CAPITAL PAIN
& ORTHO

Patient Demographics Form

Name_______________________________________Today's Date ________________________

Address____

City_______________________State______________________Zip______________________

Email____

Phone #________________________________Cell#____________________________________

Date of Accident_________________DOB _______________

Accident Type: ☐ Motor Vehicle ☐ Slip/Fall ☐ Other__________________________

Main Reason for Visit ____

Do you identify as ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Asian
☐ Hispanic ☐ Other?

Permission For Treatment

The undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Capital Pain & Ortho and staff, deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledgethat no guarantees have been made to me as a result of treatment or examination in the office.

Privacy Notice

I have received a copy of the office HIPPA Privacy Notice.

I verify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of changes in my status or changes in the information provided to this office.

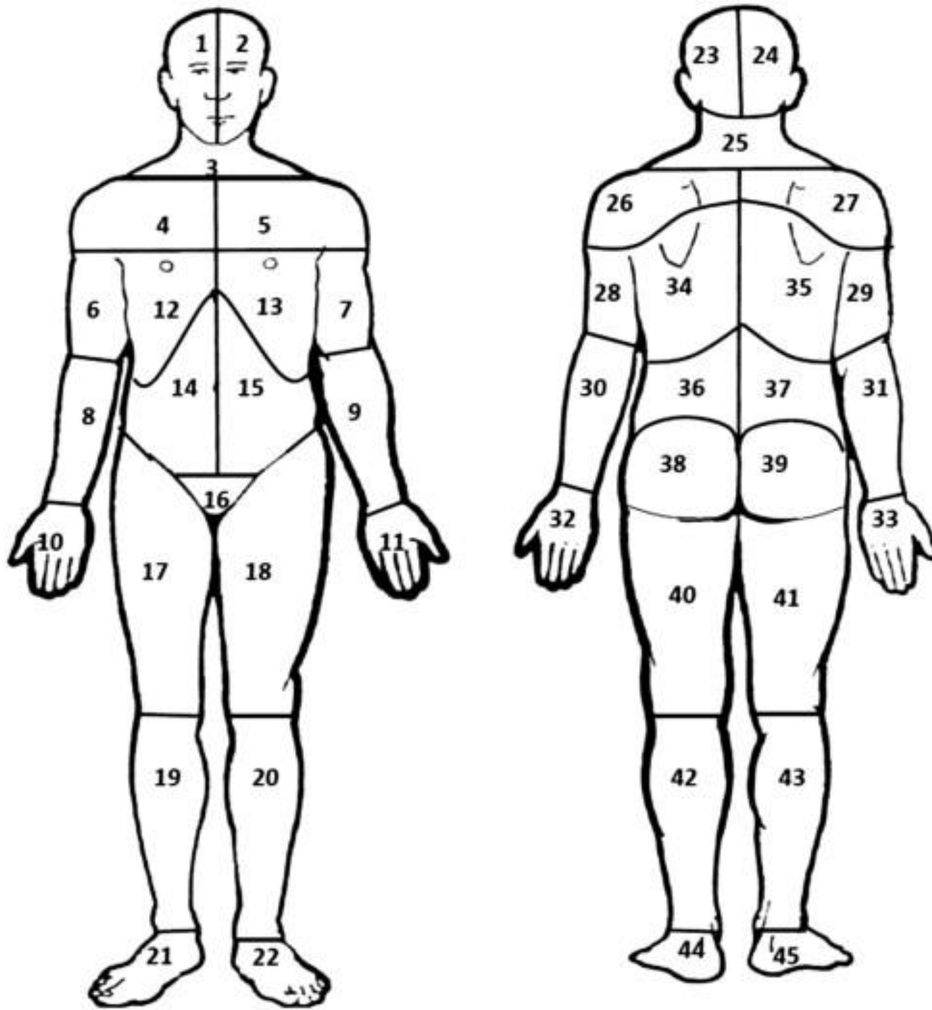
________________________ ________________________ ________________________

Date **Signature** **Witness**

A *valid government-issued* **Photo ID** required
upon checking in to your first appointment.

