Joseph A. Shehadi, M.D., L.L.C.
Neurosurgical Associates

Initial Medical History Form
(Please Print)

Name: ______________________________ Age__________

Which hand do you write with? ______________

Have you ever seen Dr. Joseph Shehadi before? Yes No

Referring Physician______________________________
Address______________________________Phone__________
Family Physician______________________________
Address______________________________Phone__________
Other physicians you have seen for this problem______________________________
Address______________________________Phone__________

REASONS FOR THIS OFFICE VISIT
(Please check **ALL** that apply)

☐ **Pain:** Where is your pain? ______________________________

On a scale of 0-10, *(where 0 is no pain and 10 is the worst pain you can imagine)*, please rate your pain:

Today: 0 1 2 3 4 5 6 7 8 9 10 **On average:** 0 1 2 3 4 5 6 7 8 9 10

How long have you had this pain? ______________________________

Is this a work-related injury? ☐ Y ☐ N Is this from a motor vehicle injury? ☐ Y ☐ N Lawyer? ☐ Y ☐ N

Date of injury (if applicable): ______________ What happened? ______________________________

____

What makes the pain better? (Check all that apply)

☐ Pain pills ☐ Rest ☐ Leaning forward ☐ Other ______________

What makes the pain worse? (Check all that apply):

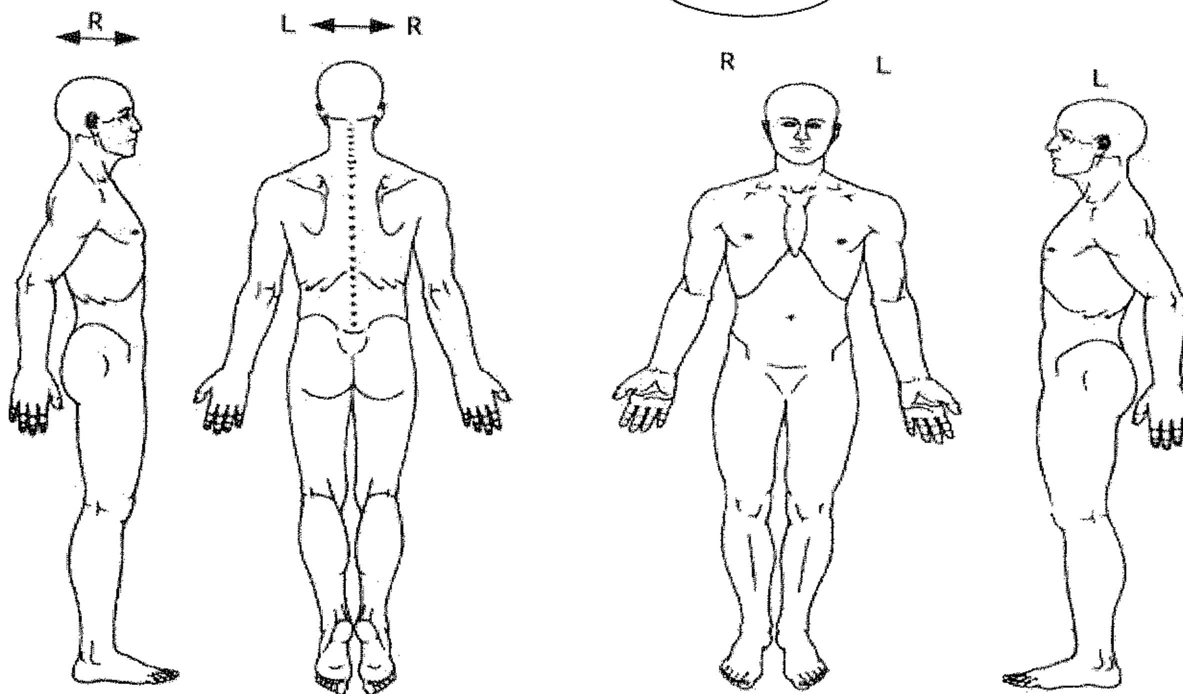
☐ physical activity ☐ prolonged sitting ☐ prolonged standing
☐ coughing ☐ sneezing ☐ other ______________

☐ **Numbness (decreased feeling):**
Where is your numbness? ______________________________

☐ **Weakness (loss of muscle power):**
Where is your weakness? ______________________________

☐ **Urine incontinence** (accidents) ☐ **Bowel incontinence** ☐ **Constipation** ☐ **Sexual Dysfunction**

Please **SHADE** in area(s) where your **PAIN** is located and (CIRCLE) areas of **NUMBNESS**



Please **Circle** the words that best describe your **PAIN**: Sharp Stinging Burning Tingling

Is your pain or numbness **constant**? □ **Y** □ **N** or **Intermittent**? □ **Y** □ **N**

Imaging Studies for this problem? **Location:**

□ X-ray ______________________

□ MRI ______________________

□ CT scan ______________________

□ EMG/NCS (nerve study) ______________________

□ Myelogram ______________________

Other____

Conservative treatments for this problem? (check all that apply):

□ Medications □ Steroid injections □ Physical Therapy □ Chiropractic care □ TENS unit

Other____

Surgical Treatments (if any) for this problem?

____

PAST MEDICAL HISTORY (e.g. diabetes, etc)

CURRENT MEDICATIONS/SUPPLEMENTS	Dose	Frequency

Pharmacy_____________________________ Phone______________________

Do you currently take **aspirin** or products containing **aspirin**? ☐ Yes ☐ No

ALLERGIES (to any medications, latex, food, or contrast dye) ____________________________

____

PAST SURGERIES/HOSPITALIZATION	Year	Doctor	Complications

FAMILY MEDICAL HISTORY

Are there any diseases that run in your family? (such as Diabetes, High Blood Pressure, aneurysms, etc):

____

Family Member	Alive	Deceased	Age	Health Status or Cause of Death
Mother				
Father				

SOCIAL HISTORY

Occupation ____

Are you currently working? ☐ Y ☐ N If not working, when was the last day you worked?______________

Are you on disability? ☐ Y ☐ N If so, for what reason? ____________________________

Tobacco:

- ❑ Yes, I smoke ______ packs of cigarettes per day and have for the past _____ years.
- ❑ No, I have never smoked cigarettes.
- ❑ No, I quit ______ years ago.

Alcohol: How many alcoholic beverages do you consume per **week**? ____________________

Are you at risk for AIDS (e.g. previous blood transfusion, drug abuse, sexual history)

□ Yes □ No If yes, please explain______________________________________

Misc.:** Is there any special information we should know about you that has not already been described? (Examples: do you have a pacemaker or any metal implantations, rare blood disorders, Jehovah's Witness etc.)____

REVIEW OF SYMPTOMS

Have you **recently** had problems with any of the following:

Constitutional

- ❑ Fever
- ❑ Weight Loss
- ❑ Excessive Fatigue
- ❑ Night Sweats
- ❑ Loss of Appetite

Eyes, Ear, Nose, Throat, Mouth

- ❑ Hearing Loss
- ❑ Wear a Hearing Aid
- ❑ Ringing in Ears
- ❑ Eye Infections
- ❑ Eye Injuries
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Ear Pain
- ❑ Ear Infections
- ❑ Sore Throats
- ❑ Mouth Sores
- ❑ Balance Disturbance (vertigo/spinning)
- ❑ Lightheadedness
- ❑ Nosebleeds
- ❑ Nasal Congestion
- ❑ Nasal Drainage
  If yes, color _________ amount __________
- ❑ Inability to smell
- ❑ Sinus Problems
- ❑ Sinus Headaches

Cardiovascular

- ❑ Chest Pain or Angina
  If yes, date of last EKG _______________
- ❑ Palpitations
- ❑ Pacemaker
- ❑ Irregular Pulse
- ❑ Heart Murmur
- ❑ High Cholesterol

Respiratory

- ❑ Asthma
- ❑ Chronic Cough
- ❑ Emphysema
- ❑ Shortness of Breath
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Lung Cancer
- ❑ Bloody Sputum When?_______________
- ❑ Last Chest x-ray? ____________________

Gastro-Intestinal

- ❑ Indigestion or pain with eating
- ❑ Trouble swallowing
- ❑ Nausea
- ❑ Vomiting If yes, when
  ____
- ❑ Blood in your vomit
- ❑ Liver problems
- ❑ Jaundice
- ❑ Abdominal Pain
- ❑ Change in your bowel habits
- ❑ Ulcers or Gastritis

Genitourinary

- ❑ Urinary Tract Infection
- ❑ Painful urination
- ❑ Blood in your urine
- ❑ Difficulty starting/stopping stream
- ❑ Incontinence
- ❑ Kidney Stones
- ❑ Prostate Cancer (males)
- ❑ Endometriosis (females)
- ❑ Uterine or Cervical Cancer (female)

Musculoskeletal

- ❑ Broken Bones, List ________________________
- ❑ Arm or leg weakness
- ❑ Back pain
- ❑ Arm or Leg pain
- ❑ Joint pain or swelling
- ❑ Arthritis

Integumentary

- ❑ Skin Cancer
- ❑ Breast pain, tenderness, swelling
- ❑ Nipple discharge

Date and result of last mammogram______________

Neurological

- ❑ Fainting Spells
- ❑ Seizures
- ❑ Problems with your memory
- ❑ Disorientation
- ❑ Difficulty with your speech
- ❑ Inability to concentrate
- ❑ Double or blurred vision
- ❑ Face weakness
- ❑ Lack of coordination in arms/legs

Psychiatric

- ❑ Depression
- ❑ Anxiety
- ❑ Other psychiatric disorders/treatments ___________

Endocrine

- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Increased appetite
- ❑ Excessive thirst or urination
- ❑ Hormone problems

Hematologic/Lymphatic

- ❑ Anemia
- ❑ Hemophilia
- ❑ Bleeding tendencies
- ❑ Persistent swollen glands/lymph nodes
- ❑ Blood transfusion

Allergic/Immunologic

- ❑ Food allergies

If yes, list ______________________________

- ❑ Inhalant (nasal allergies)
- ❑ Immunologic disorders

All the information provided above is accurate and complete to the best of my knowledge.

****Patient Signature** ____ Date ______________

I have reviewed the above information with the patient.

****Physicians Signature** ____ Date______________

PHYSICAL EXAMINATION (office use only)

- ❑ Completely normal Neuro exam
- ❑ Completely normal Neuro exam except for below:
- ❑ Pacemaker

MSE: ________________________________

CN: ________________________________

Motor: ________________________________

Sensory: ________________________________

Reflexes: ________________________________

Hoffman's sign ________________________________

Gait/stance________________________________

Cerebellum________________________________

Musculoskeletal____

NEUROIMAGING COMPLETED (office use only)

CT scan	Brain	Cervical	Thoracic	Lumbar	
MRI scan	Brain	Cervical	Thoracic	Lumbar	Contrast? Y N
X-RAY	**EMG/NCS**	**Discogram**	**Myelogram**		
Results:					

CLINICAL IMPRESSION/PLAN (Dx, Rx, imaging, DME, PT/Chiro):

____

____

____

____

____

RTO:____________________________________Joseph A. Shehadi, M.D.________________________

The HIPAA privacy rule give individuals the right to request a restriction on uses and disclosures of their personal information (PHI). The individual is also provided the right to request communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's place of employment instead of the individual's home.

Neurosurgery Associates, LLC, Joseph A. Shehadi, M.D.
393 East Town Street, Suite 110
Columbus, OH 43215
Ph: 614-220-5648
Fax: 614-220-5649

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Check *all* that apply.)

Telephone Contact

☐ Home Telephone:____________________ ☐ Cell Phone:____________________

☐ Text Message: ____________________

☐ It is OK to leave a message with detailed information.

☐ It is OK to leave a message with call-back number only.

☐ Work Telephone:________________ ☐ Other Phone #(s):____________________

☐ It is OK to leave a message with detailed information. ____________________

☐ It is OK to leave a message with call-back number only ____________________

Written Communication

☐ It is OK to mail information to my home address on file.

☐ It is OK to mail to my work/office address.______________________________

☐ It is OK to fax information to this number: ______________________________

Patient Signature: ______________________________ Date: ________________

Print Name: ______________________________ Date of Birth:____________

NOTE: if the above area is left blank, it will be assumed that you wish this practice to leave a message with call-back number at your home telephone only.

Joseph A. Shehadi, MD
Neurosurgery Associates, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT AND CONSENT

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES:

The Notice of Privacy Practices tells you how we may use and share your health records. **Please read it.**

- We will use and share your health records to treat you and to bill for the services we provide.
- We will not use your personal health information for services that you pay for privately.
- We will use and share your health records to operate this medical practice.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the **Notice of Privacy Practices.**

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact and communicate with you regarding your care and treatment.

NOTE: All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of Neurosurgery Associates Notice of Privacy Practices

Signature: ______________________ Date: ______________________
(of patient or legal representative)

Capacity of Legal Representative (if applicable)*: ______________________

*May be requested to provide verification of representative status.

CONSENT:

I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.

Please be advised that the **information authorized for disclosure may include information which may be considered a communicable or venereal disease, including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). It also may include mental health or other sensitive information.**

Signature: ______________________ Date: ______________________
(of patient or legal representative)

Capacity of Legal Representative (if applicable)*: ______________________

*May be requested to provide verification of representative status.

Joseph A. Shehadi, M.D., Neurosurgery Associates Financial Policy

Your clear understanding of our **financial policy** is important to our professional relationship. Please understand that payment of your bills is considered part of your overall treatment in our office. In order to keep your cost of healthcare to a minimum, the following financial policies have been adopted for use here at ***Neurosurgery Associates, LLC.***

Acknowledging with your signature below, you understand and accept the following:

Required at Check-In

Each time you check in for your appointment you will be required to:

1) Verify Personal Demographic and Contact Information
2) Present Current Copy of **Insurance Card**
3) Pay any Outstanding Account Balance
4) Pay your **Insurance Co-Pay** for Current Visit

Fees for Administrative Services and Penalties

- **Missed Appointment:** Missed appointments cancelled with less than 24 hour notice or "no show": **$25.00 *per occurrence.***
- **Form Completion Charge: $20.00** for each ***initial form;* $10.00** for ***renewal forms.*** These forms include: FMLA, Short-term Disability and Long-term Disability.
- **Returned Check Fee: $30.00 *per check*** will be assessed on your account.
- **All outstanding balances must be paid in full within 30 days of receiving your bill.** Outstanding balances must be resolved prior to your next visit to ***Neurosurgery Associates, LLC,*** unless other arrangements have been made with the Billing Manager. Outstanding balances are subject to a **$10.00 *late fee*** for each 30-day cycle past due.
- **Collection Charges:** Accounts that are not paid in a reasonable amount of time may be sent to an external collection agency and reported to the credit bureau, and are subject to ***additional charges*** imposed by the agency.

I understand and agree to abide by the above policies and procedures as outlined in ***Joseph A. Shehadi, M.D., Neurosurgery Associates, LLC, Financial Policy.***

Print Name:____**Date:**____
____

Patient Signature:____
____

10/2013 jls