Beth Israel Deaconess Hospital
Plymouth

Spine Care & Neurosurgery

Name: _____
Prefix First Middle Last Previous Last Name

Social Security #: _____ Date of Birth: _____ Marital Status: M S D W

Address: _____
Street City State Zip Code

Primary Phone #: _____ Secondary Phone #: _____

Is it okay to leave a detailed message at the numbers? ☐ Yes ☐ No

Email Address: _____ May we communicate via email? ☐ Yes ☐ No

Would you like to sign up for the patient portal? ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____

Emergency Contact Telephone #: _____

Do you have a Healthcare Proxy? ☐ Yes ☐ No Has this been provided to us? ☐ Yes ☐ No

Is this visit due to a workman's compensation, motor vehicle accident or personal injury claim?

Primary Insurance: _____ Policy #: _____

Subscriber: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____

Secondary Insurance: _____ Policy #: _____

Pharmacy: _____ Telephone #: _____

Address: _____

Mail Away Pharmacy: _____ Telephone #: _____

Address: _____

Primary Care Physician: _____ Telephone #: _____

Address: _____

Referral from Physician? ☐ Yes ☐ No If Yes, Name? _____

RACE (Please check)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Other Race
- ☐ Other Pacific Islander
- ☐ Unreported / Refused to Report

ETHNICITY (Please check)
- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino
- ☐ Latin American / Latin / Latino
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard

LANGUAGE (Please check)
- ☐ English
- ☐ Spanish
- ☐ Portuguese
- ☐ Other, specify:
- ☐ _____

How did you hear about us? (Please check)

☐ Mail ☐ Newspaper ☐ TV / Radio ☐ Internet ☐ Billboard ☐ Insurance Company ☐ Word of Mouth (family/friend)

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AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize and direct my payment of medical benefits to Jordan Physician Associates (JPA) for any services furnished to me or to my minor child / dependent. I authorize JPA to furnish information from the medical record as necessary, to process health insurance claims and medical benefits.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand I am responsible to JPA for charges not covered by insurance. I agree to be responsible for payment of all unpaid services rendered on my behalf or to my dependents, including any fees for collection services.

ACKNOWLEDGEMENT RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices and have been offered a copy.

PRESCRIPTION HISTORY CONSENT

I authorize JPA to obtain a history of my prescriptions during the course of medical care by JPA physicians and providers.

AUTHORIZATION TO DISCUSS PRIVATE HEALTH INFORMATION

The following is a list of family members, employers, friends, school officials, etc. that I authorize you to release my medical record to:

Person's Name	**Relationship to Patient**

This authorization must be signed by the patient or their legal representative and may be revoked at any time with written notification.

I have read, understand and agree to all the above listed information.

Patient Signature or Responsible Person	Print	Date	Time

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HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Are you: ☐ Left Handed ☐ Right Handed Height: _____ feet & _____ inches Weight: _____ lbs.

Occupation: _____ Are you working now? ☐ Yes ☐ No

Please list any medications you are currently taking: _____

_____ _____

_____ _____

_____ _____

Do you have allergies or allergic to any food, medications or other substances (i.e. latex, tape, metals, etc.)?

_____ _____

_____ _____

Reason for your visit today? _____

How and when did it start? _____

Have you ever had it before? ☐ Yes ☐ No If yes, when: _____

List any past surgeries/hospitalizations you have had: (Appendix, Gall bladder, Hysterectomy, Colon, Heart Bypass, Stents, etc.):

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Do you smoke? ☐ Yes ☐ No Have you ever smoked? ☐ Yes ☐ No

Estimated ____ packs per day How many years? _____ When did you quit? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No Estimated ____ drinks per night ___ per week ___ per month

Have you ever been treated for drug or alcohol dependency? ☐ Yes ☐ No

Have you ever sought help for psychiatric/psychological problems? ☐ Yes ☐ No If yes, please explain: _____

_____

Do you exercise? ☐ Yes ☐ No If yes, how often? _____ What do you do? _____

FAMILY HISTORY - Please list any health problems of family members: _____

_____

_____

Is there a family history of unfavorable reactions to anesthesia? ☐ Yes ☐ No If yes, please explain the reaction:

_____

_____

Name: _____ DOB: _____

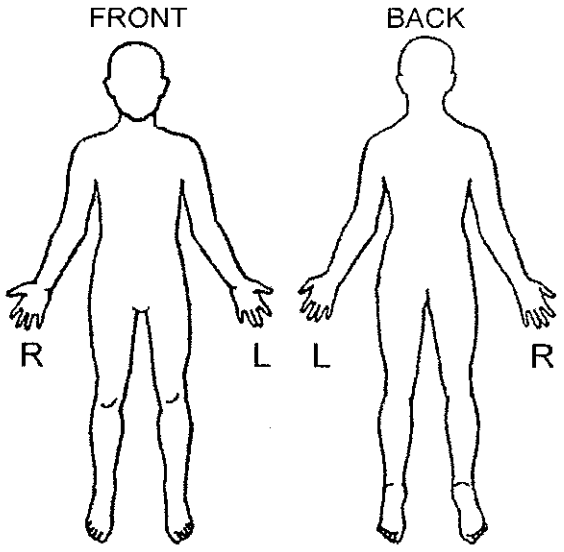
Please check if you have or had any of the following medical conditions or symptoms:

EYES, EARS, NOSE, THROAT (EENT):	☐ Visual Disturbances	☐ Difficulty Swallowing	
	☐ Chronic Sore Throat	☐ Sleep Apnea	
	☐ Chronic Nasal / Sinus Congestion		
ENDOCRINE SYSTEM:	☐ Diabetes Mellitus	☐ Thyroid Disease	☐ Hypoglycemia
HEART DISEASE:	☐ High Blood Pressure	☐ Low Blood Pressure	☐ Rheumatic Fever
	☐ Heart Attack	☐ Heart Murmur	☐ Chest Pain
	☐ Irregular Heart Beat	☐ High Cholesterol	☐ Pacemaker
LUNG:	☐ Asthma	☐ Shortness of Breath	☐ Wheezing
	☐ Chronic Coughing	☐ Pneumonia	☐ Pulmonary Embolism
	☐ Hay Fever	☐ CHF	
GASTROINTESTINAL:	☐ Ulcers	☐ Heartburn	☐ Hiatal Hernia
	☐ Hepatitis	☐ Pancreatitis	☐ Jaundice
	☐ Colitis	☐ Chronic Diarrhea	
BLEEDING:	☐ Bleeding Tendency	☐ Anemia	☐ Blood Clots
	☐ Sickle Cell Disease	☐ Blood Transfusions	☐ Bruise Easily
IMMUNE:	☐ Lupus	☐ HIV / AIDS	
NEURO:	☐ Head Aches	☐ Seizures	☐ Fainting
	☐ Numbness / Tingling	☐ Head Injury	☐ Stroke
ORTHO:	☐ Arthritis	☐ Muscle Spasms	☐ TMJ Problems
	☐ Limited Jo nt MovemenT		☐ Broken Bones
URINARY:	☐ Incontinence	☐ Chronic Urinary Tract Infections	

PAIN DRAWING

Using the following descriptive symbols, draw the location of your pain on the body outlines below

ACHE	^^^^^^^^^
BURNING	=======
NUMBNESS	000000000
PINS & NEEDLES	.....
STABBING	//////////////////
OTHER	xxxxxxx



PROMIS Short Form

Pain Intensity – Scale

Please respond to each item by marking one box per row.

In the past 7 days…	**Had no Pain**	**Mild**	**Moderate**	**Severe**	**Very severe**
How intense was your pain at its worst?....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How intense was your average pain?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	No pain	**Mild**	**Moderate**	**Severe**	**Very severe**
What is your level of pain right now?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Pain Interference – Short Form 4a

Please respond to each question or statement by marking one box per row.

In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
How much did pain interfere with your day to day activities?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How much did pain interfere with work around the home?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How much did pain interfere with your ability to participate in social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How much did pain interfere with your household chores?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Physical Function – Short Form 10a

Please respond to each question or statement by marking one box per row.

	Not at all	Very little	Somewhat	Quite a lot	Cannot do
Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Does your health now limit you in walking more than a mile (1.6 km)?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Does your health now limit you in climbing one flight of stairs?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Does your health now limit you in lifting or carrying groceries?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Does your health now limit you in bending, kneeling, or stooping?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Cannot do
Are you able to do chores such as vacuuming or yard work?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Are you able to dress yourself, including tying shoelaces and buttoning your clothes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Are you able to shampoo your hair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Are you able to wash and dry your body?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Are you able to sit on and get up from the toilet?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1