The Hixson Spine Center of Chattanooga, Inc.

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Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist**. PLEASE PRINT!**

Today's date:_____

Name:_____ **Home Phone**:_____ **Cell/Pager**:_____

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Age:_____ **Birthdate**:___/____/____ **Social Security #**:_____ **E-mail**:_____

Emergency information: **Name**:_____ **Relationship**:_____ **Phone**:_____

Your Employer:_____ **Occupation**:_____ **Years on Job**:_____

Employer Address:_____ **City**:_____ **State** :_____ **Zip**:_____

Work Hours: **(Full Time, Part Time etc...)** _____ **Work Phone**:_____

Name of spouse or parent: _____ **Birth Date**:_____

Spouse employed by:_____ **Occupation**:_____

Employer Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Health Insurance: _____ **Does your Spouse have health insurance?** Yes No

Please describe your pain? (neck, back etc...)_____

_____

Is your condition due to an accident? Yes No **Date of accident**:_____ *Auto Work Other*:_____

Have you ever been in an accident? Past year:_____ Past 5 years:_____ Over 5 years_____ Never:_____

Primary Care Physician: _____ **Phone**:_____

Address: _____ **City**:_____ **State**:_____ **Zip**:_____

I agree to pay for services rendered as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered and non covered. On all insurance assignments, the deductible must be met in the beginning unless prior arrangements have been made. If you have difficulty making an appointment please give us 24 hours notice. Therefore, a charge of $35.00 will be billed to your account for "NO SHOWS" or canceled appointments with less than 24 hours notice.

Patient's Signature;_____ Date:_____

Spouse or Guardian's Signature:_____ Date:_____

PATIENT MEDICAL HISTORY FORM

Name _____ **Date:** _____

***How many days out of an average week do you have pain?** _____
***How much time out of an average day are you in pain?** _____
***What are the worst times of day for the pain?** _____
***What are the best times of day for the pain?** _____
***How do the following activities affect your pain?**

	No Change	Relieves	Increased
Sitting	[ ]	[ ]	[ ]
Walking	[ ]	[ ]	[ ]
Standing	[ ]	[ ]	[ ]
Lying Down	[ ]	[ ]	[ ]
Looking up	[ ]	[ ]	[ ]
Looking Down	[ ]	[ ]	[ ]
Lifting	[ ]	[ ]	[ ]

***What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before?**

_____
_____
_____
_____

***Please mark each that apply to your Daily Activities**

[ ] Changes position frequently to try and get comfortable.
[ ] Walks more slowly than usual because of the problem.
[ ] Stays at home most of the time due to the problem.
[ ] Does not do jobs around the house because of the problem.
[ ] Has to use handrails to get up stairs, etc.
[ ] Has to lie down and rest frequently due to the problem.
[ ] Has to hold onto something to sit or stand from a chair.
[ ] Has to get other people to do things for you.
[ ] Has difficulty getting dressed due to the problem.
[ ] Can only stand for short periods due to the problem.
[ ] Has difficulty bending or kneeling due to the problem.
[ ] Can only walk short distances because of the problem.
[ ] Has difficulty turning over in bed due to the problem.
[ ] Has a loss of appetite due to the problem.
[ ] Has difficulty sleeping because of the problem.
[ ] Has to get dressed with someone's help.
[ ] Has more irritable because of the problem.
[ ] Has difficulty climbing stairs.
[ ] Stays in bed most of the day because of the problem.

***How often do you have to stop activities and sit or lie down to control your symptoms?**

[ ] Has to sit most of the day because of the problem.
[ ] Several times a day
[ ] Occasionally
[ ] Approximately once per day
[ ] Never
[ ] All day

***List your Hobbies & Exercise Activities**

_____
_____
_____
_____

***Social History:** [ ] Single [ ] Married [ ] Divorced Number of Children: _____

[ ] Smoker [ ] Non-Smoker [ ] Drinks Alcohol [ ] Does not drink Alcohol

[ ] Takes Recreational Drugs [ ] Does not take Recreational Drugs

***What is your current job satisfaction:** [ ] Very Satisfied [ ] Satisfied [ ] Dissatisfied [ ] Very Dissatisfied
***Are your Job Duties Physically demanding for you?** [ ] Yes [ ] No
***Have you had any disability time?** [ ] Yes [ ] No
***If you are currently working which are you performing?** [ ] Regular Duties [ ]Limited - Light Duty
***Your highest level of education attained?** [ ] High School [ ] Under Graduate [ ] Graduate

***List the Physicians and other practitioners below that you have seen for your current problem.**

1)_____ **2)**_____

3)_____ **4)**_____

***List the Medications you are currently taking:**

***List the types of Diagnostic Testing that has been performed for this problem.**

[ ] X-rays
[ ] CT Scan
[ ] Myelogram
[ ] MRI Scan
[ ] Discogram
[ ] Bone Scan
[ ] EMG
[ ] Spinal Tap

***List the treatments you have had for your problem.**

[ ] Hot packs / Ultrasound
[ ] Osteopathy
[ ] Electrical Stimulation
[ ] TENS Unit
[ ] Body Mechanics Training
[ ] Strengthening Exercises
[ ] Aerobics
[ ] Gravity Inversion - Traction
[ ] Bed Rest
[ ] Chiropractic
[ ] Massage
[ ] Physical Therapy
[ ] Trigger Point Injections
[ ] Epidural Injections
[ ] Back Brace
[ ] Acupuncture
[ ] Naturopathy

***List ALL back, neck and musculoskeletal problems you have had in the past:**

_____
_____
_____
_____

***List ALL Past Surgeries:** [ ] None _____

_____

***List ALL Past Hospitalizations:** [ ] None _____

_____

Mark if you have had any of the following symptoms in the past 5 years.

[ ] Unexplained fevers
[ ] Night sweats
[ ] Weight loss of 10 lbs or more
[ ] Loss of appetite
[ ] Excessive fatigue
[ ] Problems with depression
[ ] Difficulty sleeping
[ ] Unusual stress at work
[ ] Unusual stress at home
[ ] Easy bruising
[ ] Excessive bleeding
[ ] Lumps in neck, armpit or groin
[ ] Chest pain or tightness
[ ] Persistent or unusual cough
[ ] Trouble breathing with exercise
[ ] Trouble breathing lying flat
[ ] Coughing up blood
[ ] Swollen ankles
[ ] Stomach pain
[ ] Change in bowel habits
[ ] Persistent diarrhea
[ ] Excessive constipation
[ ] Dark black stools
[ ] Blood in stools
[ ] Pain-burning when urinating
[ ] Difficulty urinating - start / stop
[ ] Blood in urine
[ ] Need to urinate more at night
[ ] Morning stiffness
[ ] Persistent eye redness
[ ] Muscle tenderness
[ ] Dry eyes or mouth
[ ] Skin rashes
[ ] Joint pain or swelling

***Females - Mark if have the following:**

[ ] Vaginal bleeding other than period
[ ] Pap smear within last two years
[ ] Painful menstrual periods
[ ] Back pain with menstrual periods
[ ] Other menstrual problems

***Do you have any current problem with:**

[ ] anxiety
[ ] depression
[ ] irritability

***Do you have a consistent home exercise program?**

[ ] Yes [ ] No

Please Circle What Your Pain Best Describes Below
0 – 10 Numeric Pain Intensity Scale

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worse Possible Pain