

INITIAL PATIENT QUESTIONNAIRE

Name: _____ Date: _____
 Address: _____ History #: _____
 City: _____ State: _____ Zip: _____ Home Phone: _____
 Sex: _____ Age: _____ Date of Birth _____ Work Phone: _____
 Height: _____ Weight: _____ Temp: _____ Blood Pressure: _____ / _____
 Your Referring Physician's Name: _____ Physician's Phone: _____
 Address: _____
 Type of Practice (Internist, Surgeon, etc.): _____

CHIEF COMPLAINT:

Do you have?	Yes	No
Neck pain	_____	_____
Shoulder pain	_____	_____
Arm pain	_____	_____
Upper back pain	_____	_____
Lower back pain	_____	_____
Hip/leg pain	_____	_____
Any other complaints _____		

If more than one area, which is worse? _____
 How long have you had this problem? _____
 Did your symptoms follow an injury? _____ If yes; _____ at work _____ auto accident _____ other
 Describe: _____

Circle your least and greatest pain levels over the past two weeks:
 (None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

Describe your pain (check all that apply)

Constant _____ Deep _____ Dull _____ Sharp _____ Intermittent _____ Throbbing _____
 Stiffness _____ Aching _____ Shooting _____ Cramping _____ Burning _____ Stabbing _____

Is your pain worse (check one)

At night _____ in the mornings _____ at the end of the shift/day _____
 No difference between day and night _____ on a wet/cloudy day _____

Indicate which of the following activities increases (I) or decreases (D) your pain

When I first get out of bed	___	Standing	___
Getting up	___	Walking	___
Sitting	___	Bending back	___
Lying on my back/side	___	Lying on stomach	___
Leaning forwards	___	Coughing/Sneezing	___
Lifting/bending forwards	___	Twisting	___
Straining	___	Reaching over	___
Look up/turn head sideways	___	Washing/combing hair	___
Climbing stairs/walking up ramp	___	Going down stairs/ramp	___
Long car rides	___	Other _____	___

Have you had neck/back symptoms before? Y___ N___

Have you ever had previous back or neck surgery? Y___ N___

If yes, describe: _____

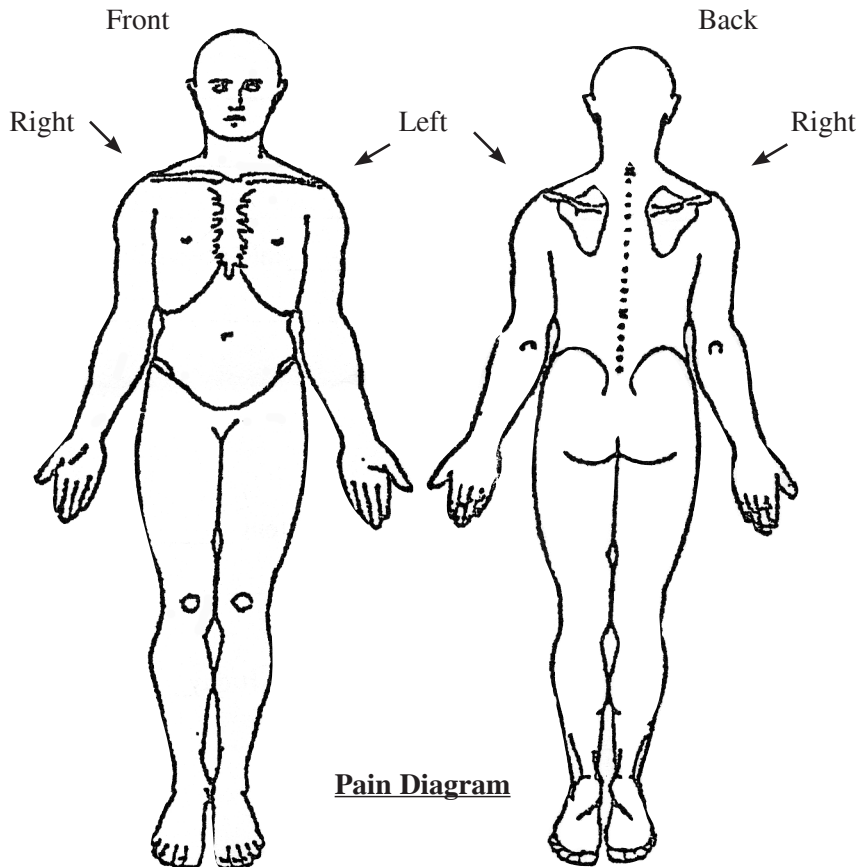
Have you had prior episodes of back symptoms for which you received Worker's Compensation? _____

Is the purpose of this exam to determine disability status for the government or an insurance agency? _____

Are you currently receiving any type of financial compensation for your back problem? _____

Do you have an attorney for your back problem? _____

Mark in the areas of your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below: PAIN = XXXXXX NUMBNESS = OOOOOO



Please list previous radiology studies you have had for this problem.

