Idaho Joint & Spine, PC

___NEW PATIENT
___INFO CHANGE

DATE:_____

PATIENT INFORMATION

(This information is regarding the person who is seeing the doctor)

Patient Name:_____
Address:_____
City, State, & Zip:_____
Date of Birth:_____Age:_____Sex:_____
Marital Status:_____Spouse's Name:_____
Social Security Number:_____

Home Phone:_____
Cell Phone:_____
Email:_____
Can we email you confidential information? □ YES □ NO
Leave confidential information on your voicemail? □ YES □ NO
Reminder Preference (Pick 1): □ Text □ Email □ Phone

Employer:_____
Employer's Address:_____
_____
Employer's Phone #:_____

Primary Care Provider (PCP):_____
Do you want your records sent to your PCP? □ YES □ NO

Responsible Party OR Policy Holder Info □ MYSELF

(If someone other than patient is responsible for the bill we will need the following)

Relationship to Patient: O Husb/Father O Wife/Mother O Other

Responsible Party Name:_____
Address:_____
City, State, & Zip:_____
Home Phone:_____
Cell Phone:_____
Employer:_____
Employer Address:_____
Social Security Number:_____
Date of Birth:_____

NEAREST RELATIVE INFORMATION

(This information will be used when we are unable to contact the patient.

Name:_____
Home Phone:_____
Cell Phone:

Referred By:

INSURANCE INFORMATION

Please select one: □ Private Insurance (Group) □ Worker's Comp* □ Auto Accident* □ Self
* Is this visit due to: □ Injury on the job? ___/___/___ date of injury □ Automobile accident ___/___/___ date of injury

Insurance Name: _____ Phone: _____
Policy Number : _____ Group Number : _____
Claims Address: _____
_____Zip: _____

Worker's Comp Adjuster: _____ Phone: _____
Attorney: _____ Phone: _____

□ Secondary Insurance:

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above-named agency to release any treatment information requested by attorneys, physicians, insurance companies, employers, health care providers or any other entity which may be concerned with the payment of charges incurred for the treatment services of Idaho Joint & Spine, PC and hereby authorize payment directly to Idaho Jpint & Spine, PC.
I accept responsibility for payment of any charges not paid for or accepted by my insurance.

_____ _____
Date Patient (If not the patient, please indicate legal relationship)

I have reviewed this office's NOTICE OF PRIVACY PRACTICES which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

_____ _____
Date Patient (If not the patient, please indicate legal relationship)

Office Use Only: □ Insurance Cards Copied □ ID Copied □ Practice Fusion □ AMD □ Lists (TY & BD)

Idaho Joint and Spine

Dr. James Whitaker, D.O.
Physical Medicine and Rehabilitation
9510 W Fairview Ave., Boise, ID 83704
(208) 322-5922 ph (844) 502-7766 fax

CANCELLATION, "NO SHOW", and LATE ARRIVAL POLICY

Office appointments & procedures which are cancelled with less than 24-hour notification or "No Show" will be subject to a $20.00 cancellation fee.

Massage Therapy appointments which are cancelled with less than 24-hour notification or "No Show" will be subject to a $30.00 cancellation fee.

We understand that situations arise in which you must cancel your appointment. It is requested that **if you must cancel your appointment you provide more than 24-hour notice**. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24-hour notice, we are unable to offer that slot to other people. Cancellations less than 24-hours will be subject to the fee. Patients who do not show up for their appointment without a call to cancel will be considered as "No Show" and are subject to the fee.

The Cancellation and "No Show" fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Your time is valuable. In order to respect your time and that of other patients, we ask that you arrive on time or 5 minutes early. **If you are more than 5 minutes late, we may not be able to keep your appointment slot and you may have to reschedule.** If this happens, you may be subject to the fees.