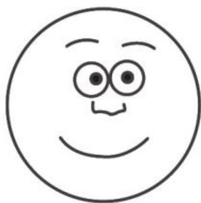
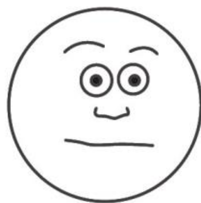
WHERE IS YOUR PAIN?

[CIRCLE NUMBER(S) OR SHADE IN AREA(S)]



WHERE IS YOUR PAIN RATING TODAY?

[Circle One]

					
0	**2**	**4**	**6**	**8**	**10**
No Pain	Hurts A Little Bit	Hurts A Little More	Hurts Even More	Hurts A Whole Lot	Hurts The Worst

Patient Demographics Form

WHERE DID YOU HURT IMMEDIATELY FOLLOWING THE ACCIDENT?

____

____

WHERE DID YOU HURT IN THE FEW DAYS FOLLOWING ACCIDENT?

____

____

DOES PAIN EXTEND TO OTHER LOCATIONS: ☐ YES ☐ NO

EXTENDS TO: ______________________________

____

CONSISTENCY OF PAIN: ☐ CONSTANT ☐ DAILY ☐ INTERMITTENT **HOW OFTEN?** ____________

DESCRIBE YOUR PAIN: ☐ ACHING ☐ BURNING ☐ SHARP ☐ DULL ☐ SHOOTING ☐ THROBBING

DO YOU EXPERIENCE: ☐ NUMBNESS ☐ TINGLING ☐ WEAKNESS

LOSS OF BOWEL OR BLADDER CONTROL: ☐ YES ☐ NO **BLOOD IN URINE OR STOOL:** ☐ YES ☐ NO

WHEN IS YOUR PAIN WORSE? ☐ MORNING ☐ AT MIDDLE OF DAY ☐ EVENING

INDICATE WHICH OF THE FOLLOWING ACTIVITIES INCREASES YOUR PAIN:

☐ BENDING FORWARD ☐ LEANING BACKWARD ☐ LAYING DOWN
☐ COUGH/SNEEZING ☐ LONG CAR RIDES / DRIVING ☐ REACHING OVERHEAD
☐ CLIMBING STAIRS ☐ LOOKING UP / TURNING HEAD ☐ LIFTING
☐ SITTING ☐ STANDING ☐ WALKING

WHAT DECREASES YOUR PAIN? ______________________________

____

HAVE YOU HAD A PRIOR ACCIDENT? ☐ YES ☐ NO

TYPE OF ACCIDENT: ☐ MOTOR VEHICLE ☐ SLIP AND FALL

DATE: ____________________

TYPE OF INJURIES: ______________________________

____

ANY PAIN BEFORE ACCIDENT? ☐ YES ☐ NO **PAIN LOCATIONS:** ____________________

MEDICATION ALLERGIES AND REACTIONS: ______________________________

____

____

ALL SURGERIES AND DATES: ______________________________

____

____

FOR FEMALES:

PREGNANT: ☐ YES ☐ NO **BREAST FEEDING:** ☐ YES ☐ NO **LAST MENSTRUAL PERIOD:** __________

PAST MEDICAL HISTORY:

- ☐ ASTHMA
- ☐ ARTHRITIS
- ☐ BLEEDING DISORDER
- ☐ CANCER
- ☐ COPD
- ☐ DIABETES
- ☐ GERD
- ☐ GI DISORDER
- ☐ HEART ATTACK
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ LIVER DISEASE
- ☐ KIDNEY FAILURE
- ☐ MIGRAINE/SEVERE HEADACHE
- ☐ NEUROLOGICAL DISORDERS
- ☐ OSTEOPOROSIS
- ☐ HIV/AIDS
- ☐ RADIATION/CH EMOTHERAPY
- ☐ RENAL/KIDNEY DISEASE
- ☐ SEIZURES
- ☐ STROKE
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS

SOCIAL AND FAMILY HISTORY:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SMOKING QTY:______________**ALCOHOL QTY:**__________________**OTHER DRUGS:** ___________________________

FAMILY HISTORY: ☐ CANCER ☐ HEART DISEASE ☐ DIABETES ☐ OTHER

OTHER SYMPTOMS: ☐ RECENT WEIGHT CHANGE ☐ DECREASED APPETITE ☐ CHEST PAIN
☐ DIFFICULTY BREATHING ☐ DIFFICULTY BREATHING WITH ACTIVITY ☐ SLEEP DISTURBANCE
☐ FEVE ☐ COUGH ☐ CHILLS ☐ DIFFICULTY WALKING ☐ HEADACHES

ALL CURRENT MEDICATIONS: PLEASE LIST MEDICATION NAME, STRENGTH, AND HOW OFTEN YOU TAKE IT

____

____

____

____

WHERE WAS THE ACCIDENT? CITY: ____

INTERSECTION:____

POSITION IN VEHICI.E? ☐ DRIVER ☐ FRONT PASSENGER ☐ REAR PASSENGER

WERE YOU WEARING A SEATBELT? ☐ YES ☐ NO **POINT OF CONTACT?** ☐ REAR ENDED ☐ T-BONED

DID YOU LOSE CONSCIOUSNESS? ☐ YES ☐ NO **DID AIR BAGS DEPLOY?** ☐ YES ☐ NO

PARAMEDICS AT ACCIDENT SCENE? ☐ YES ☐ NO **AMBULANCE TRANSPORT TO HOSPITAL?** ☐ YES ☐ NO

TREATMENT SO FAR? ☐ YES ☐ NO ☐ HOSPITAL ☐ CHIROPRACTIC ☐ PHYSICAL THERAPY
☐ INJECTIONS ☐ SURGERY

WHEN DID YOU FIRST RECEIVE ANY TREATMENT? ____

WHERE DID YOU FIRST RECEIVE ANY TREATMENT? ____

IS CURRENT TREATMENT HELPING? ☐ YES NO ☐

DESCRIBE HOW THE ACCIDENT HAPPENED: ____

____

____

HIPAA MEDICAL RELEASE FORM

Release of lnformation

l authorize the release of information which will include diagnosis, medical information, imaging reports that were rendered to me by the physicians of Capital Pain & Ortho. This information may be released to the following:

(LIST FRIENDS AND FAMILY ONLY - WE AUTOMATICALLY RELEASE TO LAWYERS AND THE PHYSICIANS THAT REFERRED YOU)

1) Name ______________________________ Relationship ____________________ Phone ________________

2) Name ______________________________ Relationship ____________________ Phone ________________

3) Name ______________________________ Relationship ____________________ Phone ________________

☐ **BY CHECKING THIS YOU DO NO WANT ANY INFORMATION RELEASED**

Please mark the area in which we can leave a message:

☐ Home ☐ Work ☐ Cell phone

lf unable to reach me, please mark the area on how to communicate

☐ Leave a detailed message on cell phone and/or text

☐ Leave a message by email

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING TO SPINE CENTERS OF AMERICA.

Information to be disclosed:

☐ Medical records for continued care ☐ Diagnostic Imaging ☐ Alcohol/Drug Therapy

☐ Transcribed hospital records ☐ Entire Medical Records ☐ Communicable disease/ (HIV/HBV))

☐ Laboratory reports ☐ Psychotherapy notes

I hereby authorize the use or disclose of my individually identifiable health information as described above. l understand that this is voluntary. I understand that the organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations.

1 understand that this consent shall be valid for a period of one year from the date of the authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation.

I further understand that the confidentiality of this information may be protected by Federal Regulations {42CFR, Part II), prohibiting any further disclosure of this information with specific written authorization of the undersigned, or as otherwise regulated.

____ ____________________

Signature of patient/Patient Legal Representative **Date**

____ ____________________

Printed name of legal representative (lf applicable) **Relationship to patient**