Osteopathic Health Care Associates
44720 Van Dyke Avenue
Utica, MI 48317

PLEASE PRINT Today's Date _____ Soc. Sec.# _____

Patient Name: Last_____ First_____ M.I. _____ Date of Birth_____

Address_____ City_____ State _____ Zip_____

Home Phone _____ Work Phone_____ Email_____ Marital Status_____ Sex ☐**M**☐***F***

Responsible party for Patient's Bills_____

Employed by _____ Business Phone _____

Spouse or Other Parent (if minor) _____

Employed By _____ Business Phone _____

If we have scheduled appointment time for you and you are unable to keep this appointment, please give us 24 hours advance notice. Failure to do so may result in a $50.00 Missed Appointment Charge.

All copays, deductibles and coinsurance payments are due at time of check-in.
Failure to provide payment at time of service will result in o $10 (ten dollar) billing charge.

- COPY FRONT & BACK OF INSURANCE CARD –

INSURANCE NAME _____

Contract/Enrollee Number_____

Group_____

Subscriber_____

Subscriber Date of Birth_____

- INSURANCE RELEASE –

I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby certify that I have provided my complete insurance information. I also understand it is my responsibility to notify O.H.C.A when any change occurs with my insurance coverage. I request payment of authorized Medicare, Blue Cross or independent insurance benefits be made either to me or on my behalf to O.H.C.A for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for the related services.

Date _____ Signed_____

INSURED OR AUTHORIZED PERSON

IN CASE OF EMERGENCY: Nearest relative or friend not living with you:

Name_____ Relationship _____ Address_____

City_____ State_____ Zip Code_____ Phone_____

To whom may we thank for referring you?

_____

_____

By signing this form, I acknowledge that I have been offered and/or received the OHCA health Notice of Privacy Practices.

Signature of Patient (or parent Guardian)_____

Date_____ Time_____

Signature of Witness_____

I authorize any associate of, OHCA to disclose or release any of my Private Health Information to the following person(s):

☐ No one other than myself - I can be reached here: Phone Number_____

☐ Spouse (Name) _____ Phone Number_____

☐ Other (Name) _____ Phone Number_____

I authorize this office to call and confirm scheduled appointments one to two days in advance and to leave a message on home voicemail / recorder or with another family member.

I will provide written notice when I choose to revoke any of the above.

Signature _____ Date_____

Witness_____

Do you have an advanced directive ? □Y N

Would you leave some information about it ? □Y N

Patient signature _____ Date _____

As of today, we are required to report statistics on race, ethnicity and preferred language for our patient population. YOUR NAME and ANY OTHER PATIENT IDENTIFIERS OR SPECIFICS WILL NOT BE REPORTED. We appreciate your participation in helping us collect this information.

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unreported/Refused *to* report
- ☐ Other Pacific Islander
- ☐ Black/Afrlcan American

Race:

- ☐ Asian
- ☐ Native Hawaiian
- ☐ American Indian/Alaska Native
- ☐ White
- ☐ More than one race
- ☐ Unreported/Refused to report

Preferred Language:

- ☐ English
- ☐ Other
- ☐ Indian (Including Hindi & Tamil)
- ☐ Spanish
- ☐ Russian

Osteopathic Health Care Associates
44720 Van Dyke Avenue
Utica, MI 48317
P(586) 221-2791 F(586) 231-0716

ADVANCE DIRECTIVE EDUCATION

Patient Name: _____ Date: _____

We at, _____, are required by the federal and state laws to educate all patients 18 years and older *on Advanced Directives and self-determination policies.*

An Advanced Directive document indicates and stipulates a person's choice of treatment should they become mentally unable to make decisions for them self due to injury or illness. A living will, durable power of attorney, or codes status in case of emergency are some of the choices that illustrate an Advanced Directive. It allows the person to state bow medical decisions are to be made when his/her ability is lost.

I. Do you have a will or Advanced Directive?

____ Yes ____ No

2. Do you want information on Living Wills and Advanced Directives?

____ Yes ____ No

3. Education materials on Advanced Directives given to patient.

____ Yes ____ No Date: _____

Patient Signature: _____Date: _____

Staff Signature: _____ Date: _____

Some information on this form may not apply to you. Just don't answer those questions. Some may seem fairly personal or odd. The reason for these questions is to appropriately document as much information as possible so that we, as the medical practitioners, will make better informed decisions regarding your care, and save time asking questions that you have already answered. This is also partly to help in auto claims and insurance claims in regard to pain issues, as these can be very difficult to document and appropriately prove to the insurance companies. Please be as specific as you can in your answers. As always, this is completely confidential as per HIPPA regulations.

NAME _____ DATE OF BIRTH _____

VETERAN? ☐Y ☐N

EDUCATION (Degree or last grade completed) _____

SPOUSE AND CHILDREN:

NAME	AGE	MEDICAL PROBLEMS	ALLERGIES

ARE YOU CURRENTLY DISABLED? ☐Y ☐N CAUSE OF DISABILITY:_____

PERMANENTLY ? ☐Y ☐N HOW LONG HAVE YOU BEEN DISABLED? _____

WHAT KIND OF WORK DO YOU DO CURRENTLY _____

Pharmacy Name:_____ Cross Streets: _____ Phone: _____

CURRENT MEDICATIONS: INCLUDE ALL HERBS, OVER THE COUNTER, AND SUPPLEMENTS:

NAME	DOSE	TIME PER DAY	PHYSICIAN PRISCRIBING	NAME	DOSE	TIME PER DAY	PHYSICIAN PRISCRIBING

ALLERGIES TO MEDICATION, ENVIRONMENTAL, FOODS ETC:	REACTION	ANY MEDICATIONS NOT TOLERATED:	REACTION

PRIMARY CARE PHYSICIAN? _____ ADDRESS:. _____ PHONE_____

PLEASE LIST ANY OTHER PHYSICIANS OR HEALTH PROVIDERS YOU ARE CURRENTLY SEEING.

NAME: _____ ADDRESS: _____

SPECIALITY: _____ PHONE: _____

NAME: _____ ADDRESS: _____

SPECIALITY: _____ PHONE: _____

Please list all surgical and medical conditions even if you don't think they are related to your current problem.

Body System	PROBLEM	DATE OR AGE	PROBLEM	DATE OR AGE	PROBLEM	DATE OR AGE	PROBLEM	DATE OR AGE
Neurological (Head, Brain, Stroke, Paralysis, Numbness etc.)								
Musculoskeletal (Broken Bones, Joint Replacements, Torn Tendons/Ligaments, Arthritis, etc)								
Cardiology/ Pulmonary (Heart, Lungs, Blood Clots; Anemia, Vein/ Artery etc)								
Endocrine (Diabetes, Thyroid, Pituitary etc)								
Dermatology (Skin, Rash:, Acne, Boils, Cysts etc)								
Reproductive (Endometriosis, PCOS, Amenorrhea, etc)								
General Surgery (Gall Bladder, Appendix, Hernia, Tonsils, Lipoma etc								
Psychiatry (Bipolar, Depression, Anxiety, etc)								

ARE YOU ADOPTED? ☐Y ☐N **IF YES DO YOU KNOW YOUR BIRTH PARENTS AND HISTORY?** ☐Y ☐N

ARE YOUR PARENTS ALIVE? **IF DECEASED:**
MOTHER ☐Y ☐N **MOTHERS AGE: _____**
FATHER ☐Y ☐N **FATHERS AGE: _____**

CAUSE OF DEATH;
MOTHER: _____

FATHER:. _____

Are you up to date on Tetanus _____

Pneumonia _____

PLEASE LIST ANY HISTORY OF MEDICAL PROBLEMS IN YOUR FAMILY:

EXAMPLES: heart problems, cancer, thyroid disease, hypertension, glaucoma diabetes, stroke, emphysema

COLON CANCER: □Y □N · **Relation.: _____ Age:_____**

HEART ATTACK BEFORE AGE 65: □Y □N · **Relation.: _____ Age:_____**

DIABETES: □Y □N · **Relation.: _____ Age:_____**

BREAST CANCER: □Y □N · **Relation.: _____ Age:_____**

_____ · **Relation.: _____ Age:_____**

_____ · **Relation.: _____ Age:_____**

_____ · **Relation.: _____ Age:_____**

_____ · **Relation.: _____ Age:_____**

SOCIAL HESTORY:

CIGARETTES, EVER? ☐Y ☐N **QUIT WHEN? _____**

YEARS SMOKED? _____ **PACKS PER DAY?, _____**

HAVE YOU EVER HAD:

CIGARS? ☐Y ☐N **CHEW/RUB?** ☐Y ☐□N **SNUFF?** ☐Y ☐N

DRINK ALCOHOL? ☐Y ☐N **HOWOFTEN? ____**

ARE YOU CURRENTLY ADDICTED TO ALCOHOL? ☐Y ☐N

HAVE YOU EVER BEEN ADDICTED TO: ALCOHOL ☐Y ☐N

PRESCRIPTION MEDS? ☐Y ☐N **"STREET DRUGS"** ☐Y ☐N

HAVE YOU EVER USED IV DRUGS OR SNORTED COCAINE? ☐Y ☐N

DO YOU EXERCISE REGULARLY? ☐Y ☐N **HOW OFTEN?_____**

WOMEN:

WHAT AGE DID YOU START YOUR PERIODS?_____ DATE OF LAST PERIOD? _____ REGULAR? □Y □N CRAMPS? □Y □N SEVERE? □Y N
NUMBER OF PREGNANCIES: _____ LIVE BIRTHS _____ MISCARRIAGES _____ C-SECTIONS? □Y N
DATE OF LAST: MAMMOGRAM _____ PAP _____ BREAST EXAM _____ DO YOU DO MONTHLY SELF BREAST EXAMS? □Y N

MEN:

DATE OF LAST PROSTATE EXAM? _____ COLONOSCOPY? _____ PSA? _____
DO YOU: HAVE TROUBLE STARTING URINATION? □Y □N GET UP MORE THAN 2 TIMES/ NIGHT TO URINATE? □Y N
DO YOU HAVE TESTICLE MASSES? □Y □N DO YOU DO. MONTHLY TESTICLE EXAMS? □Y N

Patient's signature: _____ Date: _____

Physician's signature: _____ Date: _____

Patient Name: _____ **Date of Birth:** _____

Have you sought treatment at any of the specialties below for this pain episode?

Massage or Physical Therapy	**HELPING?**	**□Y**	**□N**	**SOME CURRENTLY SEEING THEM?**	**□Y**	**N**
Chiropractor	**HELPING?**	**□Y**	**□N**	**SOME CURRENTLY SEEING THEM?**	**□Y**	**N**
Pain Management	**HELPING?**	**□Y**	**□N**	**SOME CURRENTLY SEEING THEM?**	**□Y**	**N**
Steroid Injections	**HELPING?**	**□Y**	**□N**	**SOME CURRENTLY SEEING THEM?**	**□Y**	**N**

HAVE YOU EVER HAD AN IMPLANTED NARCOTIC PUMP? **□Y** **□N** **IMPLANTED ELECTRONIC STIMULATOR?** **□Y** **N**

HAVE ANY OF THE FOLLOWING BEEN PERFORMED TO EVALUATE YOUR PAIN ISSUES?

X-RAYS/CT,MRI/BONESCAN: □Y □N RESULTS:_____ BODY REGION_____

EMG/EEG: □Y □N RESULTS:_____ BODY REGION_____

ANTHROGRAM: □Y □N RESULTS:_____ BODY REGION_____

WHEN DID THIS EPISODE OF PAIN BEGIN? _____ SUDDEN ONSET? □Y □N IS THE PAIN GETTING: BETTER WORSE SAME_____

WHAT MAKES THE PAIN BETTER? _____ WORSE? _____

HAVE YOU EVER HAD AN AUTO ACCIDENT'? □Y □N WHEN? _____ SEVERITY _____ ANY PROBLEMS AFTER? □Y N

DID YOU EVER PARTICIPATE IN SPORTS OR DO ANY MUSCLE BUILDING ACTIVITIES? □Y □N LIST THEM AND WHEN:

_____

_____

EVER HAVE A CONCUSSION OR BEEN KNOCKED OUT? □Y □N EVER HAVE THE WIND KNOCKED OUT OF YOU? □Y N

IS THERE ANYTHING ELSE YOU WANT ME TO KNOW ABOUT YOU OR THIS PAIN EPISODE THAT HAS NOT BEEN ASKED ALREADY?

_____

_____

PLEASE DESCRIBE WHAT YOUR PAIN IS LIKE, IN YOUR OWN WORDS, INCLUDING ANY PROBLEMS OR ISSUES WE HAVE NOT ALREADY ADDRESSED.

_____

_____

DATE_____

Oswestry Pain Questionnaire

Sorry, but here are a few more questions that are aimed at documenting how your pain has affected your everyday life.

Section 1 - Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain Meds
- ☐ The pain is bad but I manage without taking pain meds
- ☐ Pain kills give complete relief from pain
- ☐ Pain meds give moderate relief from pain
- ☐ Pain meds give very little relief from pain
- ☐ Pain meds have no effect on the pain and I do not use. them

Section 2 - Personal Care

- ☐ I can look after myself normally without extra pain.
- ☐ I can look after myself normally but it causes extra pain
- ☐ It Is painful to core for myself even if I om slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, Wash with difficulty and stay in bed

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but It gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift only very light weights.
- ☐ I can not lift or carry anything at all

Section 4 - Walking

- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from walking more than I mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 1/4 mile
- ☐ I can only Walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

Section 5 - Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than 1/2 hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing more than 1 hour
- ☐ Pain prevents me from standing more than 1/2 hour
- ☐ Pain prevents me from standing more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 - Sleeping

- ☐ Pain does not prevent me from sleeping
- ☐ I can sleep well only by using tablets
- ☐ Even when I take tablets I have less than six hours sleep
- ☐ Even when I take tablets I have less than four hours sleep
- ☐ Even when I take tablets I have less than two hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 - Sex Life

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life Is normal but causes some extra pain
- ☐ My sex life Is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life Is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 - Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home
- ☐ I don't have a social life because of pain

Section 10 - Traveling

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to Journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital