PATIENT HEALTH HISTORY QUESTIONAIRE

Name: _____ Date: _____

Date of Birth: _____ Weight: _____ Height: _____

Is your problem related to a work injury or accident? ☐ Yes ☐ No

What is your current pain complaint? _____

If this was caused by an accident, did you ever have issues with your back or neck prior to this accident? ☐ Yes ☐ No

Date of Injury or Onset of symptoms: _____/_____/_____

Is there a possibility you are pregnant? ☐ Yes ☐ No

GENERAL MEDICAL (Check or List any that you have had In the past or present)

Heart Disease	☐ Yes	☐ No		Kidney Disease	☐ Yes ☐ No
Arthritis	☐ Yes	☐ No		Depression/Anxiety	☐ Yes ☐ No
Osteoporosis	☐ Yes	☐ No		High Cholesterol	☐ Yes ☐ No
Asthma	☐ Yes	☐ No		COPD	☐ Yes ☐ No
Thyroid Disorder	☐ Yes	☐ No		Reflux/Heartburn	☐ Yes ☐ No
Stomach Ulcers	☐ Yes	☐ No		Alcoholism/Drug Addiction	☐ Yes ☐ No
High Blood Pressure	☐ Yes	☐ No		Liver Disease	☐ Yes ☐ No
Sleep Apnea	☐ Yes	☐ No		HIV/AIDS	☐ Yes ☐ No
Seizures	☐ Yes	☐ No		Diabetes	☐ Yes ☐ No
Stroke	☐ Yes	☐ No		Bleeding Disorder	☐ Yes ☐ No
Cancer	☐ Yes	☐ No	- If Yes, Please list:	Type: _____	
Autoimmune Disorder	☐ Yes	☐ No	- If Yes, Please list:	Type: _____	

Other: _____

SURGICAL HISTORY (Operation and Year)

_____

_____

_____

_____

_____

_____

_____

Name: _____ DOB: _____

Page 1

FAMILY HISTORY

Were your parents, grandparents, or siblings ever diagnosed with:

High Blood Pressure	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No			

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Are you employed? ☐ Yes ☐ No If so, **Title**/**Duties**: _____

Are you disabled? ☐ Yes ☐ No If so, date disability began? _____ / _____ / _____

Tobacco use? ☐ Yes; packs per day _____ ☐ No ☐ Previously, but quit

Alcohol use ☐ None ☐ Rarely ☐ Moderately ☐ Daily

Illegal drug use ☐ None ☐ Yes; type/frequency _____

Are you working? ☐ Yes ☐ No With Restrictions? ☐ Yes ☐ No

If no, last day worked? _____ Does employer have light duty? ☐ Yes ☐ No

Have you been injured on the job before? ☐ Yes ☐ No If yes, body part(s) _____

Are you on any special diet? ☐ Yes ☐ No _____

Do you CURRENTLY exercise? ☐ Yes ☐ No If yes, how often? _____

Hobbies: _____

Name and Phone Number of your **MEDICAL DOCTOR**:

_____

Name and Phone Number of your **PHARMACY**:

_____

Do you have any known drug allergies ☐ Yes ☐ No List with reaction(s):

_____

_____

_____

_____

_____

_____

_____

_____

Name: _____ DOB: _____

Conditions/symptoms that **Currently** apply to you:

