



### PATIENT HISTORY

Please Print and fill out completely

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hand Dominance:  Left  Right

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

#### History of Present Injury (Why are you here today?)

Injury to:  Left  Right  Both  
 Arm  Shoulder  Elbow  Wrist  Hand  
 Leg  Upper Leg  Knee  Lower Leg  Ankle  Foot  
 Other \_\_\_\_\_

Did your problems result from a specific injury?  Yes  No Injury/Accident Date (mm/dd/yr yyy) \_\_\_\_\_

Did your problems begin following:  Work Injury?  Motor Vehicle Accident? What state? \_\_\_\_\_

How did you get injured? \_\_\_\_\_

If neither, how long have you had the condition? \_\_\_\_\_ First Noticed: \_\_\_\_\_

Please rate your pain on a scale of 1 to 10 (10 being the most painful): \_\_\_\_\_

Is the pain:  Constant  Occasional  Sharp  Dull  Aching  Stabbing  Throbbing

What symptoms are you experiencing?  Locking  Catching  Giving Way  Popping  Grinding  Other

What, if anything, makes your symptoms better? \_\_\_\_\_

What, if anything, makes your symptoms worse? \_\_\_\_\_

Have you seen another physician for this injury?  Yes  No

If yes, who? \_\_\_\_\_ Date: \_\_\_\_\_

What treatments have you tried?  Nothing  Physical Therapy  Exercise  Acupuncture  Chiropractic

Injections (specify: ESI; Facets; Sacroiliac; Selective Nerve Root Block; Synvisc; Hyaligan)

Medications \_\_\_\_\_  Other \_\_\_\_\_

#### Have you had the following tests?

Test	Date(mm/yyyy)	What facility?
<input type="checkbox"/> Xrays	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Other	_____	_____

Regular Exercise:  Yes  No Type of exercise and activity you enjoy: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Patient Name: \_\_\_\_\_

Practitioner's Initials: \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please check any previous surgical procedures, list the date and describe surgery:

- Appendectomy                       Hernia Repair                       Arthroscopy: Lower Extremity    Upper Extremity
- Spine/Back Surgery                   Heart Surgery                       Total Joint Replacement           Fracture Repair
- Other: \_\_\_\_\_

**SOCIAL HISTORY**

- Special Diet:  Yes  No    Any Restrictions? \_\_\_\_\_
- Tobacco Use:  Yes  No    Type: \_\_\_\_\_    Duration: \_\_\_\_\_    Quit Date: \_\_\_\_\_
- Alcohol Use:  Yes  No    Frequency: \_\_\_\_\_
- Drug Use:  Yes  No    Frequency: \_\_\_\_\_
- Caffeine Use:  Yes  No    Frequency: \_\_\_\_\_

**ALLERGIES**

Are you allergic to any medications?    Sulfa  Yes  No    Latex  Yes  No     No known drug allergies

Please list all medications that you are allergic to: \_\_\_\_\_

Please list food allergies (i.e., eggs, shellfish): \_\_\_\_\_

**MEDICAL HISTORY**

- Anemia                       Depression                       Hepatitis A or B                       Osteoporosis
- Arthritis                       Diabetes                       High Blood Pressure                       Rheumatoid Arthritis
- Asthma                       Emphysema                       HIV                       Stroke / Seizures
- Blood Clots                       Heart Disease                       Irregular Heartbeat                       Thyroid
- Cancer                       Liver Disease                       Chemical Dependency and/or Alcoholism
- Other: \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No    If yes, when? \_\_\_\_\_

**MEDICATIONS**

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any over the counter medications. Include Vitamin, Mineral and Herb supplements.

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**GASTROINTESTINAL HISTORY**

Do you have a history of Peptic Ulcer Disease?  Yes  No    if yes, when? \_\_\_\_\_

Do you have a history of GI. stomach bleed?  Yes  No    If yes, when? \_\_\_\_\_

Do you take any medications for your stomach? (Please include over the counter medications, i.e. Pepto, Tums, Xantac, etc., dosage and frequency): \_\_\_\_\_

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? (Please include all over the counter medications such as Advil, Aleve, and previously prescribed medications, such as Celebrex, and Vioxx. List all you have tried: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Practitioner's initials: \_\_\_\_\_

**FAMILY HISTORY**

Please check family history conditions:

- Blood clots                       Diabetes                       Hypertension                       Rheumatoid Arthritis
- Cancer                               Heart Disease                       Osteoporosis                       Stroke / Seizures

Please describe any immediate family history of medical problems: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Check if you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have any problems, please check the negative/none box.

1. CONSTITUTIONAL GENERAL                       None                       Weight Loss                       Weight Gain                       Insomnia                       Chronic Fatigue

Other \_\_\_\_\_

2. EYES     None                       Vision Change                       Glasses/Contacts                       Cataracts                       Glaucoma

Other \_\_\_\_\_

3. EARS, NOSE THROAT                       None                       Loss of hearing                       Seasonal Allergies                       Sinus Pain                       Ringing

Other \_\_\_\_\_

4. CARDIOVASCULAR                               None                       Chest Pain                       Edema                       Hypertension                       Palpitations

High cholesterol                       Other \_\_\_\_\_

5. RESPIRATORY                                       None                       Asthma                       Wheezing                       Frequent Cough

Other \_\_\_\_\_

6. GASTROINTESTINAL                               None                       Heartburn                       Indigestion                       Acid Reflex                       Ulcer Problems

Abdominal Pain                       Peptic Ulcer                       GI, Stomach Bleed

Other \_\_\_\_\_

7. MUSCULOSKELETAL                               None                       Arthritis                       Muscle Weakness                       Joint Pain                       Back Pain

Other \_\_\_\_\_

8. SKIN     None                       Rash                       Ulcers                       Scars

Other \_\_\_\_\_

9. NEUROLOGICAL                                       None                       Headaches                       Seizures                       Numbness                       Dizziness

Other \_\_\_\_\_

10. PSYCHIATRIC                                       None                       Depression                       Crying                       Anxiety                       Mood Swing

Other \_\_\_\_\_

11. ENDOCRINE     None                       Diabetes                       Hypothyroid                       Hyperthyroid                       Hot Flashes

Other \_\_\_\_\_

12. HEMATOLOGY                                       None                       Easy Bruising                       Bleeding                       Anemia

Other \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

# Steadman Hawkins Clinic - Denver

## Request for Confidential Communications Regarding Medical Information

I, \_\_\_\_\_, wish to request that the communication about my health and medical care, which contains Protected Health Information (PHI), be communicated to me in the following manner:

(Please check how you would like to receive your Protected Health Information and provide the information we will need to send the information to you at your preferred location)

\_\_\_\_\_ By telephone at my home number: \_\_\_\_\_

\_\_\_\_\_ By telephone at a different number: \_\_\_\_\_

\_\_\_\_\_ By FAX at this number provided: \_\_\_\_\_

\_\_\_\_\_ By EMAIL at this email address: \_\_\_\_\_

\_\_\_\_\_ By mail at an address other than the one on the record

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Please do not leave messages regarding my PHI on my answering machine

\_\_\_\_\_ SHCD may leave an appointment reminder message on my answering machine

\_\_\_\_\_ SHCD may discuss and/or leave messages about my PHI and/or accounting issues with the following individuals:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

If you cannot be reached at the designated alternative location you specify, SHCD may use other means to contact you.

By signing this form, this communication request will remain in force until revoked in writing.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Month/Day/Year

\_\_\_\_\_  
Patient Account Name

\_\_\_\_\_  
Patient Account Number

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
SHCD Employee

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Month/Day/Year

*Steadman Hawkins Denver Clinic*

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of outpatient office charges at the time of the visit, unless other arrangements have been made. The Steadman Hawkins Denver Clinic will bill my insurance, provided all of the necessary information is given to the clinic. If any insurance company does not submit payment within 45 days, I understand that I will be responsible for any outstanding balance. I understand the Steadman Hawkins Denver Clinic will bill my insurance for any surgical charges, though I will be required to provide a deposit prior to the surgery based on an estimated financial responsibility.

NOTICE OF "NON-COVERED" SERVICES

I am aware that my insurance carrier or Medicare may consider some services performed by the Steadman Hawkins Denver Clinic "non-covered", therefore I will become fully responsible for payment of these services.

WAIVER OF "USUAL, CUSTOMARY AND REASONABLE" CLAUSES

(For patients with "UCR" coverage) I acknowledge that the fees charged by Steadman Hawkins Denver Clinic for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," due to specialized services and staff. However, I agree to pay fees in full, even if the amount is greater than what I am reimbursed for from my insurance company.

BILL TO/PAYMENT INSTRUCTIONS

Initial

I hereby authorize and request the Steadman Hawkins Denver Clinic to bill my insurance company for all services provided to me. I also authorize payment of medical benefits to the Steadman Hawkins Denver Clinic for any services provided to me and billed by the Steadman Hawkins Denver Clinic.

PERMISSION TO RELEASE MEDICAL INFORMATION

I authorize the Steadman Hawkins Denver Clinic to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third-party payers or their reviewing agencies. This information must be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to the Steadman Hawkins Denver Clinic or its affiliates until written notice revoking it is provided.

I release the Steadman Hawkins Denver Clinic of all responsibility for loss of confidentiality through access and or copies made of records released in compliance to this authorization.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payments and release of information.

Patient's Name \_\_\_\_\_

Patient's or Legal Guardian's Signature: \_\_\_\_\_ Date \_\_\_\_\_

If Legal Guardian, Relationship to Patient \_\_\_\_\_



# THE STEADMAN HAWKINS CLINIC DENVER

\_\_\_\_\_  
Name of Patient (please print)

\_\_\_\_\_  
Date of Birth

## Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received The Steadman Hawkins Clinic Denver's Notice of Privacy Practices.

\_\_\_\_\_  
Signature of patient or patient representative

\_\_\_\_\_  
Date

## Documentation of Good Faith Efforts To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

*(For use when acknowledgment cannot be obtained from the patient.)*

The patient presented to the office/hospital on \_\_\_\_\_ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:  
\_\_\_\_\_  
\_\_\_\_\_
- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe below):  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Employee Completing Form

\_\_\_\_\_  
Date

*[Note: Providers are required to make good faith efforts to obtain acknowledgement that each patient has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider's Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgment. The regulation does not specify how those "Good Faith Efforts" should be documented. This example form is meant to serve as an example of one way that a provider could satisfy this requirement.]*