Dr. Joseph J. Solan
Confidential Patient Health Record

Date: ___/___/_____

Personal History

Circle One: Divorced Married Single Separated Widowed Birth Date: ___/___/_____ Age: _____
First: _____ Middle: _____ Last: _____ Gender: Male / Female
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ County: _____ Country: _____
Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
Social Security #: _____-_____-_____ Fax #: (_____)_____-_____
Driver's License #: _____ State: _____ Email Address: _____
Spouses Name: _____
Ages of Children: _____

Employer

Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: (_____)_____-_____ Type of Work: _____

How did you hear about us? _____

Emergency Contact

Name: _____ Phone Number: (_____)_____-_____
Address: _____
Relationship: _____

Who Is Responsible For Your Bill?

☐ Self ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (be specific): _____
Personal Health Insurance Carrier: _____ Health ID Card #: _____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ Primary Care Physician: _____
Insured Person's Social Security #: ___-___-___ Pharmacy: _____

CURRENT HEALTH CONDITION

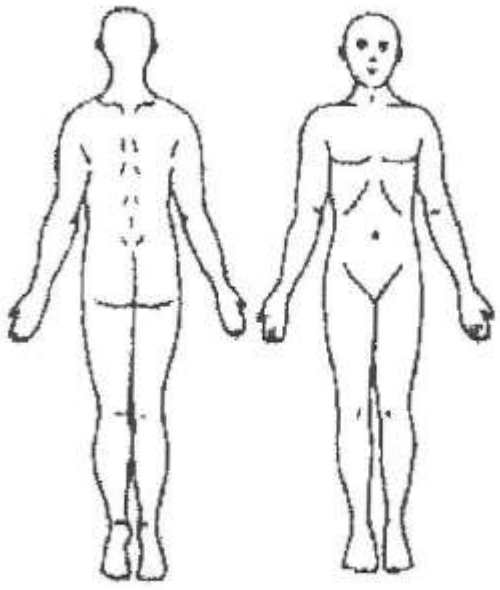
Chief complaint (Why you are here today): _____
_____
_____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this condition begin? ___/___/_____
Has it ever occurred before? ☐ Yes ☐ No
When? _____
Is the condition: ☐ Auto Related ☐ Work Related
☐ No Injury ☐ Other
Explain: _____
_____
Date of Accident: _____
Time of Accident: _____
Complaint/Pain Onset Date: _____
If Work Related:
Have you filed an injury report with your employer? ☐Yes ☐ No
Claim #: _____

Use the letters below to indicate the type and location of you sensations right now:
A= Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other



Have you seen other doctors for this condition? ☐ Yes ☐ No If yes, Who? (Name) _____
Location of Office: _____ Type of Treatment: _____
Were you satisfied with the results of your treatment? ☐ Yes ☐ No Explain: _____
Are you currently taking any prescription medications? ☐ Yes ☐ No. If yes, please mark or list below (be specific).
☐ Allergy Medication ☐ Anti-Depressants ☐ Blood Pressure Medication ☐ Insulin ☐ Muscle Relaxers
☐ Nerve Pills ☐ Pain Killers ☐ Other (please be specific): _____

Do you wear any of the following? ☐Yes ☐No. If yes, please mark: ☐ Heel Lifts ☐ Innersoles ☐ Arch Supports ☐ Orthotics

Please list any other conditions you feel we should know about – even if unrelated: _____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all of the sections, even if "DENY".

Constitutional: I... ☐ Deny Any Constitutional Issue (s)
☐ Chills ☐ Daytime Somnolence (Drowsiness) ☐ Fatigue ☐ Fever ☐ Night Sweats
☐ Weight Gain ☐ Weight Loss

Eyes/Vision: I... ☐ Deny Any Eyes/Vision Issue (s)
☐ Blindness ☐ Blurred Vision ☐ Cataracts ☐ Change in vision ☐ Double Vision
☐ Eye Pain ☐ Field Cuts (visual field defect) ☐ Glaucoma ☐ Itching (around the eyes) ☐ Photophobia
☐ Tearing ☐ Wears Glasses and/or Contact lenses