It is our policy that after three (3) "No Show" appointments or cancellations less than 24 hours in a 12-month period or if a patient is regularly late to appointments then we reserve the right to discharge you from our practice.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be addressed to Sarah at (208) 322-5922.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____ Date of birth _____
Patient Name (Please Print)

_____ _____
Signature of Patient or Patient Representative Date

Idaho Joint and Spine

Dr. James Whitaker, D.O.
Physical Medicine and Rehabilitation
9510 W Fairview Ave., Boise, ID 83704
(208) 322-5922 ph

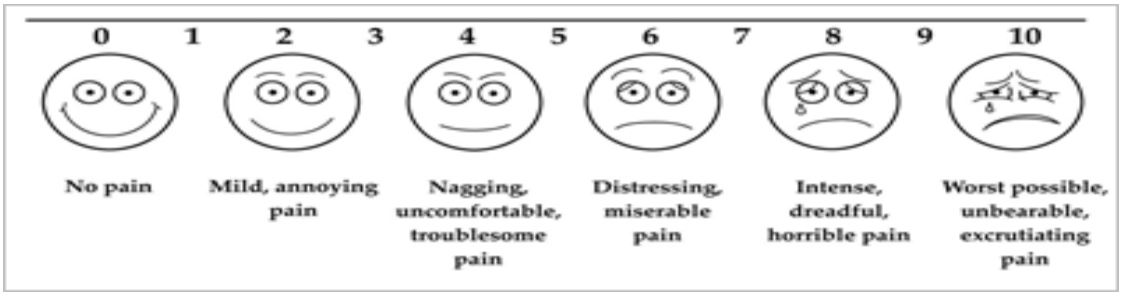
NEW PATIENT QUESTIONNAIRE

Name: _____

DOB: _____ **Age:** _____ **Gender:** _____

INFORMATION ABOUT YOUR PRESENT INJURY OR CONDITION

1. What are your symptoms? _____
   _____
   _____
   _____
2. When and how did your symptoms begin? _____
   _____
3. What makes your symptoms better? _____
   _____
4. What makes your symptoms worse? _____
   _____
5. If you have had any treatments for your symptoms, what were they and when? _____
   _____
   _____
6. Using the pain scale below, answer the following questions:

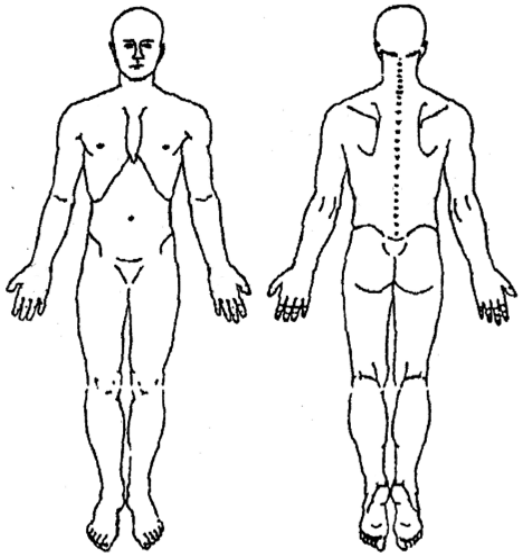


   a. How would you rate your pain today? _____
   b. Over the last five days, what were your pain levels?
      Lowest _____ Highest _____ Average _____

Please continue to the next page.

7. Using the symbols given below, mark the areas on your body where you feel the described sensation. Include all affected areas.

Aching: Δ Δ Δ Δ
Numbness: ======
Pins & Needles: O O O O O
Burning: X X X
Stabbing: / / / / /
Other: ……



8. Have you recently had or do you **now** have: ☐ **NONE of the Below**

☐ Fever or Chills	☐ Excessive Fatigue	☐ Weight Gain	☐ Weight Loss
☐ Change in Vision	☐ Eye Pain	☐ Change in Hearing	☐ Ear Pain
☐ Snoring	☐ Nose Bleeds	☐ Difficulty Swallowing	☐ Gum Trouble
☐ Neck Pain	☐ Neck Lumps	☐ Cough	☐ Wheezing
☐ Shortness of Breath	☐ Chest Pain	☐ Palpitations	☐ Abnormal Heartbeat
☐ Swollen Ankles	☐ Nausea	☐ Vomiting	☐ Constipation
☐ Diarrhea	☐ Loss of Bowel Control	☐ Loss of Bladder Control	☐ Difficulty Urinating
☐ Blood in Urine	☐ Hives	☐ Rash	☐ Backache
☐ Muscle Pain	☐ Muscle Weakness	☐ Knee Pain	☐ Shoulder Pain
☐ Headaches	☐ Numbness	☐ Tingling	☐ Lack of Coordination
☐ Recent Falls	☐ Depression	☐ Anxiety	☐ Poor Sleep
☐ Easy Bruising	☐ Large Lymph Nodes	☐ Hair Change/Loss	☐ Increased Appetite

9. Do you use any of the following? ☐ **NONE of the Below**

☐ Crutches	☐ Cane	☐ Artificial Limb
☐ Walker	☐ Brace/Splint	☐ Wheelchair
☐ Other _____		

10. Do you need assistance with any the following: ☐ **NONE of the Below**

☐ Dressing	☐ Bathing	☐ Caring for hair	☐ Shaving
☐ Yard Work	☐ Eating	☐ Meal Preparation	☐ Using the toilet
☐ Housework	☐ Shopping	☐ Walking	☐ Driving a Car
☐ Other _____			

Please continue to the next page.

11. What medical conditions do you have? (Check all that apply.) ☐ **NONE of the Below**

☐ Head Trauma	☐ Diabetes	☐Hearing Problems	☐ DVT
☐ Heart Attack	☐ COPD	☐ Asthma	☐ GERD
☐ Arthritis	☐ Gout	☐ Psoriasis	☐ Seizures
☐ Stroke	☐ Depression	☐ Thyroid Disease	☐ Vision Problems
☐ Cancer	☐ Fractures	☐ High Blood Pressure	☐ Kidney Problems
☐ Liver Problems	☐ Osteoporosis	☐ Pregnant (Currently)	☐ Previous C-Section
☐ Sleep Apnea	☐ Fibromyalgia	☐ Irritable Bowel	☐Chronic Fatigue Syndrome

☐ **Other**: _____

12. What surgeries or hospitalizations have you had? ☐ **NONE**

What _____ When _____

What _____ When _____

What _____ When _____

13. Have you had any previous injuries? ☐ Yes ☐ No

If YES, what was injured and when did it occur? _____

_____

_____

14. What Medications do you take? ☐ **NONE**

Name of Medication	Dosage / Amount	Frequency / How Often?

15. Do you have any allergies? ☐ Yes ☐ No If yes, please list below.

_____

_____

Please continue to the next page.

TELL US ABOUT YOURSELF:

16. Right Handed? ☐ or Left Handed? ☐

17. Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

18. Highest Education Level?_____

19. Current or Most Recent Employment (Company, Location, Position, How long?)_____

_____

_____

_____

20. Do you use tobacco? ☐ Yes ☐ No

If Yes, how many packs per day? _____ For how many years? _____

21. Have you ever used tobacco? ☐ Yes ☐ No If Yes, when did you quit? _____

22. Do you consume alcohol? ☐ Yes ☐ No

If Yes, how much? _____ How often?_____

23. Do you or did you use illicit drugs? ☐ Yes ☐ No

If Yes, what type? _____ How often or When?_____

24. What are your hobbies and interests?_____

25. What medical problems run in your family?_____

_____

_____

26. Any other information you feel the physician needs to know._____

_____

_____

***** ***I attest that this information is true and accurate to the best of my knowledge.***

PATIENT SIGNATURE_____ **DATE**_____

DOCTOR SIGNATURE_____ **DATE**_____

Office Use Only:
BP: _____/_____
HR: _____
Height: _____
Weight:_____