<u>Date</u>	<u>Location</u>
MRI _____	_____
CT Scan _____	_____
Myelogram _____	_____
Bone Scan _____	_____
EMG _____	_____
Xrays _____	_____

PREVIOUS TREATMENT:

Put a check next to each type of treatment you have had for your back/neck in the past. Then check the column that best describes the effect of the treatment.

<u>Treatment</u>	Check if you have had this	Did it make things		
		<u>Better</u>	<u>Worse</u>	<u>No change</u>
Hot packs/ice	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Massage	_____	_____	_____	_____
TENS/Electrical Stim	_____	_____	_____	_____
Yoga/Tai-Chi	_____	_____	_____	_____
Exercises	_____	_____	_____	_____
Traction/DRS	_____	_____	_____	_____
Bed Rest	_____	_____	_____	_____
Pool therapy	_____	_____	_____	_____
Biofeedback	_____	_____	_____	_____
Injections	_____	_____	_____	_____
Braces/Splints	_____	_____	_____	_____
Medication	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Chiropractic Adjustments	_____	_____	_____	_____

MEDICAL HISTORY:

Have you ever had:

___ AIDS or HIV testing	___ Phlebitis or blood clots	___ Kidney Stones
___ Asthma/Breathing problems	___ Stroke	___ Arthritis
___ Cancer	___ Thyroid trouble	___ Seizures
___ Radiation/Chemotherapy	___ Kidney Infections	___ Ulcer
___ Migraine or other severe head pain	___ Heart Attack	___ Tuberculosis
___ High Blood Pressure	___ Diabetes	___ Hepatitis
___ Chronic Fatigue Syndrome	___ Fibromyalgia	___ Other: _____

PAST SURGICAL HISTORY:

Year	Operation	Place Hospitalized
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you had previous back surgery;

What were your symptoms before the surgery? (indicate **R** for right side, **L** for left side, **B** for both sides and circle all that applies)

- Neck pain____ Shoulder pain/numbness/weakness____
- Arm pain/numbness/weakness____ Wrist/hand pain/numbness____
- Back pain____ Hip/buttock/thigh pain/numbness/weakness____
- Leg pain/numbness/weakness____ Ankle/foot pain/numbness/weakness____
- Urinary complaints____ Bowel complaints____ Impotence____
- Walking/gait disturbances____ Balance/falls/clumsiness____

Did your symptoms improve after surgery?_____ If yes, how long afterwards?_____

Did you get worse after surgery?_____ If yes, explain:_____

Were you released back to work after surgery?_____ If so, when?_____

ALLERGIES

Name of medicine/substance	Type of reaction	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICINES: List all medicines that you have taken recently. Include vitamins and nonprescription medicine.

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

FAMILY HISTORY:

- Spinal Problems Y____N____ If yes, describe:_____
- Bleeding Disorders Y____N____ If yes, describe:_____
- Heart Disease Y____N____ If yes, describe:_____
- Cancer Y____N____ If yes, describe:_____
- Diabetes Y____N____ If yes, describe:_____

SOCIAL HISTORY:

How many years of schooling? (circle one)

Less than high school High School Graduate Technical School Diploma 1-3 years of college
College Graduate Post Graduate or Professional Degree

Marital Status: Single____ Married____ Divorced____ Remarried____ Widowed____ Separated____

How many years?_____

Number of children?_____ Ages:_____

Who lives with you at home?_____

Work status: Working____ Not Working____ Student____ Disabled____ Retired____

Primary Occupation: _____ Employer: _____

How long have you worked at your present job?_____ If not working, last date worked: _____

Spouse's Occupation:_____

Have you ever smoked?_____ Type/Amount:_____ Years:_____ If quit, when? _____

Amount of alcohol consumed in a typical week?_____ Cups of caffeinated drinks per day? _____

Have you used: Marijuana _____ Cocaine _____ Heroin_____ Other_____

Do you get any regular exercise? Describe: _____

REVIEW OF SYSTEMS:

Check all that apply.

Constitutional

Fever____
Chills____
Night sweats____
*Weight loss*____
Loss of appetite____

Allergy/Immune

Drug allergy____
Seasonal allergy____
Food allergy____
*Iodine allergy*____
Transplant____

Neurologic

Paralysis____
Tremors____
Spasticity____
Seizures____
Muscle atrophy____
Double vision____

Musculoskeletal

Joint stiffness/swelling____
Muscle pain/swelling____
Fatigue____
Fractures____

Hemo-lymphatic

Anemia____
*Excessive bleeding*____
Easy bruising____
Lymphoma____
Leukemia____
Cancer____
Lymph node swelling____

CV/respiratory

Shortness of breath____
Wheezing____
Cough____
Coughing up blood____
Chest pains____
Palpitations____
Leg swelling____

GI

Difficulty swallowing____
Heartburn____
Nausea/vomiting____
Constipation____
Diarrhea____
Blood in stool____
Stomach pain____

Endocrine

Obesity____
Thyroid disorder____
*Diabetes*____
Menopause____
Menstrual irregularities____
Pelvic Pain____
Addison's disease____

HENT

Loss of vision____
Eye Redness____
Headaches____
Dizziness____
*Glaucoma*____

Skin/integumentary

Rash____
Ulcer____
Eczema____
Hives____

GU

Pain urinating____
Incontinence____
Blood in urine____
Dribbling____
Sexual Difficulties____
Pregnant____; LMP____