Constitutional			Respiratory		
Fever (unexplained)	Y	N	Pneumonia	Y	N
Chills	Y	N	Asthma	Y	N
Night Sweats	Y	N	Emphysema	Y	N
Weight Loss (unexplained)	Y	N	Bronchitis	Y	N
Weight Gain (unexplained)	Y	N			
Fatigue	Y	N			
ENT			Gastrointestinal		
Loss of Hearing	Y	N	Abdominal Pain	Y	N
Sinus Problems	Y	N	Blood in Stool	Y	N
Tooth/Gum Trouble	Y	N	Nausea/Vomiting (not due to flu)	Y	N
Ringing in Ears	Y	N	Indigestion/Heartburn	Y	N
			Stomach Ulcers	Y	N
			Irritable Bowel Syndrome	Y	N
Psychiatric			Miscellaneous		
Depression	Y	N	History of Alcohol Abuse	Y	N
Sleeping Disorder	Y	N	History of Drug Abuse	Y	N
Anxiety	Y	N	Hepatitis	Y	N
Bipolar	Y	N	Liver Disorder	Y	N
Cardiovascular			Genitourinary		
Heart Attack	Y	N	Bladder Problems	Y	N
Mitral Valve Prolapse	Y	N	Frequent Urinary Infection(s)	Y	N
Abnormal Heart Rhythm	Y	N	Blood in Urine	Y	N
High Blood Pressure	Y	N	Kidney Stones	Y	N
Stroke / Mini-Stroke	Y	N	History of Kidney Disease	Y	N
Chest Pain	Y	N	Sexual Dysfunction	Y	N
Leg Pain with Exercise	Y	N	Difficulty Urinating	Y	N
Raynaud's Disease	Y	N	Painful Urination	Y	N
Musculoskeletal			Neurological		
Low Back Pain	Y	N	Dizzy Spells	Y	N
Mid Back Pain	Y	N	Seizures or Convulsions	Y	N
Neck Pain	Y	N	Headaches	Y	N
Osteoporosis	Y	N	Multiple Sclerosis	Y	N
Joint Swelling	Y	N	Tingling / Numbness	Y	N
Weakness	Y	N	Memory Loss	Y	N
			Coordination Loss	Y	N
Hematology			Endocrine		
Anemia	Y	N	Diabetes	Y	N
Blood Clots	Y	N	Thyroid Dysfunction	Y	N
Sickle Cell	Y	N	Gout	Y	N

Name: _____ DOB: _____

SYMPTOMS

What are your main complaints at this time?

- ☐ Neck Pain
- ☐ Back Pain
- ☐ Tingling
- ☐ Difficulty Walking
- ☐ Bowel Problems
- ☐ Bladder Problems
- ☐ Weakness; of _____
- ☐ Numbness; of _____
- ☐ Other _____

_____

Do your symptoms interfere with your daily activities? ☐ Yes ☐ No

What, if anything, makes your symptoms worse?

- ☐ Walking
- ☐ Prolonged Standing
- ☐ Bending Backwards
- ☐ Twisting
- ☐ Lifting
- ☐ Pushing
- ☐ Climbing Stairs
- ☐ Sex
- ☐ Sitting
- ☐ Other: _____

What, if anything, makes your symptoms better?

- ☐ Lying Down
- ☐ Massage
- ☐ Ice
- ☐ Sitting
- ☐ Heat
- ☐ Bending Backwards
- ☐ Standing
- ☐ Medications
- ☐ Leaning Forward

TREATMENTS

Have you tried any of the following since your symptoms began?

Treatment	Did it help?	
☐ Physical Therapy	☐ Yes	☐ No
☐ Home Exercises	☐ Yes	☐ No
☐ Limiting Activity	☐ Yes	☐ No
☐ Brace	☐ Yes	☐ No
☐ Injections	☐ Yes	☐ No
☐ Non-steroidal anti-inflammatories for at least 3 weeks	☐ Yes	☐ No

- ☐ Celebrex
- ☐ Advil
- ☐ Mobic
- ☐ Ibuprofen
- ☐ Naproxen
- ☐ Diclofenac
- ☐ Other _____

Name: _____ DOB: _____

Medication List

This form has to be completed/updated at every visit. PLEASE **DO NOT** write "same as last visit".
Please list actual drug name (example: Lisinopril) –do not write "blood pressure medication"
Please list ALL medications INCLUDING over the counter, prescribed by our office or by another physician.

Medication:	Do you take this medication daily:		
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed

Have you used prescription medications that are **NOT** prescribed to you in the last 30days?

YES NO If Yes, Please List: _____

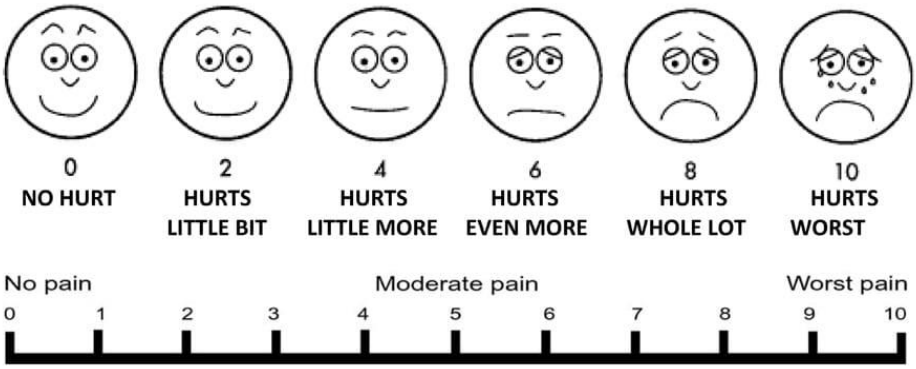
Have you used recreational or illegal drugs in the last 30 days:

YES NO If Yes, Please List: _____

Todays Date: _____

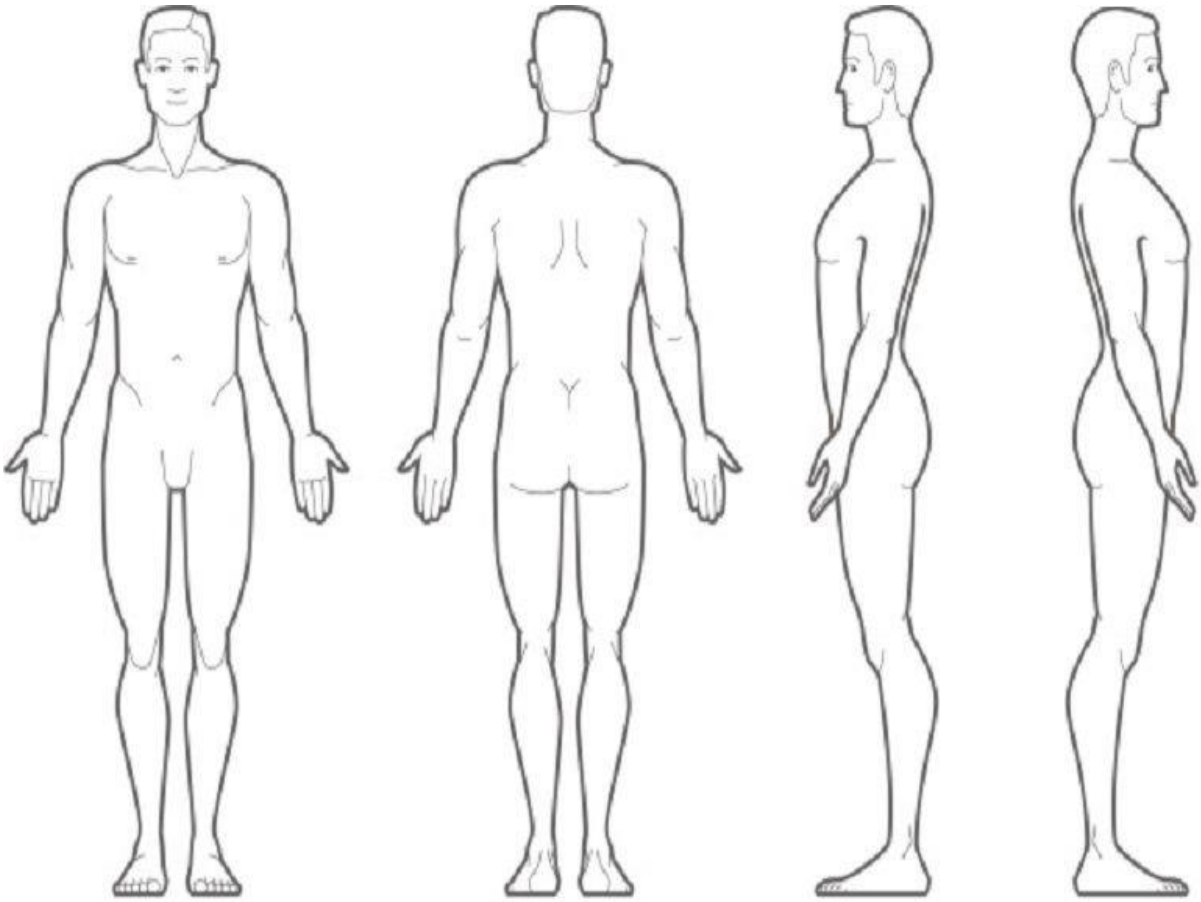
Name: _____ DOB: _____

On the line below, CHECK the box that reflects your pain score **TODAY**.



Use the appropriate Letters shown below to mark the areas on your body where you feel these described sensations. Include ALL areas affected by your pain, including areas where your symptoms radiate.

Letter B = Burning Letter N = Numbness Letter T = Tingling Letter A = Ache Letter S = Stabbing



Name: _____ DOB: _____

NECK PAIN **D**ISABILITY **I**NDEX

Please circle only ONE number for each question that best describes your current pain/issue.

PAIN INTENSITY

0 I have no pain at the moment in my neck
1 The pain is mild at the moment in my neck
2 The pain in my neck comes and goes and is moderate
3 The pain in my neck is moderate and does not vary much
4 The pain in my neck is severe but comes and goes
5 The pain in my neck is severe and does not vary much

PERSONAL CARE (washing, dressing etc.)

0 I can look after myself without causing extra pain in my neck
1 I can look after myself normally but it causes pain in my neck
2 It is painful to look after myself and I am slow and careful due to my neck pain
3 I need some help due to neck pain but manage most of my personal care
4 I need help every day in most aspects of self-care due to my neck pain
5 I do not get dressed; I wash with difficulty and stay in bed

LIFTING

0 I can lift heavy weights without extra pain in my neck
1 I can lift heavy weights, but it causes extra neck pain
2 Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned (such as on a table)
3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned (such as on a table)
4 I can only lift very light weights due to my neck pain
5 I cannot lift or carry anything at all due to my neck pain

READING

0 I can read as much as I want to with no pain in my neck
1 I can read as much as I want with slight pain in my neck
2 I can read as much as I want with moderate pain in my neck
3 I cannot read as much as I want because of moderate pain in my neck
4 I cannot read as much as I want because of severe pain in my neck
5 I cannot read at all because of my neck pain

Name: _____ DOB: _____

NECK PAIN **D**ISABILITY **I**NDEX (Continued)

HEADACHE

0 I have no headache at all
1 I have a slight headaches that come infrequently
2 I have moderate headaches that come infrequently
3 I have moderate headaches that come frequently
4 I have severe headaches that come frequently
5 I have a headache most of the time

DRIVING

0 I can drive my car without neck pain
1 I can drive my car as long as I want with slight neck pain
2 I can drive my car as long as I want with moderate neck pain
3 I cannot drive my car as long as I want because of moderate neck pain
4 I can hardly drive my car at all because of severe pain in my neck
5 I cannot drive my car at all

SLEEPING

0 I have no trouble sleeping due to neck pain
1 My sleep is slightly disturbed (less than 1 hour lost) due to neck pain
2 My sleep is mildly disturbed (1 to 2 hours lost) due to neck pain
3 My sleep is moderately disturbed (2 to 3 hours lost) due to neck pain
4 My sleep is greatly disturbed (3 to 5 hours lost) due to neck pain
5 My sleep is completely disturbed (5 to 7 hours lost) due to neck pain

RECREATION

0 I am able to engage in all recreational activities with no pain in my neck
1 I am able to engage in all recreational activities with some pain in my neck
2 I am able to engage in most, but not all, recreational activities because of neck pain
3 I am able to engage in only a few of my usual recreational activities due to neck pain
4 I can hardly do any recreational activities because of pain in my neck
5 I cannot do any recreational activities at all due to my neck pain

Name: _____ DOB: _____

FMLA and Disability Paperwork Fee Agreement

It is the policy of your Physician and *The Orthopedic and Spine Institute of St. Louis* that an upfront fee will be collected in order to complete any type of forms relating to FMLA or Disability Paperwork. The current fee(s) is $60 for the first two pages and $10 for each additional page. These rates are subject to change without notice. It can take up to 14 business days for these forms to be completed due to the high volume of paperwork our office receives. You will need to plan accordingly with your employer or disability insurance on getting these forms to our office in advance.

It is the responsibility of the patient to complete all "patient portions" on the forms PRIOR to giving them to our office, as well as signing any patient signature portions. This will prevent any delay in sending your paperwork in a timely manner; as it requires your signature in order for our office to share your health information (per HIPAA Guidelines).

By signing below, you are acknowledging that you have read, understand, and agree to the Policy and Fee(s) listed above

Signature: _____ Date: _____/_____/_____

Name: _____ DOB: _____

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy pertaining to Office and Surgical Treatment, which we require that you read and agree to prior to treatment.

- Failing to pay your copay puts both you and your surgeon in violation of contract with your health insurance plan, therefore copays are due at the time of service. No Exceptions.
- It is your responsibility to know your own insurance benefits, covered benefits and exclusions.
- We will attempt to confirm your insurance coverage prior to your treatment. However, it is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible for any charges rendered.
- A copy of a photo ID and insurance card(s) are required for every patient at each visit. An I.D. and insurance card is required for our records in order to protect patients from insurance fraud. *Providing a copy of your insurance card does not guarantee coverage of services*.
- If Surgery is scheduled, you will be responsible for any unmet portion of your deductible, as well as your co-insurance (if applicable) *prior* to your surgery taking place. This amount will be calculated per your insurance contract agreement therefore, your surgery will be canceled if you are unable to uphold your financial responsibility.

I have read the financial policies contained above, and my signature below serves as acknowledgement and understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Printed Name of Patient/Responsible Party Relationship to Patient

Name: _____ DOB: _____

HIPAA Privacy Authorization Form

I, _____, give permission to The Orthopedic and Spine Institute of St. Louis to:

- ☐ Use the following protected health information, and/or
- ☐ Disclose the following protected health information to:

_____

_____

_____

(Name(s) of person / entity to receive information – e.g., Spouse, Physician, Attorney)

Information that may be disclosed (check all that apply):

- ☐ Medical Records
- ☐ Treatment Records
- ☐ Other;
- ☐ Appointment Information
- ☐ Diagnostic Records

_____

_____

_____

This protected health information is being used or disclosed for the following purposes:

_____

_____

_____

This authorization expires: _____

(Specify date or event that relates to the purpose of this use or disclosure)

*If a date is not listed, this will not expire until a new form is completed, or a written notification is received

If the person or entity receiving this information is not a Health Care Provider or Health Care Plan covered by Federal Privacy Regulations, the medical records or information being disclosed (to other individuals or Institutions) may no longer be protected by these regulations.

You may revoke this authorization in writing at any time by sending a written notification to:
The Orthopedic and Spine Institute of St. Louis, attention HIPAA Privacy Officer at 10435 Clayton Road, Suite 120, St. Louis, MO 63131. Your notice will not apply to actions taken by the requesting person / entity prior to the date they receive your written request to revoke this authorization.

HIPAA Acknowledgement

I, _____, understand that at any time I can request of copy of The Orthopedic and Spine Institute of St. Louis' notice of Privacy Practices, and it will be provided to me.

_____ _____

Signature of Patient/Responsible Party Date

Name: _____ DOB: _____

Patient Referral Form

The Orthopedic and Spine Institute of St. Louis
David S. Raskas, M.D.

Please take a moment to complete the following form inquiring how you were referred to our office. If more than one option applies, please indicate that below. We thank you in advance for your time and for your trust in our care.

Please complete the portion below that applies to how you were referred to our office:

Physician Name & Phone Number: _____

Attorney Name & Phone Number: _____

Hospital / Urgent Care Name: _____

Insurance or Work Comp: _____

Friend / Relative (Name): _____

Other: _____

☐ I am a former patient

If you were not referred, did you find our office through one of the following:

Internet Search: _____

Digital / Billboard Ad: _____

Magazine / Brochure: _____

Radio / Television

_____

Attended Information Seminar: _____

Other (please list): _____