Ears, Nose and Throat: I... ☐ Deny Any Ears, Nose and Throat Issue (s)
☐ Bleeding ☐ Dental Implants ☐ Dentures ☐ Difficulty Swallowing ☐ Discharge
☐ Dizziness ☐ Ear Drainage ☐ Ear Infection(s) ☐ Ear Pain ☐ Fainting
☐ Headaches ☐ Head Injury (history of) ☐ Hearing Loss ☐ Hoarseness ☐ Loss of Smell
☐ Nasal Congestion ☐ Nose bleeds (frequent) ☐ Post Nasal Drip ☐ Rhinorrhea (Runny nose) ☐ Sinus Infections
☐ Snoring ☐ Sore Throats (frequent) ☐ Tinnitus (Ringing in Ears) ☐ TMJ problems

Respiration: I... ☐ Deny Any Respiratory Issue (s)
☐ Asthma ☐ Cough ☐ Coughing up blood ☐ Shortness of Breath ☐ Sputum Production ☐ Wheezing

Cardiovascular: I... ☐ Deny Any Cardiovascular Issue (s)
☐ Angina (chest pain or discomfort) ☐ Chest Pain ☐ Claudication (leg pain or achiness) ☐ Heart Murmor
☐ Heart Problems ☐ Orthopnea (difficulty breathing while lying down) ☐ Palpitations (irregular or forceful beating of the heart)
☐ Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath) ☐ Shortness of Breath with Exertion or Exercise
☐ Swelling of Legs ☐ Ulcers ☐ Varicose Veins

Gastrointestinal: I... ☐ Deny Any Gastrointestinal Issue (s)
☐ Abdominal Pain ☐ Belching ☐ Black, Tarry Stools ☐ Constipation ☐ Diarrhea
☐ Difficulty Swallowing ☐ Heartburn ☐ Hemorrhoids ☐ Indigestion ☐ Jaundice (yellowing of the skin)
☐ Nausea ☐ Rectal Bleeding ☐ Abnormal Stool Caliber (quality) ☐ Abnormal Stool Color
☐ Abnormal Stool Consistency ☐ Vomiting ☐ Vomiting Blood

Female: I... ☐ Deny Any Female Issue (s)
☐ Birth Control Therapy ☐ Breast Lumps/Pain ☐ Burning Urination ☐ Cramps ☐ Frequent Urination
☐ Hormone Therapy ☐ Irregular Menstruation ☐ Urine Retention ☐ Vaginal Bleeding ☐ Vaginal Discharge

Male: I... ☐ Deny Any Male Issue (s)
☐ Burning Urination ☐ Erectile Dysfunction ☐ Frequent Urination ☐ Hesitancy/Dribbling ☐ Prostate Problems
☐ Urine Retention

Endocrine: I... ☐ Deny Any Endocrine Issue (s)

☐ Cold Intolerance ☐ Diabetes ☐ Excessive Appetite ☐ Excessive Hunger ☐ Excessive Thirst
☐ Frequent Urination ☐ Goiter ☐ Hair Loss ☐ Heat Intolerance ☐ Unusual Hair Growth
☐ Voice Changes

Skin: I... ☐ Deny Any Skin Issue (s)

☐ Changes in Nail Texture ☐ Changes in Skin Color ☐ Hair Growth ☐ Hair Loss ☐ Hives ☐ Itching
☐ Paresthesia (numbness, prickling, or tingling) ☐ Rash ☐ History of Skin Disorders ☐ Skin Lesions/Ulcers ☐ Varicosities

Nervous System: I... ☐ Deny Any Nervous System Issue (s)

☐ Dizziness ☐ Facial Weakness ☐ Headaches ☐ Limb Weakness ☐ Loss of Consciousness
☐ Loss of Memory ☐ Numbness ☐ Seizures ☐ Sleep Disturbance ☐ Slurred Speech
☐ Stress ☐ Strokes ☐ Tremors ☐ Unsteadiness of Gait

Psychologic: I... ☐ Deny Any Psychologic Issue (s)

☐ Anhedonia (inability to experience joy or enjoy life) ☐ Anxiety ☐ Appetite Changes ☐ Behavioral Change(s)
☐ Bipolar Disorder ☐ Confusion ☐ Convulsions ☐ Depression ☐ Insomnia ☐ Memory Loss
☐ Mood Change(s)

Allergy: I... ☐ Deny Any Allergy Issue (s)

☐ Anaphylaxis (history of) ☐ Food Intolerance ☐ Itching ☐ Nasal Congestion ☐ Sneezing

Hematology: I... ☐ Deny Any Hematologic Issue (s)

☐ Anemia ☐ Bleeding ☐ Blood Clotting ☐ Blood Transfusion(s) ☐ Bruises easily ☐ Fatigue ☐ Lymph Node Swelling

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: I... ☐ Deny Any Childhood Illness (es)

☐ ADD ☐ Allergies/Hayfever ☐ Asthma ☐ Atopic Dermatitis (Eczema) ☐ Bedwetting
☐ Cerebral Palsy ☐ Chicken Pox ☐ Depression ☐ Diabetes ☐ Ear Infections
☐ Fetal Drug Exposure ☐ Food Allergies ☐ Headaches ☐ Hepatitis ☐ HIV
☐ Measles ☐ Mumps ☐ Rash ☐ Scoliosis ☐ Seizure Disorder
☐ Sickle Cell Anemia ☐ Spina Bifida ☐ Other (please describe): _____

Adult Illness: I... ☐ Deny Any Adult Illness (es)

☐ Alzheimers ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer
☐ Chicken Pox ☐ Crohn's/Colitis ☐ CRPS (RSD) ☐ CVA (stroke) ☐ Cystic Kidney Disease
☐ Depression ☐ Diabetes (Insulin) ☐ Diabetes (Non insulin) ☐ Ear Infections (frequent) ☐ Emphysema
☐ E ye Problems ☐ Fibromyalgia ☐ Heart Disease ☐ Hepatitis ☐ HIV
☐ Hypertension ☐ Influenzal Pneumonia ☐ Liver Disease ☐ Lung Disease ☐ Lupus Erythema (discoid)
☐ Lupus Erythema (systemic) ☐ Multiple Sclerosis ☐ Parkinson's Disease ☐ Pleurisy ☐ Pneumonia
☐ Psychiatric Problems ☐ Scoliosis ☐ Seizure Disorder ☐ Shingles ☐ STD's (unspecified)
☐ Suicide Attempt(s) ☐ Thyroid Problems ☐ Vertigo
☐ Past history of similar symptoms to your current condition ☐ Other Illness (please be specific): _____

Surgeries: I... ☐ Deny Any Surgery (ies)

☐ Angioplasty ☐ Appendectomy ☐ Caesarian Section ☐ Cardiac Catheterization ☐ Carpal Tunnel Repair
☐ Coronary Artery Bypass ☐ Cosmetic ☐ D & C ☐ Dental Surgery ☐ Gallbladder
☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Hysterectomy ☐ Joint Reconstruction ☐ Joint Replacement
☐ Laminectomy ☐ Mastectomy ☐ Pacemaker Insertion ☐ Rotator Cuff ☐ Spinal Fusion
☐ Tonsilectomy ☐ Other (please be specific): _____

Ob/Gyn: I... ☐ Deny Any Ob/Gyn Issue (s)

I... ☐ have never been pregnant ☐ have been pregnant in the past ☐ am currently pregnant

_____ Number of pregnancies _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies
_____ Number of miscarriages _____ Number of terminated pregnancies _____ Number of Epidural Injections
_____ Number of C-Sections _____ Number of vaginal deliveries

Menstrual History: Age of Onset _____

My menses is ☐ Regular ☐ Irregular; I am currently in ☐ Metaphase ☐ Menopause; Date of Last Menses ____/____/____

Injuries: I... ☐ Deny Any Injury (ies)

☐ Back Injury ☐ Broken Bones ☐ Severe Fall ☐ Fracture ☐ Disability
☐ Head Injury ☐ Industrial Accident ☐ Joint Injury ☐ Severe Laceration ☐ Motor Vehicle Accident
☐ Mild/Moderate Soft Tissue Injury ☐ Severe Soft Tissue Injury