Psychiatric

Poor sleep____
Depression____
Anxiety____
Stress at work/home____
Panic spells____

SOUTHERN BONE & JOINT SPECIALISTS

1500 Ross Clark Circle, Dothan, AL/ 345 Healthwest Drive, Dothan, AL
404 North Main Street, Enterprise, AL

New
 Update

Patient's Name _____
(Last) (Suffix) (First) (Middle Initial)

Address _____

City _____ ST _____ Zip Code _____ Home # () _____

Cell # () _____ Employer/School _____ Work # () _____

Preferred Method of Contact Home # Cell # Work#

Preferred Method for Appointment Reminders Phone Text Email _____

For access to our patient portal email address is required- please list above

Your clinical summary will not be available on the portal until the day following your appointment.

Date of Birth _____ Social Security Number _____

Gender Male Female **Marital Status:** Single Married Widow Divorce

Race: American Indian Asian Black/African American White Alaskan Native Pacific Islander
 Hispanic Multiracial Native Hawaiian Unknown Other Decline

Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline

Preferred Language: English Spanish Other

Is this problem due to an accident? Yes No If yes, please list date of accident: _____

Accident occurred in state of: _____ Type of Accident: On the job Auto Home Other: _____

Were you referred to SBJ? Yes No If Yes, who referred you? _____

INSURANCE INFORMATION- COPAY AMOUNT \$ _____

Primary Insurance _____
Contract # _____
Policyholders Name _____
Relationship to Patient _____
DOB _____ SS# _____

Secondary Insurance _____
Contract # _____
Policyholders Name _____
Relationship to Patient _____
DOB _____ SS# _____

Pharmacy Preference:

Name _____ Location _____ Phone # _____

RESPONSIBLE PARTY INFORMATION

Name of Father/Guardian _____
Date of Birth _____
Address _____
City _____ ST _____ Zip _____
Social Security # _____
Cell # _____
Employer _____
Work # _____

Name of Mother/Guardian _____
Date of Birth _____
Address _____
City _____ ST _____ Zip _____
Social Security # _____
Cell # _____
Employer _____
Work # _____

EMERGENCY CONTACT INFORMATION

Emergency Contact _____ Relationship _____ Phone () _____

Southern Bone & Joint Specialists Patient Consent

Name _____

Account# _____

I, _____ understand that as part of my healthcare, **Southern Bone & Joint Specialists (SBJS)** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that a copy of our **Notice of Privacy Practices** is available at each of our locations and/or our website www.southernbone.com. The **Notice of Privacy Practices** provides a more complete description of information uses and disclosures. **SBJS** complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Medication Protocol for Patients of SBJS: In an attempt to provide the best possible care for our patient, the following protocol for prescribing medication has been established. It is important that you read and understand these policies.

1. Your physician will not prescribe pain medication for chronic pain or lasting three months or longer.
2. Post-operative medication will be decreased in 4-6 weeks during the post-op period and will slowly be eliminated completely.
3. Pain medications will not be called in and/or written after business hours, on weekends or holidays.
4. Our staff will be given 24 hours to call in your prescriptions.
5. If you are experiencing pain lasting for more than three months, you will be referred to pain management.
6. Due to recent DEA policy changes, Hydrocodone prescriptions can no longer be called in or sent electronically to pharmacies. All prescriptions for any type of Hydrocodone medication (Hydrocodone, Lortab, Norco, Vicodin, etc.) must now be printed and signed by a physician and picked up at our office (photo ID required).
7. We are not responsible for written prescriptions lost in the mail and will not be able to replace/refill the prescription until the appropriate time (expiration of the previous prescription).
8. In order to continue receiving prescriptions for pain medications, you must keep scheduled follow up appointments.

Please list below the names of any individuals who we may disclose any medical and/or account billing information on your behalf. These people will be allowed to act as your personal representative. Please identify anyone you authorize to pick up prescriptions for you.

Name	Relationship	Authorized to pick-up Prescriptions
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>

RELEASE, ASSIGNMENT, AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize release of my medical and financial records to my referring physician, my parent or guardian, my employer if the injury is job-related, school officials if injury is school related, insurance companies, third party administrators or payor, or government agencies or their agents who may be responsible for payment. I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that if my account becomes delinquent it will be placed with Prim and Mendheim LLC. Further, I agree to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1 and ½ percent per month(18% PER ANNUM) (2) I agree and hereby consent that I will be responsible for reasonable collection costs, and attorney’s fees in and costs of court incurred by this office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit or after a judgment has been issued in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction and I waive all right to claim exemption. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing. Furthermore, I agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waive my right to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy I understand my credit history will be investigated and thoroughly reviewed.

Patient or Guardian’s Signature

Date

Southern Bone & Joint Specialists - Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication - This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

Southern Bone & Joint Specialists Attn: Privacy Manager P.O. Box 729 Dothan, AL 36302 or 334-836-2255

We will not retaliate against you for filing a complaint.

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