Comprehensive History Questionnaire

Name: _____ Date : _____

Height_____ Weight_____ Handed: RT☐ LT☐ Ambidextrous☐

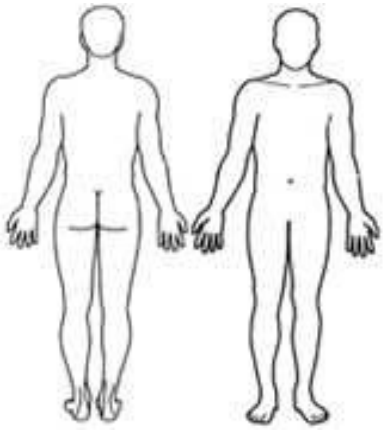
How did you hear about us?_____
Name of Family Physician:_____ Doctor's Phone number (if known)_____

Chief Complaint: (brief description of your current orthopaedic problem) _____

History of Present Illness: (answer these questions regarding your current problem(s) only)
(may indicate on the pictogram below)

Where on your body are you having this problem?

_____
_____



What symptoms are you experiencing?_____
_____
_____

How long have you had this problem?_____
_____

Have you had similar pains in the past?
yes no If yes, when?_____
_____

How did it happen?_____
_____

Injury? yes no If yes, give date:_____
Where did it occur?_____

Work related? yes no If yes, give date of injury?_____
How did accident happen?_____
Are you working now? yes no

How severe is this for you? (place an "X" on the line below)
No pain (0)----------(10) Worst pain of your life

What makes it worse? (eg. sitting, standing, walking, exercise, coughing/sneezing)
_____
_____

What makes it better? (eg. lying, sitting, standing, walking, exercise, pain pills)_____
_____

Any previous treatment for this problem? (eg. emergency room, physical therapy, chiropractic or other alternative treatments)
_____
_____

Have you had any of the following diagnostic studies for your current problem?

Diagnostic X-rays	yes	no	Date:_____
MRI (magnetic resonance imaging)	yes	no	Date:_____
EMG (electromyogram) / NCV (nerve conduction velocity)	yes	no	Date:_____
Other_____			Date _____

Review of Systems: (please indicate yes or no)

Constitutional
- fever Y N
- weight change Y N

Eyes
- visual change Y N

Ears, Nose, Mouth
- hearing change Y N
- sinus problems Y N
- dental problems Y N

Cardiovascular
- chest pain Y N
- hypertension Y N
- shortness of breath Y N

Respiratory
- tuberculosis Y N
- pneumonia Y N
- asthma Y N

Endocrine
- diabetes Y N
- if Yes – Insulin dependent? Y N
- thyroid problem Y N

Gastrointestinal
- nausea/vomiting Y N
- blood in stool Y N

Genitourinary
- urinary infections Y N
- incontinence Y N

Skin
- infections Y N
- lesions/ulcers Y N

Neurologic
- seizures Y N
- paralysis Y N

Psychiatric
- depression Y N

Hematologic
- blood clots Y N
- bleeding Y N

Past Medical History: (please circle those medical conditions for which you are followed by your doctor)

AIDS/HIV	Circulatory Problems	High Cholesterol	Rheumatoid Arthritis
Anemia	Diabetes	High Blood Pressure	Shortness of Breath
Arthritis	DVT/Blood Clots	Irregular Heartbeat	Sinus Problems
Artificial Heart Valves	Ear/Eye Problems	Kidney Problems	Sleep Apnea
Asthma	Foot/Leg Cramping	Liver Diseases/Hepatitis	Stomach Ulcer
Bleeding Disorders	Gout	Nervous Problems	Stroke
Cancer	Headaches	Osteoporosis	Thyroid Disorder
Chemical Dependency	Heartburn/Acid Reflux	Psychiatric Care	Other_____
Chest Pain	Heart Disorders	Respiratory/Lung Disorders	Other_____

Past Surgical History: (please list prior surgeries, especially those related to your current problem)

1._____ 2._____

3._____ 4._____

Allergies: (circle or write in any medication allergies that apply) None ☐

Penicillin	Latex	Aspirin	Advil, Aleve, Motrin
Morphine	Aspirin	Sulfa Drugs	Other _____
Novocain	Adhesive tape	Shrimp,Iodine,Merthiolate	Other_____

Medications: (please list name, dose, and frequency)

1._____ 2._____

3._____ 4._____

5._____ 6._____

Family Medical History: (list medical illnesses affecting your immediate family)

1._____ 2._____

3._____ 4._____

Social History: (please check all that apply)

single married widowed divorced/separated

tobacco use (packs per day):_____ alcohol use (drinks per week):_____

Midwest Sports Medicine Institute

Patient Registration Form

Today's Date_____ E-mail address_____
Patient's Name_____Sex_____Marital Status_____
Date of Birth_____Age_____Social Security Number _____
Address_____City_____State_____Zip_____
Home Phone( )_____Work( )_____Cell ( )_____
Patient Employed By_____Occupation_____
Employer's Address_____
Spouse's Name _____Social Security Number _____
Employed By_____Work Phone_____

Name of Person to Contact in an Emergency _____
Phone Number _____ Relationship to Patient_____

Insurance

Primary Insurance Company_____
Primary Cardholder_____
Relationship to Patient_____
Date or Birth _____
Social Security Number _____

Secondary Insurance Company_____
Secondary Card Holder _____
Relationship to Patient _____
Date of Birth _____
Social Security Number _____

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If Patient is a Minor or Student Complete this section

Fathers Name_____
Address _____
Phone _____ _____
Employer _____
Work Phone _____
Social Security Number _____
Date of Birth _____

Mothers Name_____
Address_____
Phone_____
Employer _____
Work Phone _____
Social Security Number _____
Date of Birth _____

Release of Medical Health Information

In the event that Midwest Sports Medicine Institute is unable to contact me, I give full permission to Midwest Sports Medicine Institute to contact the individuals that I have designated below for the purpose of disclosing information pertinent to my case. This would include, but not limited to information regarding tests, reports, scheduling and business information. By my signature below, I agree to hold harmless and waive any liability against Midwest Sports Medicine Institute for the disclosure of information to the individual(s) designated below.

Name		Phone
_____	_____	_____
_____		_____
_____		_____

I understand this release will be in effect unless changed or revoked by myself either in writing or by completing a new release.
Patient Name (print)_____ _____ Date _____
Patient Name (signature) _____

Midwest Sports Medicine Institute Financial Policy

Thank you for choosing Midwest Sports Medicine Institute as your health care provider. Please understand that payment of your bill is considered a part of your treatment. Your clear understanding of our financial policy is important to our professional relationship.

---- All Patients must complete our "Patient Registration and Medical form" prior to seeing the doctor.
---- FULL PAYMENT is due at the time of service unless prior arrangements have been made.
---- Copays are due at the time of service.
__ There will be a $25.00 service charge on all returned checks.
--- The charges made for your visit depend on the nature and the complexity of your problem. If you have any questions regarding the the charges made for any visit, please feel free to contact our billing office.

--- Any charge that becomes sixty (60) days old without satisfactory payment provision having been made will be considered delinquent. MSMI reserves the right to turn over delinquent accounts to a debt collection agency or an attorney for collection. Costs associated with

the collection efforts will be added to the balance due to MSMI.

----We accept cash, checks and Visa /Mastercard.

Insurance Plans ---- **If you have a Managed care plan (HMO, EPO, POS or PPO), co-payments are due at the time of service in addition to any deductibles or fees for which you are responsible. If you have an Indemnity plan (80/20 plan), 20% payment is due at the time of service in addition to deductibles for which you are responsible. Insurance is a contract between you and your insurance company. We are not party to this contract. By law, insurance companies are required to pay health care providers within 30-45 days. If they do not fulfill their financial obligations, the responsibility will be transferred to the patient. You are responsible for the timely payment of your account. If this account is assigned to a collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees, cost of collections and/or collection agency fees, to which may be added pre-judgment and/or post-judgment interest at the current legal rate. Ninety (90) days after the date of service any unpaid amounts will be assessed late payment charges of 0.5% monthly.**

Covered Services------ **Some health plans do not cover all services. If we are aware that your plan excludes certain services you will need to pay for those services at the time they are rendered.**

Medicaid/Public Aid------ **If Medicaid/Public Aid covers you, you must present medical eligibility proof at the time you register for each service.**

I understand the above listed financial policy and agree to abide by this agreement.

Signature_____ Date_____

Medicare------- **I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information) Regulations pertaining to Medicare assignment of benefits also apply.**

Release of Information and Authorization for Assignment of Benefits

I authorize Midwest Sports Medicine Institute to release to my insurance company or its representatives, information including the diagnosis and the records of any treatment or examination rendered to me that they may require processing my claim for benefits. I authorize and request that my insurance company pay directly to the above named practice the amount due me in my pending claim for medical treatment of services, by reason of such treatment or services rendered to me. This assignment will remain in effect until revoked by me in writing. I understand and agree that,(regardless of my insurance policy, I am responsible for the entire balance on my account, for all professional services provided to the patient(or myself). I have read all the information contained in the Financial policy. I certify that, to the best of my knowledge, this information completed is correct and true. I will notify this office in case of any changes to my health or any of the attached information.

Signature _____ Date_____