Spine Group Arizona

HONORHEALTH Scottsdale Osborn Medical Center

OFFICE USE ONLY - PATIENT LABEL HERE

Initial Patient Assessment

Today's Date: ___/___/___

Patient Information

Last Name: _____ First Name:_____

Primary Phone:_____

Secondary Phone: _____

E-Mail: _____

Date of Birth: ___/___/___ Age: ____

Gender: M / F Height: _____ Weight:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How did you hear about us?

Referring Doctor:

PCP (leave blank if same as Referring Doctor):

Your Symptoms, Previous Tests, & Treatments

What problem or issue brings you in today?

☐ Back Pain ☐ Neck Pain

☐ Other:

When did it start, and what were you doing when it started (i.e., working, fall, accident)?

The pain occurred: ☐ All of a sudden ☐ Slowly

Was there an injury? ☐ Yes ☐ No

If yes, describe:

What is the timing of your pain? Check all that apply:

☐ Constant ☐ Comes & Goes

☐ Getting Worse ☐ Getting Better

☐ Not changing/staying about the same

Does the pain shoot down the arm or leg? ☐ Yes ☐ No

If yes, describe:

Describe your pain in words (select all that apply):

☐ Sharp ☐ Dull ☐ Achy

☐ Burning ☐ Stabbing ☐ Numbness

☐ Tingling ☐ Pulling ☐ Cramping ☐ Tightness

What makes your pain worse (i.e., sitting, standing, lifting)?

What makes your pain better (i.e., rest, ice, heat, pills)?

Do you have numbness or tingling? ☐ Yes ☐ No

If yes, where?

Do you have any weakness (arm/leg)? ☐ Yes ☐ No

If yes, where?

Do you have trouble walking due to the pain? ☐ Yes ☐ No

Any bowel/bladder issues or groin numbness? ☐ Yes ☐ No

What diagnostic tests have you had for this?

☐ X-Ray ☐ MRI

☐ CT Scan ☐ Bone Scan

☐ EMG (electromyography)

What treatments have you had so far?

☐ Medications ☐ Physical Therapy

☐ Injections ☐ Chiropractic

☐ Psychological ☐ Acupuncture

Have you ever had back or neck surgery? ☐ Yes ☐ No

If yes, describe:

Is there a law suit pending due to your pain? ☐ Yes ☐ No

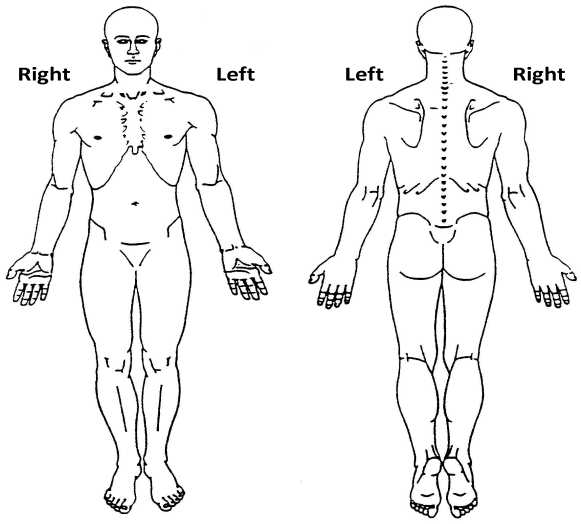
Your Pain

Please indicate on this line how severe your pain is:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Pain Possible**

Please draw where your pain is:



Does your pain affect your ability to work? ☐ Yes ☐ No

If yes, describe:

If you are not working due to your pain, how long have you been off of work?

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Medications

Please list ALL of your medications with doses and frequencies, including supplements:

Past Medical History

Please list ALL of your **medical conditions** (i.e., high blood pressure, high cholesterol, diabetes, thyroid disease, heart disease, etc.) AND **surgeries** that you have had:

Please list any **allergies** including any reactions to anesthesia:

Family History

Your mother is: LIVING or DECEASED

Your father is: LIVING or DECEASED

Indicate which family members (if any) have/had these medical issues (example: writing "brother" next to diabetes):

Cancer	Heart Problems	Stroke
Diabetes	High Blood Pressure	Arthritis
Epilepsy	AIDS/HIV	Bleeding disorders
Hepatitis	Back/neck problems	Migraines
Muscle diseases	Nerve diseases	Psych problems
Stomach problems		Thyroid problems
Other:		

Social History

Do you use tobacco?	No	Yes (how much?)
Illicit drug use?	No	Yes (which drugs?)
History of drug abuse?	No	Yes (describe)
Do you drink alcohol?	No	Yes (drinks per week?)

Do you use an assistive device (cane / walker / wheelchair)?

How many falls have you had in the last 12 months?

None One, WITH injury One, WITHOUT injury

2+, WITH injury 2+, WITHOUT injury

Current Work Status (please circle):

Full-time / Part-time / Off-duty due to injury / Parent / Not working

Retired / Off-duty for other reason

If off-duty, when was the last time you worked?

Occupation and Employer:

Review of Systems

Recently, have you had any of these symptoms (please circle)?

Fevers/Chills	Weight Loss
Chest Pain	Shortness of Breath
Worse Pain at Night	Night Sweats
Vision Changes	Black Stools
Bloody Stools	Rash
Dizziness	Suicidal Thoughts

Important Activities

Please **list three important activities** that you are unable to do or that you are having difficulty doing as a result of your problems with **zero (0)** being **unable to perform** the activity and **ten (10)** being **able to perform** the activity at your pre-injury level:

1) _____

0 1 2 3 4 5 6 7 8 9 10

2) _____

0 1 2 3 4 5 6 7 8 9 10

3) _____

0 1 2 3 4 5 6 7 8 9 10

Follow up Assessment

As part of our commitment to improve health care, we are collecting data on our patients using a secure website (your personal information is always protected). Is it ok if a link to an assessment related to your care here is emailed to you? ☐ Yes ☐ No

Emergency Contact

My emergency contact is:

Relationship:

Phone Number:

Office Use Only

Evaluation Date:

Provider:

Harvinder S. Deogun Other:

Kylie Scott

Steven Karstetter

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Patient Name: _____ DOB: _____

Male: _____ Female: _____

Primary phone: _____ Secondary phone: _____

Email: _____

Social Security Number: _____

Referring source/How did you hear about us? _____

Marital Status: Single: _____ Married: _____ Divorced: _____ Widowed: _____

Who would you like to list as your emergency contact?

Name: _____ Relationship: _____

Address: _____ Phone :(_____) _____ _____

Who is the adult guarantor of your account? _____Date of Birth: _____

Address: _____ Phone :(_____) _____ _____

Is this appointment accident related? _____

Are you employed? Yes_____ No _____ Employer Name: _____

Do you have health insurance? Yes __ No__ If so, what insurance co? _____

Member/Subscriber Number:_____ Group Number_____

Who is the subscriber, or policy holder? _____

Relationship to you? _____ Their date of birth _____/_____/_____

Is your insurance through your employer? Yes __ No___ How many employees in the company? 1-19, 20-99, 100+

HONORHEALTH™

Medical Group

Privacy Notice Acknowledgment and Communication Consent

Patient Name: _____ DOB _____
PLEASE PRINT NAME

Name and phone number of your family physician:

_____ (_____) _____ - _____

Please list below the pharmacy you would like us to use as well as cross streets:

_____

At times, we will call you with appointment reminders or leave general information messages on your voicemail.

Can we leave messages on your home phone?
Yes No
____ ____ Home Number:_____

Can we leave messages on your cell phone?
Yes No
____ ____ Cell Phone:_____

Can we mail test results to your home?
Yes No
____ ____

Please provide any person(s) to be included in issues regarding your health and permission to pick up prescriptions.

1) Name: _____ Relationship:_____
2) Name: _____ Relationship: _____

Must be signed below prior to information given:

My signature below authorizes communication consent as well as acknowledges that I have received a copy of the HonorHealth Network Notice of Privacy Practices. I acknowledge that I can revoke this communication consent, in writing, at any time.

_____ _____
Patient Name (please print) Date

_____ _____
Patient or Person Authorized to Sign If not patient relationship to patient (parent, legal guardian, Personal representative, etc.)

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OUR NO SHOWS, CANCELLATIONS, AND LATE ARRIVAL POLICY

Your HonorHealth Medial Group Specialists and Administration at Spine Group Arizona want to ensure that you and other patients have access to high quality care when you need it. We believe in honoring patients who schedule and keep their appointments to accommodate everyone in a fair and efficient manner. To ensure maximum access to healthcare needs for all of our patients, please be aware of the following:

Scheduled Appointments: The patient is responsible for scheduling and keeping their appointment. If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know. This allows enough time for your appointment to be offered to another patient. Failure to provide at least a 24-hour notice counts as a no-showed appointment. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not always possible in this case. These situations will be considered on a case to case basis.

Cancellations vs. No Shows: No showed appointments (or cancellations within 24 hours) will be documented in your records with us. Failure to give any prior notice for cancellations or failing to appear for an appointment will be counted as a no show. After two no showed appointments, you will be given a warning about no showing to your next appointment. Three no showed appointments will result in no longer being put on our schedule any time in advance. You must call same day for an appointment. Any openings will be given to you if available.

Late Arrivals: For your first visit, we ask that you arrive 15 to 30 minutes prior to your scheduled appointment time for check-in and paperwork to ensure you are seen in a timely manner. For subsequent (follow-up) visits, or for your first visit if you have already completed and brought your paperwork, we ask that you arrive 10 minutes prior to your scheduled appointment time.

If you arrive late (by 10 minutes or more), you will be given these options:

- You may reschedule the appointment to a later time that day or wait for a no show/cancellation
- You may reschedule the appointment to a different day

Please sign below to indicate your agreement with our clinic policies:

Your Name: _____

Signature: _____

Today's Date: _____

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OUR PAIN MEDICATION POLICY

Please initial next to **each statement** indicating your agreement to our clinic policies:

_____ In the course of my treatment, I may receive pain medications. It is important to note that all physicians are required by federal law to follow stringent policies related to the use of prescription drugs, especially narcotics. Therefore, if I receive narcotic medications, I agree to not receive any other narcotics from any other physician without authorization from Spine Group Arizona.

_____ I will be responsible for making sure I do not run out of my pain medications on weekends and holidays. Spine Group Arizona will not provide pain prescriptions or refills during the weekend which begins each Friday at noon and ends the following Monday at 8:30 AM, unless you are seen in the office for an appointment.

_____ If I received pain medications that are considered controlled substances (such as narcotics which may include Vicodin and Percocet), I agree that refills for these medications will be done **only** in the office during an appointment (i.e., not over the phone). Further, I agree that refills will **NOT** be done during interventional procedures (such as epidurals) due to time constraints.

_____ I agree to give Spine Group Arizona at least two business days for non-controlled substances and at least one week for controlled substances for all refill requests. This gives the clinic staff a chance to review your request for refill.

_____ I agree to keep all of my medications in a safe and secure place. Spine Group Arizona will not provide refills for pain medications are stolen or lost, with a one-time only exception if there a police report indicating a theft.

_____ I agree not to give my prescription medications to anyone else. I also agree not to take anyone else's pain medications.

_____ I agree that Spine Group Arizona generally does not provide high dose or chronic (long-term) narcotics or benzodiazepines.

_____ I agree that Spine Group Arizona is a multi-disciplinary clinic and as such generally does not just provide narcotics or benzodiazepines as sole treatment.

_____ I agree that failure to comply with these policies may result in cessation of being prescribed controlled substances.

Please sign below to indicate your agreement with our clinic policies:

Your Name: _____

Signature: _____

Today's Date: _____

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Patient Name: _____ DOB: _____

Male: _____ Female: _____

Primary phone: _____ Secondary phone: _____

Email: _____

Social Security Number: _____

Referring source/How did you hear about us? _____

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Is your insurance through your employer? Yes __ No___ How many employees in the company? 1-19, 20-99, 100+