Immunizations: I... ☐ Deny Any Immunization (s)

☐ DTaP(diptheria, tetanus, and pertussis) ☐ Flu ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
☐ Influenza ☐ IPV (Polio) ☐ MMR (measles, mumps, and rubella) ☐ Pneumococcal
☐ PPD (Mantoux Test-TB) ☐ Small Pox ☐ TB ☐ Varivax (chicken pox) ☐ Whooping Cough (Pertussis)

Non-Drug Allergies: I... ☐ Deny Any Non-Drug Allergy (ies)

☐ Animals ☐ Dairy ☐ Eggs ☐ Food Coloring ☐ Mold ☐ Pollen ☐ Wheat
☐ Other (please be specific): _____

Family History

		Condition (please be specific)
General Family	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	
Father	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	
Mother	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	
Paternal Grandfather	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	
Paternal Grandmother	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	
Maternal Grandfather	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	
Maternal Grandmother	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	
Son (s)	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	
Daughter (s)	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	
Brother (s)	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	
Sister (s)	☐ Alive ☐ Deceased; ☐ Normally Developed ☐ No Significant Disease ☐ Has/Had:	

Social History

Alcohol: ☐ Never ☐ Social Consumption only ☐ Beer ☐ Liquor ☐ Wine ; _____ oz ____ glasses; ☐ Day ☐ Week ☐ Month

Diet (please mark all that apply): ☐ High Fat ☐ High Fiber ☐ High Protein ☐ High Salt
☐ Low Calorie ☐ Low Carb ☐ Low Fiber ☐ Low Salt ☐ Low Sugar

Education (please mark the highest level completed): ☐ Preschool ☐ Elementary ☐ Middle ☐ Junior High ☐ Votech
☐ In High School ☐ Did Not Finish High School ☐ High School Diploma ☐ Post High School Classes ☐ Assoc/Technical Degree
☐ In College ☐ College Degree ☐ In Graduate School ☐ Graduate Degree ☐ Doctorate ☐ Other: _____

Drugs: ☐ Deny any illegal drug use ☐ Deny use of IV drugs ☐ Have not used drugs since _____ ☐ Have used drugs for _____

Tobacco: ☐ Deny Tobacco Use ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker ☐ Quit smoking
☐ Smoke; # _____ per ☐ Day ☐ Week ☐ Month ☐ Chew; #_____cans per ☐ Day ☐ Week ☐ Year

QUADRUPLE VISUAL ANALOGUE SCALE

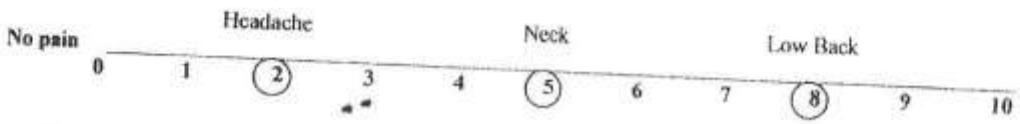
Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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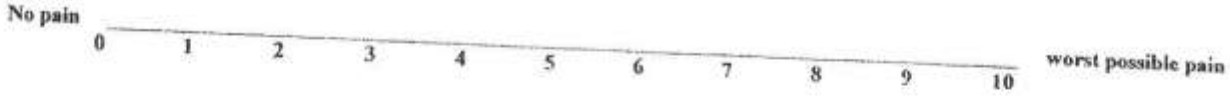
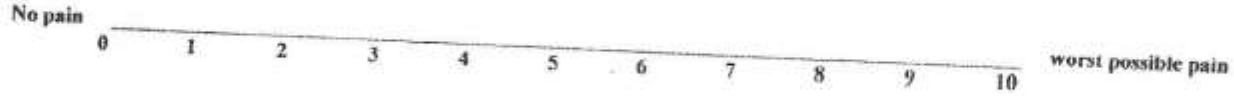
1 – What is your pain RIGHT NOW?



2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Dr. Joseph J. Solan / Back Pain Center
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Back Pain Center's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority