____
_____/_____/_____

Please list all medications, dosage, frequency and route (or you may attach a separate list):

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Have you ever been diagnosed and/or treated for any of the following conditions (circle all that apply):

CONSTITUTIONAL

Weight Loss

Fatigue

Fever

EYES

Glasses/Contacts

Eye Pain

Double Vision

Cataracts

CARDIOVASCULAR

Murmur

Chest Pain

Palpitations

Fainting/Spells

Short of Breath

Difficulty Lying Flat

Swelling in Ankles

Pacemaker/Defibrillator

ENDOCRINE

Loss of Hair

Heat Intolerance

Cold Intolerance

PSYCHIATRIC

Anxiety

Depression

Mood Swings

Difficulty Sleeping

RESPIRATORY

Cough

Coughing Blood

Wheezing

Chills

GASTROINTEST

Heartburn/Reflux

Nausea/Vomiting

Constipation

Change Bowel Mvts

Diarrhea

Jaundice

Abdominal Pain

Black/Bloody Bowel Mvts

GENITOURINARY

Burning/Frequency

Nighttime

Blood in Urine

Erectile Dysfunction

Bladder Leakage

Abnormal Leakage

ALLERGIC

Hives/Eczema

Hay Fever

HEMATOLOGY/LYMPH

Bruise Easily

Gums Bleed Easily

Enlarged Glands

MUSCLE/BONE

Joint Pain/Swelling

Stiffness

Muscle Pain

Bone Pain

SKIN

Rashes/Sores

Lesions

Itching/Burning

NEUROLOGICAL

Loss of Strength

Numbness

Headaches

Tremors

Memory Loss

FEMALES ONLY

Age Onset of

Periods _____

Periods Regular?

Yes _____ No _____

Age Onset of

Menopause _____

Number of Pregnancies _____

Please list any allergies that you have (For example: medications, latex, food, bee stings): _____

Is there any additional information? _____

The above information is true to the best of my knowledge:

Signature (Parent/Guardian of Minor): _____ DOB: ____/____/____ Date: ____/____/____

Personal Injury Intake Form

Patient Information

Date: _____ Date of Birth: ___/___/___
Name: _____ Social Security: ___-___-___
Address: _____
Street City State Zip
Email Address: _____
Home Phone: _____ Cell Phone: _____
Gender: _____ Height: _____" Weight: _____ lbs
Marital Status: _____ Number of Children: _____
Employer: _____ Occupation: _____ Work Phone: _____
Employer Address: _____
Street City State Zip
Attorney: _____ Phone: _____
Emergency Contact: _____ Relation: _____
Emergency Contact Phone Number: _____
If under 18 years, name of Parent or Guardian: _____
PCP Name: _____ Phone: _____
How did you hear about our office? Website Gym Member Walk-in Yellow Pages
 Friend/Former Patient Doctor _____
 Other _____

Accident Information

Date: _____ Time: _____ AM PM Was it reported YES NO
Auto accident occurred in: _____ Street: _____
Please explain in detail how the accident occurred: _____

Please list symptoms felt immediately after the accident: _____

Were you in a work vehicle at the time of the accident? YES NO
Were you the DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER?
Were you wearing a seat belt? SHOULDER HARNESS LAP HARNESS
Where were you taken after the accident? _____
If hospital, how were you taken? AMBULANCE PRIVATE VEHICLE OTHER
Were X-Rays done? YES NO An MRI? YES NO CAT scan? YES NO
Have you seen any other doctor(s) since the accident? YES Name _____ NO
Have you missed any work since the accident? YES NO Date(s) _____
Did you ever experience similar symptoms prior to the accident? YES NO
Has your condition IMPROVED WORSENER or STATED SAME since the accident?
Please share any other information that might be important to your diagnosis and
treatment: _____

Signature (Parent/Guardian of Minor): _____ Date: ___/___/___

Medical History Form

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

Occupation: _____ Gender: _____ PCP: _____

Referring Physician (MD): _____ Next appointment w/ referring MD: ___/___/___

Please answer the following questions:

What injury or condition brings you here today? _____

When did you first notice your condition (date of onset)? _____

How did this injury occur? _____

Is your condition due to a motor vehicle accident? Yes No If yes, date of accident? _____

Have you had any falls in the past 12 months? Yes No If yes, how many times? _____

Did the fall(s) result in injury? Yes No If yes, please describe: _____

Please describe above: _____

Are you seeing (or have you been seen by) any other specialists for your current condition (e.g.: doctor, psychologist, chiropractor, physical therapist, etc.)? Please list: _____

Have you been treated by another physical therapist/chiropractor in the past for this or any other condition?

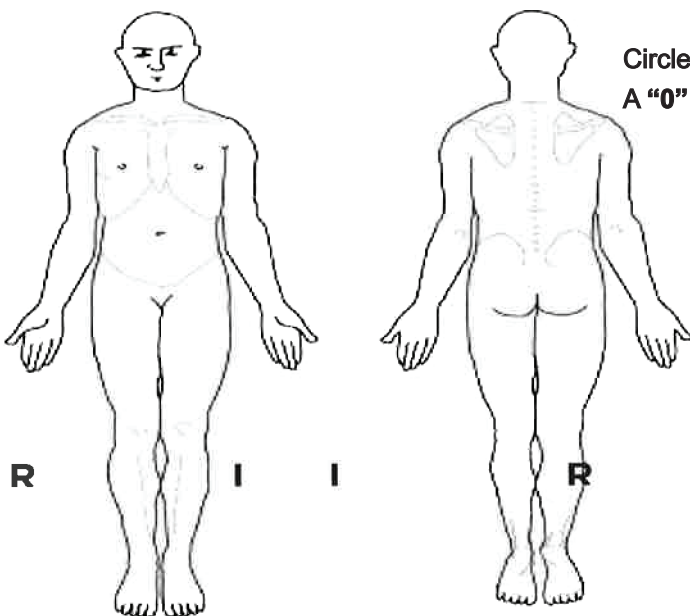
Yes No

If Yes, by whom/when? _____

What tests have you had for this condition? X-ray MRI CT scan Other: _____

Please mark where you have symptoms on the picture below.

Sharp Pain: ////////////// Achy Pain: ^^^^^^ Burning Pain: XXXXXX Numbness: 0000



Circle the number corresponding with the intensity of your symptoms.
A "0" = No Pain where as a "10" = most severe pain imaginable

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Since this condition began your symptoms have: decreased not changed increased

Designate Individuals Authorization Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

DOB: _____

Patient Signature (Parent/Guardian of Minor)

Date: _____

Acknowledgement of Office Policies ~ NeuroSpine Associate

The follow is NeuroSpine's policies governing appointment scheduling, payment terms, and information releases. **Please read carefully** and be sure to ask questions you might have before signing the document.

Appointment Scheduling: We at NeuroSpine Associates are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a 24 hour cancellation notice for all appointments. If you miss three (3) appointments in a three (3) week period without notifying NeuroSpine (emergencies considered), you may be dismissed from care and your file may be closed.

Consent for Treatment: I, the undersigned, give NeuroSpine Professional Staff my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment.

Assignment of Payment: I hereby authorize my insurance company and/or my attorney to pay direct to NeuroSpine any monies due on my account for professional services rendered.

Acknowledgement and Understanding: It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance: I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

Authorization to Release Information: I have read and fully understand NeuroSpine's Notice of Information Practices. I understand that NeuroSpine may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments, understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that NeuroSpine will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

Patient Requests for Records: I instruction the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, x-rays, or lab results to this office.

I understand I have the option to seek any/all of the same services these clinics provide elsewhere. I certify that I have read and understand all appointment and office policies listed above.

Patient Signature (Parent/Guardian of Minor): _____ **Date:** _____
Name (Please Print): _____ **DOB:** _____