TIMOTHY C. SHEN, M.D.
SPINE, SPORTS, AND OCCUPATIONAL MEDICINE

PATIENT HISTORY FORM

Name: _____ **Age:**_____ **Sex:** ☐ Male ☐ Female **Height:**_____ **Weight :**_____

Physican Who Sent You:_____ **Primary Physician:**_____

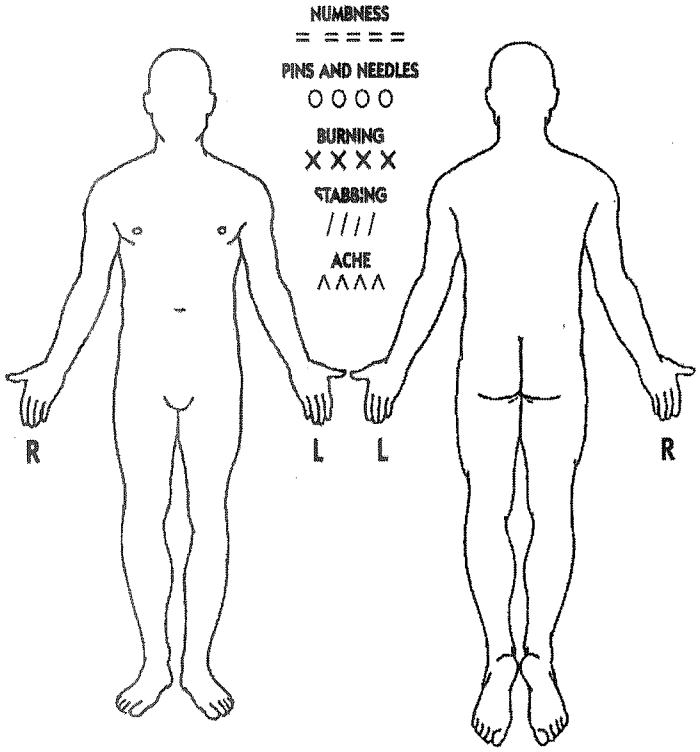
Employer: _____ **Job Title:**_____

When did pain start: _____ **Date of Injury:**_____ **How did symptoms start:**_____

_____

Pain began: ☐ Suddenly ☐ Gradually **Related to:** ☐ Work ☐ Accident ☐ Unsure ☐ Other_____

WHERE IS YOUR PAIN NOW? Mark all that apply:



WHAT MAKES SYMPTOMS:

	Worse	Better
Walking	☐	☐
Standing	☐	☐
Sitting	☐	☐
Lying down	☐	☐
Bending	☐	☐
Bowel Movement	☐	☐
Driving	☐	☐
Coughing/ Sneezing	☐	☐
Rising from Sitting	☐	☐

RATE YOUR PAIN

At it's worse

No Pain **1 2 3 4 5 6 7 8 9 10** Worse Pain Imaginable

On Average

No Pain **1 2 3 4 5 6 7 8 9 10** Worse Pain Imaginable

Pain in arm(s)/leg(s) compared to neck/back: ☐ More than ☐ Same as ☐ Less than

Is there weakness of your arms/legs? ☐ Yes ☐ No

How long can you sit with no/ minimal pain? _____ minutes How long can you stand with no/ minimal pain? _____ minutes

How far can you walk with no/minimal pain? _____

Have you had trouble controlling your bowels or bladder? ☐ Yes ☐ No If yes, is this a new problem? ☐ Yes ☐ No

What treatments have you had for this pain? ☐ medications ☐ physical therapy ☐ chiropractic ☐ steroid injections

☐ home/Pool Exercises ☐ aternative treatments (massage therapy, acupuncture, magnets, etc.) ☐ surgery

What studies have you had for your symptoms: ☐ X-rays ☐ CT scan ☐ MRI ☐ Bone Scan ☐ Myelogram

☐ EMG/Nerve test ☐ Blood work ☐ Discogram ☐ Other_____

MEDICAL HISTORY:

