Patient Information

Last Name: _____First Name: _____ Sex: ___
Date of Birth: _____ SS#: _____-_____-_____
Address: _____ City: _____State: ___
Zip Code: _____ Work# ( ) ____-_____ Home# ( ) ____-_____
Mobile# ( ) ___-_____ Email: _____
Marital Status: Single___ Married ___ Divorced ___ Widowed ___ Domestic Partner___
Employer's Name: _____ Employer's Address_____
Referring Physician's Name: _____
Injury: Work or Auto related? _____ Date Accident Occurred: _____
Emergency Contact: _____ Phone# ( ) _____-_____

Insurance Information

Primary Insurance Co. Name: _____Policy#:_____
Subscriber Name: _____ SS#:____-___-____ Date of Birth: _____
Subscriber Employer's Name: _____

Secondary Insurance Co. Name: _____ Policy #:_____
Subscriber Name: _____ SS#:____-___-_____ Date of Birth: _____

Third Party Insurance Co. Name: _____ Claim #: _____
Adjustor's Name: _____ Adjustor's #:_____
State Accident Occurred: _____

Patient Questionnaire/ History

What is your Chief Complaint? _____
_____

Rate your chief complaint in order of severity from worst (5) to least (1)

Pain____ Decreased Motion____ Swelling/edema____ Stiffness____
Loss of function_____

Indicate the nature of your pain and symptoms: ___Sharp ___Dull ___Piercing ___Shooting ___Aching ___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing

When and how did this problem begin? _____
_____

What makes your symptoms/ pain worse? _____
_____
What makes your symptoms/ pain lessen? _____
Rate your pain on a visual scale (0-10) 0 no pain 10 excruciating pain: _____
Worst it has been_____ past 2 to 4 weeks_____ Past 24 hours_____ at this moment_____
Are your symptoms worse in the: _____Morning _____Afternoon _____Evening _____ Inconsistent_____

Are your symptoms: ___Improving ____Worse __Stable___

Medical History

Has this problem affected your daily life or routine? Briefly describe in what ways._____

Please answer the following questions: By circling Yes or No
1) Do the current problems interrupt your sleep? Yes or No
2) Do have a history of Seizures? Yes or No
3) Have you had a history of headaches? Yes or No
4) Do you experience any dizziness or vertigo? Yes or No
5) Do you have a Pacemaker? Yes or No
6) Do you have any intolerance to hot or cold? Yes or No
7) Do you have any bruising or bleeding disorders? Yes or No
8) Have you had any skin changes, such as rashes or discoloration? Yes or No
9) Do you have any Metal Implants? Yes or No
10) Have you had a recent episode of nausea/vomiting? Yes or No
11) Are you pregnant? Yes or No
12) Do you have osteoporosis? Yes or No Date of your last bone scan:
13) Do you have any Medical allergies? Yes or No
14) Have you noticed any shortness of breath or in exercise tolerance? Yes or No
15) Do you use any assistive device? (Cane, foot orthotics) Yes or No
16) Do you have high blood pressure? Yes or No
17) Do you have any cardiac problems? Yes or No
18) Do you have diabetes? Yes or No
19) Have you ever had cancer of any sort? Yes or No
20) Do you have a history of neck or back problems? Yes or No
21) Do you have a hernia? Yes or No

Any other illness or past injuries I should be aware of? _____

Past surgeries: Yes ___No___
If yes, give brief details:

_____
List the medications you are currently taking (over the counter/prescriptions):

_____

_____

Use of Tobacco: Yes ____No ____ Use of Smokeless Tobacco: Yes ____No____

Patient's signature: _____Date Signed: _____

Specialists
HOSPITAL SHREVEPORT
Orthopedic & Spine Surgery
Physical Therapy · Pharmacy

WORKERS COMPENSATION ACKNOWLEDGEMNET FORM

Patient's Name: _____ Date of Birth: __/__/_

Street Address: _____ Social Security #: ____-___-_____

City/State/Zip: _____

Please check one of the following:

Is your visit today the result of a work-related injury? ☐ Yes ☐ No-**PLEASE SIGN AT BOTTOM**

Do you have an attorney? ☐ Yes ☐ No

If yes, Name of Attorney _____ Phone Number _____

Please be advised that if you are being seen as a result of a work-related injury you **MUST NOTIFY the front desk receptionist immediately.** If you fail to notify us of such a claim, your health insurance may deny coverage and you will ultimately be responsible for all charges related to medical care you receive at SPECIALISTS HOSPITAL SHREVEPORT

In the event that your Workers Compensation denies your case, you will be responsible for all charges related to medical care that you receive in this case and as a courtesy, we will file your primary health insurance company for payment, if applicable. If your insurance company denies due to their timely filling requirements, you will also be responsible.

We maintain strict guidelines on the processing of work-related claims. In order to process paperwork in a timely manner please provide us with the following information.

Workers Compensation Information

Workers Comp Carrier: _____ Claim #: _____ Date of Injury: _____

Adjustor's Name: _____ Adjustor's #:_____

Please signify your understanding of the matter by signing in the space provided below.

Patient Signature: _____ Date signed:

Cancellation/No-Show Policy

We respectfully request that if you must cancel an appointment, please call us 24 hours in advance or you will be subject to a **$25.00** cancellation fee. If appointments are not kept, your treatment program may be terminated after the second no-show or third cancellation. This will be documented in your medical record and forwarded to your physician.