MISSOURI SPINE INSTITUTE

John D. Spears, D.O.

Office Use Only

Right/Left Handed

BP: _____/_____ Pulse: _____

Height: _____ Weight: _____ BMI: _____

Primary Care Physician: _____

Cardiologist:_____

Date: _____/_____/_____

Patient Name: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F

Address:_____

_____

Best number to contact you: (_____)-_____-_____

Alternate contact number: (_____)-_____-_____

Please tell us how you were referred to our office:

- ☐ Family doctor/another physician: _____
- ☐ Family friend/relative: _____
- ☐ Previous patient of Dr. Spears: _____
- ☐ Radio Advertisement
- ☐ T.V. Advertisement
- ☐ Magazine Advertisement
- ☐ Web-site (*www.mospineinstitute.com*)
- ☐ Other:_____

Symptoms/chief complaint:

_____

_____

_____

_____

When did the problem begin/Date of injury? _____ How did the injury occur? _____

****Did this injury happen at work?** **YES** NO **If yes, how?** _____

(If yes, and you have an existing claim *or* you have not yet filed a claim to your employer, please let the receptionist know *prior* to your appointment)

Is this injury/problem a result of a motor vehicle accident? YES NO If yes, explain?_____

What area of the body do you have pain/problem(s)? _____

Do you have radiating pain, numbness or weakness? YES NO If yes, where? _____

Is the problem getting worse, better or staying the same? _____

What activities can you *NOT* do because of this? _____

Have you had this problem before? YES NO Have you seen another doctor for this problem? YES NO

If yes, name of doctor & treatment provided: _____

Have you had a nerve conduction study or an EMG performed ***recently***? YES NO If yes, when and by whom? _____

Have you ever had any Epidural Steroid Injections done ***recently***? YES NO If yes, when? _____ How Many? _____

If you *have* had ESI's, did they provide you any relief, even if it was temporary? YES NO If yes, how long?_____

Have you had Physical Therapy ***recently***? YES NO If yes, when? _____Did PT help your symptoms? YES NO

Have you had any other treatment(s) not mentioned above for this problem? YES NO If yes, please explain: _____

Current Medications*:* ☐ ***See attached list***

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Do you have any medication allergies? ☐ NO If yes, please list:

_____

Missouri Spine Institute- Past Medical History:

Do ***you*** have or had any of the following medical conditions/diseases:

☐ Liver ☐ Heart ☐ Lung ☐ Diabetes ☐ Blood Clots: _____
☐ Kidney ☐ Seizure ☐ Blood Pressure ☐ Arthritis ☐ Cancer:_____

☐ Infection(s): _____ ☐ Other, please explain:_____

When was your last tetanus shot? _____

Have *you* ever had any surgeries? If **yes**, please list below:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Have *you* ever been hospitalized for any reason ***other than*** the surgeries listed above? If **yes**, please list below:

_____ _____ _____
_____ _____ _____

(Females only):
Menstrual History: Age of onset: _____ Regular periods: _____ Age of menopause: _____

Are you pregnant or currently trying to get pregnant? YES NO

Family History:

Do any of your immediate ***relatives*** have any of the following medical conditions/diseases?

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Strokes ☐ Heart Disease
☐ Arthritis/Gout ☐ Parkinson's disease ☐ Epilepsy ☐ Tuberculosis
☐ Alcoholism ☐ Lung Disease ☐ Diabetes ☐ Kidney Disease
☐ Nervous Breakdown ☐ Bleeding Tendency ☐ Heart Attack ☐ Cancer (Type): _____

				If deceased:
If alive:				
Father:	Age_____	Health (circle one) Good Fair Poor		Age: _____ Cause: _____
Mother:	Age_____	Health (circle one) Good Fair Poor		Age: _____ Cause: _____
Siblings:	Age_____	Health (circle one) Good Fair Poor		Age: _____ Cause: _____
(brothers & sisters)	Age_____	Health (circle one) Good Fair Poor		Age: _____ Cause: _____

Social History:

Highest Level of Education: _____

Employed: ☐ No ☐ Yes If yes, where? _____

Have you ever lived outside the United States? ☐ No ☐ Yes If yes, where? _____

Military Service: ☐ No Yes ☐ If yes, rank and type of discharge: _____

Are you a smoker? ☐ No ☐ Yes If yes, how much? _____How much alcohol do you consume? _____

Missouri Spine Institute- Review of Systems:

Please *circle* if you have any of the following:

Eyes:

Redness/Discharge	Yes	No
Glasses or Contacts	Yes	No
Blurred/Double Vision	Yes	No
Cataracts	Yes	No
Glaucoma	Yes	No

Other: _____

Ears/Nose/Throat:

Sore throat	Yes	No
Nosebleed	Yes	No
Runny Nose	Yes	No
Hoarse	Yes	No
Hearing Loss	Yes	No

Other: _____

Cardiovascular:

Chest Pain	Yes	No
Heart Murmur	Yes	No
Lower Leg Swelling	Yes	No
Irregular Heart Rate	Yes	No
High Blood Pressure	Yes	No

Other: _____

Respiratory:

Shortness of Breath	Yes	No
Cough	Yes	No
Asthma	Yes	No
Coughing up blood	Yes	No
Hay fever with wheezing	Yes	No
Post Nasal Drip	Yes	No

Other: _____

Gastrointestinal:

Diarrhea	Yes	No
Abdominal pain/bloating	Yes	No
Gallstones	Yes	No
Ulcers	Yes	No
Jaundice	Yes	No
Bloody stools	Yes	No

Other: _____

Genitourinary:

Burning/Painful Urination	Yes	No
Vaginal/Penile Discharge	Yes	No
Urinary Frequency	Yes	No
Unable to control urine	Yes	No
Blood in urine	Yes	No

Other: _____

Musculoskeletal:

Pain muscle	Yes	No
Neck/Back pain	Yes	No
Joint pain or swelling	Yes	No
Arm/leg inflammation	Yes	No
Difficulty moving limbs	Yes	No

Other: _____

Skin/Breast:

Rash	Yes	No
Lesions	Yes	No
Skin Cancers	Yes	No
Eczema	Yes	No
Masses	Yes	No

Other: _____

Neurological:

Headache	Yes	No
Numbness/Weakness	Yes	No
Seizures	Yes	No
Paralysis	Yes	No

Other: _____

Psychiatric:

Change in mental state	Yes	No
Confusion	Yes	No
Depression	Yes	No
Agitation	Yes	No

Other: _____

Endocrine:

Fatigue	Yes	No
Increase in hair growth/loss	Yes	No
Heat Intolerance	Yes	No
Increased thirst	Yes	No

Other: _____

Hematologic/Lymphatic:

Bleeding Tendency	Yes	No
Lymph Node enlargement/pain	Yes	No
Anemia	Yes	No

Other: _____

Allergy/Immunology:

Runny Nose	Yes	No
Skin- Itching/Rash	Yes	No
Asthma	Yes	No
Sneezing	Yes	No

Other: _____

Physician's Signature:_____ **Date**: _____/_____/_____

MISSOURI SPINE INSTITUTE

OPEN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Middle Initial _____ Last Name _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____

I, hereby authorize Missouri Spine Institute to release any and all Protected Health Information (PHI) maintained in my Medical Record to the following individuals, concerning my status as a patient, treatment or payment of services provided by Missouri Spine Institute.

Name	Relationship to Patient

This authorization is given freely with the understanding that:

1. This authorization is valid for a period of 180 days, unless revoked by me.
2. I may revoke this authorization at any time, except where information has already been released, by completing Missouri Spine Institute' Revocation of Authorization Form.
3. Individuals listed on this form will be able to receive any and all information related to my status as a patient, treatment or payment of services provided to me by Missouri Spine Institute during the time period in which this authorization is valid.
4. Individuals not listed above will be unable to received any information regarding treatment or payment for services provided to my without my prior written authorization.
5. Missouri Spine Institute, and its workforce members are hereby released from any legal responsibility or liability for disclosure of any of my Protected Health Information as indicated and authorized herein.

_____ _____

Print Patient's Name (or personal representative) Date

_____ _____

Patient's signature (or personal representative) Witness

_____ _____

Relationship to Patient Date

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I acknowledge that I have read a summary of Missouri Spine Institute's Notice of Privacy Practices and consent to the use or disclosure of my protected health information by Missouri Spine Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Missouri Spine Institute, and as required by law.

I also acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patient of this practice concerning my Protected Health Information (PHI), as it is outlined in this notice. I am aware Missouri Spine Institute reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Name of Patient or Personal Representative

_____

Signature of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority