HONORHEALTH

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

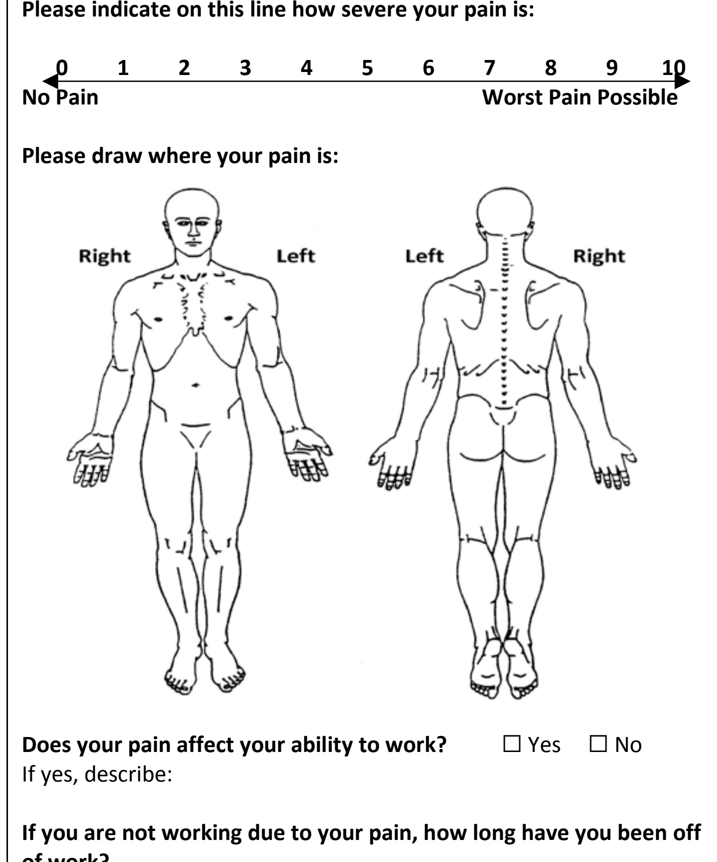
Your Pain

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?

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

Provider:
Dr. Hennehoefer

 Physician Review: Date:

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+

OUR NO SHOWS, CANCELLATIONS, AND LATE ARRIVAL POLICY

Your HonorHealth Medical 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: ______________________________

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 prescribing controlled substances.

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

Your Name: ____

Signature: ____

Today's Date: ____