ALABAMA SPINE & REHABILITATION CENTER

Full Legal Name:_____Today's Date: _____

Occupation:_____Male____Female____

Address:_____City:_____

State:_____Zip:_____Email (write legibly): _____

Phone (Primary):_____Phone (Home): _____

Date of Birth:_____Age:_____Social Security #: _____

PLEASE FILL OUT INSURANCE INFORMATION BELOW EVEN IF YOUR CARDS WERE TURNED IN:

Primary Insurance:_____Contract #: _____

Insured Name:_____*If not you*, Insured Date of Birth: _____

Secondary Insurance:_____Contract #: _____

Primary Care Physician (Address & Phone if known): _____

PATIENT QUESTIONNAIRE:

Reason for seeking care? _____

Who might we ask referred you to us? _____

When was your most recent MRI or X-ray? _____

If pain is present, how long has it been occurring? _____

If pain is present, what alleviates the pain? _____

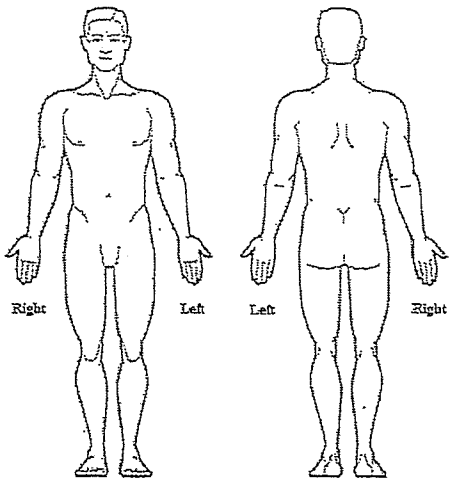
If pain is present, what worsens the pain? _____

Height?____feet___inches Weight?_____pounds

Do you smoke Y/N? _____

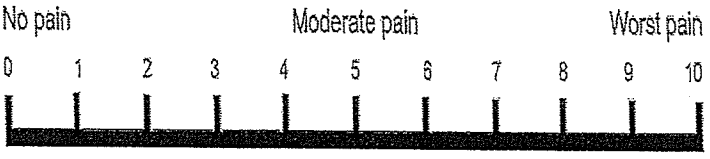
Alcohol Y/N?_____Daily?_____Weekly?_____Social Occasions? _____

Caffeinated drinks per day? _____



Please **mark where** you feel pain on the figure/s to the ←left:

Please **circle** the degree of pain you currently have below where "0" is no pain & "10" is worst pain:



Social History Information Sheet

Name _____ Today's Date _____

DOB _____Height ____ ft ____ in Weight _____

Reason for Today's Exam _____

Past Medical History: Please check any illnesses/conditions which YOU have had.

☐High Blood Pressure	☐DVT	☐Lung Disease	☐Stroke
☐High Cholesterol	☐Pulmonary Embolus	☐Asthma	☐Diabetes
☐Vein Trouble	☐Tuberculosis	☐Heart Trouble	☐Pneumonia
☐Kidney Disease	☐Nervous Disorder	☐Seasonal Allergies	☐HIV
☐Thyroid Problems	☐Sinus	☐Arthritis	☐Hepatitis
☐Drug Abuse/Alcoholism	☐Tonsillitis	☐Gastrointestinal	☐Osteoporosis
☐Joint Replacement	☐Bleeding Disorder	☐Cancer: if yes, what type _____	

Other: _____

Surgical History and or Surgical Complications: _____

_____

Family Medical History: Please check any illnesses/conditions immediate FAMILY has had.

☐High Blood Pressure	☐DVT	☐Lung Disease	☐Stroke
☐High Cholesterol	☐Pulmonary Embolus	☐Asthma	☐Diabetes
☐Vein Trouble	☐Tuberculosis	☐Heart Trouble	☐Pneumonia
☐Kidney Disease	☐Nervous Disorder	☐Seasonal Allergies	☐HIV
☐Thyroid Problems	☐Sinus	☐Arthritis	☐Hepatitis
☐Drug Abuse/Alcoholism	☐Tonsillitis	☐Gastrointestinal	☐Osteoporosis
☐Joint Replacement	☐Bleeding Disorder	☐Cancer: if yes, what type _____	

Other: _____

Social History

Occupation _____ Marital Status _____ Children: Yes ___ No ___

Tobacco Use ☐Never☐In the Past☐Presently How Much _____ How Long _____

Alcohol Use ☐Daily☐Occasional☐None Other substance use or abuse ☐Yes ☐No

System Review: Please describe any active problem or symptom

General Symptoms (i.e. fever, weight gain/loss, fatigue) _____

Eyes/Ears/Nose/Throat _____ Heart _____

Lung _____ Allergies/Rashes _____ Nerves _____

Muscles/Bones/Joints _____ Bleeding/Lymph Nodes _____

Psychiatric _____ Abdomen _____ Skin and/or Breasts _____

OB/Genital/Urinary _____ Endocrine (diabetes/thyroid) _____

Allergic to Latex ☐Yes ☐No **Allergic to Medications** ☐Yes ☐No

Please List _____

Current Medications _____

_____

Alabama Spine & Rehabilitation Center

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Alabama Spine & Rehabilitation Center** to use and/or disclose certain protected health information (PHI) about me to any participating hospitals or clinics that I want my records send to. This authorization permits **Alabama Spine & Rehabilitation Center** to use and/or disclose the following individually identifiable health information about me. Things include: patient demographics, MRI or X-Ray reports, doctor's notes, prescriptions, medical history. The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on **May 2013.** The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.I do not have to sign this authorization in order to receive treatment from **Alabama Spine & Rehabilitation Center**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at **Alabama Spine & Rehabilitation Center.**

CONSENT FOR TREATMENT & AUTHORIZATION: I do hereby consent for treatment at Alabama Spine & Rehabilitation Center. I authorize ASRC to release medical and supporting documentation of same as compiled in my medical record during this treatment or subsequent treatments for purposes as to benefit payment. I further authorize my insurance benefits to be paid directly by ASRC when indicated on a claim. I understand I am financially responsible for the charges for services rendered.

Scheduling for Physical Therapy Guidelines: If late for a scheduled appointment, 20 minutes or greater, the appointment will be canceled and the patient will have to reschedule. Patient understands that if patient misses 3 consecutive scheduled visits in a row or if patient misses 2 consecutive scheduled or nonscheduled weeks or more of physical therapy, without physical therapist's consent, patient will be automatically discharged from physical therapy.

Signed by: _____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date