# 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:_________________________________
Reminder Preference (Pick 1): □ Text □ Phone
***By selecting text, you agree that we can send text messages regarding appointments. Please reply "Y" to each message to confirm.**
Preferred Pharmacy:
Employer:_________________________________
Employer's Phone #:_________________________
Primary Care Provider (PCP):____________________
Do you want your records sent to your PCP? □ YES □ NO

**Policy Holder Info OR Responsible Party** □ MYSELF
(If someone other than patient is responsible for the bill we will need the following)
**Relationship to Patient:** O Spouse O Parent O Other
**Name:**_________________________________
**Date of Birth:**_________________________________
Address:_________________________________
City, State, & Zip:_________________________________
Home Phone:_________________________________
Cell Phone:_________________________________
Employer:_________________________________
Employer Address:_________________________________
Social Security Number:_________________________

**NEAREST RELATIVE INFORMATION**
(This information will be used when we are unable to contact the patient.
Name:_________________________________
Relationship to Patient:_________________________
Phone Number:
Referred By:

## INSURANCE INFORMATION

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

Primary Insurance: _________________________ Policy Number_________________________
Secondary Insurance:_________________________ Policy Number_________________________

Worker's Comp Insurance Company: _________________________ Claim Number_________________________
Worker's Comp Adjuster: _________________________ Phone: _________________________

Liable Insurance Company Name: _________________________ Claim Number_________________________
Attorney: _________________________ Phone: _________________________

**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 Joint & 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

# Idaho Joint and Spine

**Dr. James Whitaker, D.O.** Physical Medicine and Rehabilitation

1760 N Mitchell St, Boise, ID 83704 (208) 322-5922 ph (208) 576-6932 fax

## FINANCIAL POLICIES

Thank you for choosing to involve us in your healthcare. We are committed to providing you with quality healthcare. Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Thus, this policy is designed to outline our financial policies. Please read it, ask any questions you may have, and sign the bottom of the form. Additional questions can be addressed to our office manager, Sarah, at (208) 322-5922 or info@idahojointandspine.com. If you would like a copy, please let us know.

1. **Missed and Cancelled less than 24-hour appointments**. Appointments which are cancelled with less than 24-hour notification or "No Show" will be subject to a **$40.00 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. 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 unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. It is our policy that after three (3) "No Show" appointments or cancellations less than 24 hours during a 12-month period then we reserve the right to discharge you from our practice.
2. **Late Arrival**. Your time is valuable. In order to respect your time and that of other patients, we ask that you **arrive 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. If you are regularly late to appointments then we reserve the right to discharge you from our practice.
3. **Massage Appointments**. Massage Therapy appointments which are cancelled with less than 24-hour notification or "No Show" will be subject to a **$40.00 fee** and fall under #1 above.
4. **Insurance**. We participate in most insurance plans, including Medicare and Medicaid (Idaho). If you are insured by a plan we do not participate with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment is expected in full each visit until we can verify your coverage. Knowing your insurance coverage is your responsibility. We will attempt to assist in verifying benefits and coverage, but this is not a guarantee. Please contact your insurance company with any questions you may have regarding your coverage.
5. **Co-payments, Co-insurances, and Deductibles**. All co-payments, co-insurances, and deductible amounts must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect these amounts from patients can be considered fraud and violate our contracts. Please help us in upholding the law and keeping our insurance contracts by paying your portions at each visit.
6. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of visit.
7. **Proof of insurance**. All patients must complete our patient information before seeing the doctor. We must obtain a copy of your driver's license or valid legal ID and current valid insurance to provide proof of insurance. If you fail to provide us with correct information in a timely manner, you may be responsible for the balance of your claim. If the coverage you provide is not valid, you will be responsible for the balance.
8. **Claims Submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
9. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Please be aware that if your insurance company requires a referral to see a specialist and it is your responsibility to ensure that happens.
10. **Nonpayment**. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**Please sign that you have read, understand and agree to this Financial Policy.**

_____________________________________________ _____________________

**Patient Name (Please Print)** **Date of birth**

_____________________________________________ _____________________

**Signature of Patient or Patient Representative** **Date**

# Idaho Joint and Spine

**Dr. James Whitaker, D.O.**
Physical Medicine and Rehabilitation
1760 N Mitchell St, Boise, ID 83704
(208) 322-5922 ph (208) 576-6932 fax

## NEW PATIENT QUESTIONNAIRE FOR HEADACHE AND MIGRAINE MANAGMENT

**Printed Name:** ____________________________________________

**DOB:** ________________________ **Age:** ________ **Gender:** ____________________________

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

**Aching:** ∆ ∆ ∆ ∆

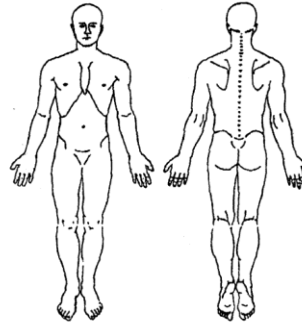
**Numbness:** ======

**Pins & Needles:** O O O O O

**Burning:** X X X

**Stabbing:** / / / / /

**Other:** ……



**HEADACHE HISTORY**

Please mark the types of headaches you have:
☐ Migraine ☐Tension ☐Sinus ☐ Cluster ☐Menstrual ☐Unknown

How old were you when you first started experiencing headaches of any type? ________
How old were you when you first started experiencing bad headaches? ________
How many days per month do you get headaches of any type? ________
How many days per month do you get bad headaches (interfere with ability to do things? ________
How many days per month do you take medication to relieve your headaches? ________
How painful do your headaches usually get? 1 (almost no pain) to 10 (worst pain imaginable) ________
Number of unscheduled visits to doctor's office for headache treatment in the *past 6 months* ________
Number of visits to the ER or Urgent Care for headache treatment in the *past 6 months* ________
Does anyone else in your family have headaches? ☐ NO ☐ YES If yes, who? ________

**HEADACHE SYMPTOMS** (Please mark symptoms that typically occur just before or during a headache)

| | | | | | |
|---|---|---|---|---|---|
| ☐ | H/A lasting longer than 4 hours | ☐ | Temporary paralysis | ☐ | Pain when chewing |
| ☐ | Pulsating/throbbing pain | ☐ | Speech problems | ☐ | Agitation/Restlessness |
| ☐ | Pain increased with activity | ☐ | Difficulty swallowing | ☐ | Loss of consciousness |
| ☐ | One-sided pain | ☐ | Dizziness | ☐ | Shortness of breath/chest pains |
| ☐ | Moderate to severe pain | ☐ | Ringing in ears/Ear pain | ☐ | Flushing/blushing |
| ☐ | Light sensitivity | ☐ | Eyelid/Face | ☐ | Chills |
| ☐ | Sound sensitivity | ☐ | Eye Irritation and/or tearing | ☐ | Fever |
| ☐ | Nausea and/or vomiting | ☐ | Drooping runny nose | ☐ | Excessive sweating |
| ☐ | Vision Change Before H/A | ☐ | Nasal congestion | ☐ | Hallucinations |
| ☐ | Vision Change After H/A begins | ☐ | Tenderness of scalp | ☐ | Diarrhea |
| ☐ | Face numbness | ☐ | Tenderness of temples | ☐ | Constipation |
| ☐ | Arm/Leg numbness | ☐ | Neck/shoulder stiffness | ☐ | Frequent Urination |

Do you have any warning symptoms occurring before (6-48 hrs) the onset of a headache? ☐Yes ☐No
If yes, explain: ____________________________________________
Any other problems that you think may be causing or intensifying your headaches? ________________
____________________________________________________________________________

**HEADACHE TRIGGERS** (Please mark things that trigger your headaches)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Stress | ☐ | Hormones | ☐ | Sleep | ☐ | Sadness/Depression |
| ☐ | Let-down Periods | ☐ | Weather | ☐ | Not Eating | ☐ | Anger/Frustration |
| ☐ | Neck pain/Stiffness | ☐ | Lights/Glare | ☐ | Caffeine | ☐ | Sexual Activity |
| ☐ | Relationships | ☐ | Perfume/Odors | ☐ | Alcohol | ☐ | Smoke |
| ☐ | Worry/Anxiety | ☐ | Heat | ☐ | MSG | ☐ | Sweeteners |
| ☐ | Altitude | ☐ | Travel | ☐ | Exercise | ☐ | Other Foods |

Do you use caffeine? ☐ Yes ☐ No If Yes, # beverages per day? ______________________________

**PREVIOUS TESTS FOR HEADACHE:**

| Test | Yes/No | Results of Test | Year |
|---|---|---|---|
| Neurological Consult (most recent) | ___________ | _____________________________________ | _________ |
| Headache Specialist (most recent) | ___________ | _____________________________________ | _________ |
| CT scan of Brain | ___________ | _____________________________________ | _________ |
| MRI scan of Brain | ___________ | _____________________________________ | _________ |
| MRI or CT scan of Neck | ___________ | _____________________________________ | _________ |
| EEG (brain wave tracing) | ___________ | _____________________________________ | _________ |
| Sinus x-ray or scan | ___________ | _____________________________________ | _________ |
| Spinal Tap | ___________ | _____________________________________ | _________ |
| Angiogram (arteriogram) | ___________ | _____________________________________ | _________ |
| EKG (heart) | ___________ | _____________________________________ | _________ |
| ENT (ear, nose, & throat) consult | ___________ | _____________________________________ | _________ |
| TMJ Specialist | ___________ | _____________________________________ | _________ |
| Allergy Testing | ___________ | _____________________________________ | _________ |
| Other Testing: | ___________ | _____________________________________ | _________ |

**PREVIOUS TREATMENTS FOR HEADACHE** (Please note different kinds of treatments you have tried for your headaches)

| Treatment | Yes/No | Who treated you? (Name of Dr, Location) | Treatments Effective? | Year(s) |
|---|---|---|---|---|
| Acupuncture | ______ | _______________________ | ____________________ | _________ |
| Physical Manipulation | ______ | _______________________ | ____________________ | _________ |
| Psychotherapy/Counseling | ______ | _______________________ | ____________________ | _________ |
| Physical Therapy | ______ | _______________________ | ____________________ | _________ |
| Trigger Point Injections | ______ | _______________________ | ____________________ | _________ |
| Nerve Blocks | ______ | _______________________ | ____________________ | _________ |
| In-Patient Hospitalization | ______ | _______________________ | ____________________ | _________ |
| Other Treatments: | ______ | _______________________ | ____________________ | _________ |

**ALL <u>CURRENT</u> MEDICATIONS** ☐ **NONE**

*The last 2 pages of this form contain a list of common medications for your reference.*

| Name of Medication | Dosage / Amount | | Frequency / How Often? | Date Started | Is the med effective? | Side Effects Experienced |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**ALL PAST HEADACHE MEDICATIONS** ☐ **NONE**

List only medications you are no longer taking. Include all over the counter supplements, and vitamins.

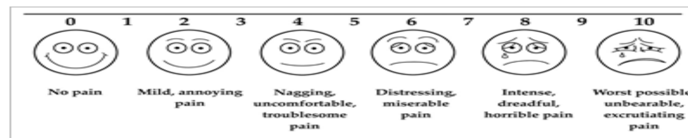
*The last 2 pages of this form contain a list of common medications for your reference.*

| Name of Medication | Dosage / Amount | Frequency / How Often? | Date Started | Date Stopped | Reason for Discontinuation |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

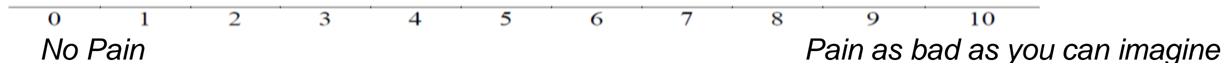
Do you have any allergies? ☐ Yes ☐ No If yes, please list below.

_______________________________________________________________

Using the pain scale below, rate your current pain level using a scale 0-10:_________________

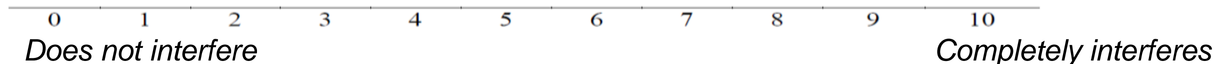



What number best describes your pain on average in the past week?



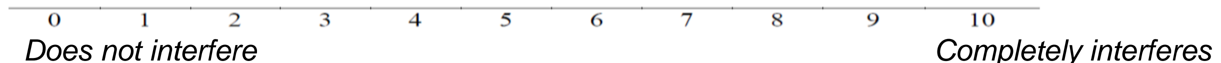

*No Pain* *Pain as bad as you can imagine*

What number best describes how, during the past week, pain has interfered with your enjoyment of life?




*Does not interfere* *Completely interferes*

What number best describes how, during the past week, pain has interfered with your general activity?




*Does not interfere* *Completely interferes*

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

## MEDICAL HISTORY

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**: ______________________________

What surgeries or hospitalizations have you had? Please list approximate dates. ☐ **NONE**

______________________________

Have you had any previous injuries? ☐ Yes ☐ No

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

## TELL US ABOUT YOURSELF:

Right Handed? ☐ or Left Handed? ☐

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

Highest Education Level? ______________________________

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

______________________________

Do you use tobacco? ☐ Yes ☐ No

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

Have you ever used tobacco? ☐ Yes ☐ No If Yes, when did you quit? ____________

Do you consume alcohol? ☐ Yes ☐ No

If Yes, how much? ____________ How often? ____________

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

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

What are your hobbies and interests? ______________________________

What medical problems run in your family? ______________________________

## HEADACHE IMPACT TEST – 6

| | Never (6 pts) | Rarely (8 pts) | Some Times (10 pts) | Very Often (11 pts) | Always (13 pts) |
|---|---|---|---|---|---|
| When you have headaches, how often is the pain severe? | | | | | |
| How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities? | | | | | |
| When you have a headache, how often do you wish you could lie down? | | | | | |
| In the past 4 weeks, how often have you felt too tired to work or do daily activities because of your headaches? | | | | | |
| In the past 4 weeks, how often have you felt fed up or irritated because of your headaches? | | | | | |
| In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities? | | | | | |

| **For Office Use Only** | **Total Score:** |
|---|---|

## HOW HEADACHES IMPACT YOUR LIFE – MIDAS

Please answer the following questions about *ALL your headaches* you have had over the last 3 months. Write the *number of days* on the line next to each question. Write "0" if you did not do the activity in the last 3 months.

1. How many days in the last 3 months did you miss work or school because of headaches? _______ days
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (**Do not include days you counted in question 1**). _______ days
3. How many days in the last 3 months did you not do household work because of headaches? _______ days
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (**Do not include days you counted in question 3**). _______ days
5. How many days in the last 3 months did you miss family/social/leisure activities because of headaches? _______ days

| **For Office Use Only** | **Total Score:** |
|---|---|

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please mark only one answer)* | **Not at All (0 points)** | **Several Days (1 point)** | **More Than Half the Days (2 points)** | **Nearly Every Day (3 points)** |
|---|---|---|---|---|
| Little interest or pleasure in doing things | | | | |
| Feeling down, depressed, or hopeless | | | | |
| Trouble falling or staying asleep, or sleeping too much | | | | |
| Feeling tired or having little energy | | | | |
| Poor appetite or overeating | | | | |
| Feeling bad about yourself — or that you are a failure or have let yourself or your family down | | | | |
| Trouble concentrating on things, such as reading the newspaper or watching television | | | | |
| Moving or speaking so slowly that other people could have noticed OR the opposite — being so fidgety or restless that you have been moving around a lot more than usual | | | | |
| Thoughts that you would be better off dead or of hurting yourself in some way | | | | |
| (Office Use Only) Column Totals: | | | | |

## GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please mark only one answer)* | **Not at All (0 points)** | **Several Days (1 point)** | **More Than Half the Days (2 points)** | **Nearly Every Day (3 points)** |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on the edge | | | | |
| 2. Not being able to stop or control worrying | | | | |
| 3. Worrying too much about different things | | | | |
| 4. Trouble relaxing | | | | |
| 5. Being so restless that it's hard to sit still | | | | |
| 6. Becoming easily annoyed or irritable | | | | |
| 7. Feeling afraid as if something awful might happen | | | | |
| (Office Use Only) Column Totals: | | | | |

## EPSWORTH SLEEPINESS SCALE

*This refers to your usual way of life in recent times. (Even if you have not done some of these things recently, try to work out how they would have affected you.) Use the following scale to choose the most appropriate number for each situation:*

| How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? *(Please mark only one answer)* | **Would Never (0 points)** | **Slight Chance (1 point)** | **Moderate Chance (2 points)** | **High Chance (3 points)** |
|---|---|---|---|---|
| 1. Sitting and Reading | | | | |
| 2. Watching TV | | | | |
| 3. Sitting inactive in a public place (e.g., theatre) | | | | |
| 4. As a passenger in a car for an hour without a break | | | | |
| 5. Lying down to rest in the afternoon when circumstances permit | | | | |
| 6. Sitting and talking with someone | | | | |
| 7. Sitting quietly after lunch without alcohol | | | | |
| 8. In a car, while stopped for a few minutes in traffic | | | | |
| (Office Use Only) Column Totals: | | | | |

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

**PATIENT SIGNATURE** ______________________________________ **DATE** __________________

**DOCTOR SIGNATURE** ______________________________________ **DATE** __________________

***(The last two pages of this form are for reference only to fill out the medications portion.)***