Medication allergies and type of reactions:_____

_____

Are you allergic to contrast dye? ☐ Yes ☐ No ☐ Uncertain

Medications (list): :_____

_____

CURRENT MEDICAL PROBLEMS (check all that apply):

☐ Heart disease or heart attack	☐ Diabetes	☐ Thyroid disease	☐ Liver or kidney or problems
☐ Pacemaker or heart valve	☐ Blood Clots/DVT	☐ Depression	☐ AIDS/HIV
☐ High blood pressure	☐ Ulcers or Reflux	☐ Arthritis/Gout	☐ Neuropathy
☐ Irregular heart beat	☐ Emphysema/ COPD	☐ Bleeding condtion	☐ Cancer (type/Location) _____
☐ Stroke	☐ Seizures	☐ Osteoporosis	_____
☐ Asthma	☐ Other:_____		

SURGICAL History (list type and date):_____

_____

_____

SOCIAL HISTORY: ☐ Married ☐ Separated/divorced ☐ Single ☐ Widowed

Tobacco use: ☐ None ☐ Smoke _____packs per day _____ years smoked

Alcohol use: ☐ None ☐ Occasional/ social ☐ Daily

Occupation:_____ Employer:_____

FAMILY HISTORY:_____

_____

REVIEW OF SYSTEMS:

		YES	NO		YES	NO		YES	NO
General:	Weight loss			Fatigue			Recurrent fevers		
Skin:	Rash			Ulceration			Excess dryness		
Hematologic	Bruising			Easy bleeding			Swollen glands		
Head/ face:	Headaches			Hair loss			Facial pain		
Eyes:	Blurry			Dry eyes			Excess tearing		
ENT:	Ringing ears			Bloody noses			Trouble swallowing		
Heart:	Chest pain			Racing heart			Leg Swelling		
Lung/Chest:	Coughing			Congestion			Short of breath		
GI:	Tarry stools			Bloody stools			Abdominal pain		
Urinary:	Frequency			Bloody urine			Burning		
Reproductive:	Pelvic pain			Testes pain			Painful intercourse		
Musculoskeletal:	Muscle pain			Joint pain			Joint swelling		
Neurologic:	Dizziness			Weakness			Unsteady walking		
Psychiatric	Depression			Anxiety			Mood swings		

☐ All others systems negative

Other symptoms:_____

_____

_____ _____

Signature of patient or responsible party Date

2999 Regent Street Suite 225 , Berkeley CA, 94705 / (510) 704-7760 FAX (510) 704-7765
350 30th Street Suite 530, Oakland California, 94609 / (510) 422-5150 FAX (510) 422 5149
25 Orinda Way Suite 100-A, Orinda CA 94563 / (925) 258-9571 FAX (925) 258-9572

Acknowledgement of Receipt of Notice

I understand Cal Sports is required by law to maintain the privacy of and provide individuals with access to the Notice of Our Legal Duties and Privacy Practices with respect to protected health information

I hereby acknowledge that I can receive a full copy of this medical practice's Notice of Privacy Practices.

Name of Patient: _____DOB:_____

Signed: _____ Date: _____

If not signed by the patient, please indicate your relationship to the patient, print your name and provide a telephone number below

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator/POA of an incompetent patient

Print Name: _____ Telephone: _____

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices

by e-mail at: _____.

For Office Use Only. Signed form received by: _____

- ❑ Acknowledgment refused:

Reasons for refusal:

_____

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FINANCIAL POLICY California Sports and Orthopaedic Institute Tax ID: 56-2491950

Thank you for choosing California Sports and Orthopaedic Institute for your medical care. We are committed to providing you and your family with quality care. In turn, you are committing to financial responsibility for the medical services provided by our office. It is important for our patient/physician relationship that you read and understand our financial policy.

Insurance - We participate with many Insurance plans and require that you present your current insurance card/cards at the time of visit. If you are insured by a plan that we participate with but do not provide insurance information or we are not able to verify your coverage, payment in full is required at the time of your appointment.
Medicare - Medicare will be billed by Cal Sport. Covered services are determined by Medicare. You are responsible for paying your annual deductible and co-insurance amounts if they are not paid by your Secondary Insurance. