



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): <input type="checkbox"/> Text <input type="checkbox"/> Phone Call <small>*By selecting text, you agree that we can send text messages regarding appointments. Please reply "Y" to each message to confirm.</small>
Preferred Pharmacy: _____
Employer: _____
Employer's Phone #: _____
Primary Care Provider (PCP): _____
Do you want your records sent to your PCP? <input type="checkbox"/> YES <input type="checkbox"/> NO

Policy Holder Info OR Responsible Party <input type="checkbox"/> MYSELF <small>(If someone other than patient is responsible for the bill we will need the following)</small>
Relationship to Patient: <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Other
Name: _____
Date of Birth: _____
Social Security Number: _____
<i>*Sponsor Social Security Number Required for Tricare</i>
Address: _____
City, State, & Zip: _____
Cell Phone: _____
Employer: _____
Employer Address: _____
NEAREST RELATIVE INFORMATION <small>(This information will be used when we are unable to contact the patient.)</small>
Name: _____
Relationship to Patient: _____
Phone Number: _____
Referred By: _____

INSURANCE INFORMATION

Please select one: <input type="checkbox"/> Health Insurance <input type="checkbox"/> Worker's Comp* <input type="checkbox"/> Auto Accident* <input type="checkbox"/> Self
* Is this visit due to: <input type="checkbox"/> Injury on the job? ___/___/___ date of injury <input type="checkbox"/> 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: _____

Liabile Insurance Company Name: _____ Claim Number _____
Attorney: _____ Phone: _____

By signing below, I acknowledge that the information I provided is correct to the best of my ability.
Assignment of Benefits and Release of Information: I authorize my insurance payments to be paid directly to Idaho Joint and Spine, PC. I understand that I am financially responsible for all non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.
Notice of Privacy Practices Acknowledgment: By signing below, I acknowledge that I have been shown a copy of the Notice of Privacy Practices. I understand I am entitled to receive a copy of this document.
Medicare Patients: I authorize Idaho Joint and Spine to release to the Centers of Medicare and Medicaid services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made to Idaho Joint and Spine who accepts assignment.
_____ Date _____ Patient (If not the patient, please indicate legal relationship)

Office Use Only: <input type="checkbox"/> _____ Insurance Cards Copied <input type="checkbox"/> _____ ID Copied <input type="checkbox"/> _____ Practice Fusion <input type="checkbox"/> _____ AMD
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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. and Daniel Dean, PA

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

Printed Name: _____ **DOB:** _____

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

Using the symbols below, mark the areas where you feel the described sensations.

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

- 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) _____
- How long do your headaches typically last? _____
- How old were you when you first started experiencing headaches of any type? _____
- How old were you when you first started experiencing bad headaches? _____
- 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)

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

Do you have warning symptoms before (6-48 hrs) the onset of a headache? Yes No

If yes, explain: _____

HEADACHE TRIGGERS (Please mark things that trigger your headaches)

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

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

Please mark the box for any that apply to your medical history:

<input type="checkbox"/> Neurology	<input type="checkbox"/> MRI or CT of the Neck	<input type="checkbox"/> Physical Manipulation
<input type="checkbox"/> Headache Specialist	<input type="checkbox"/> EEG (Brain Wave Tracing)	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> ENT	<input type="checkbox"/> Sinus X-ray or Scan	<input type="checkbox"/> Psychotherapy/Counseling
<input type="checkbox"/> TMJ Specialist	<input type="checkbox"/> Spinal Tap	<input type="checkbox"/> In-Patient Hospitalization
<input type="checkbox"/> Allergy Specialist	<input type="checkbox"/> Angiogram (Arteriogram)	<input type="checkbox"/> Trigger Point Injections
<input type="checkbox"/> CT of the Brain	<input type="checkbox"/> EKG (Heart)	<input type="checkbox"/> Nerve Blocks
<input type="checkbox"/> MRI of the Brain	<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Cervical Injections

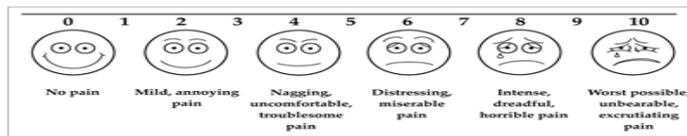
Other: _____

Have you recently had or do you **now** have:

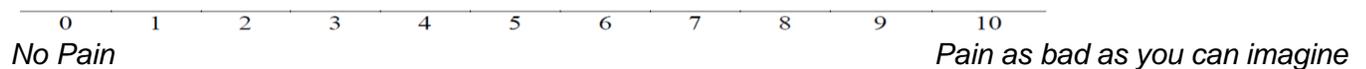
NONE of the Below

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

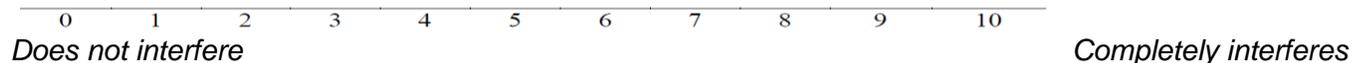
Using the pain scale below, rate your current pain level using a scale 0-10: _____



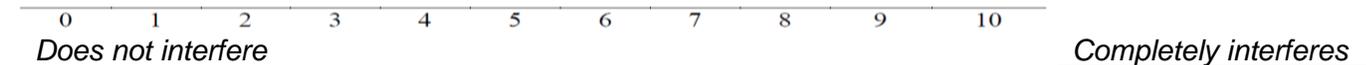
What number best describes your pain on average in the past week?



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



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



HEADACHE IMPACT TEST – 6

For Office Use Only: PEG Score: _____

	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?					

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

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? <i>(Please mark only one answer)</i>	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				

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? <i>(Please mark only one answer)</i>	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				

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? <i>(Please mark only one answer)</i>	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				

ALL CURRENT MEDICATIONS

NONE

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.

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.

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:

1. Right Handed? or Left Handed?
2. Marital Status: Married Single Separated Divorced Widowed
3. Highest Education Level? _____
4. Current or Most Recent Employment (Company, Location, Position, How long?)

5. Do you use tobacco? Yes No
If Yes, how many packs per day? _____ For how many years? _____
6. Have you ever used tobacco? Yes No If Yes, when did you quit? _____
7. Do you consume alcohol? Yes No
If Yes, how much? _____ How often? _____
8. Do you or did you use illicit drugs? Yes No
If Yes, what type? _____ How often or When? _____
9. What are your hobbies and interests? _____
10. What medical problems run in your family? _____

11. 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** _____

PROVIDER SIGNATURE _____ **DATE** _____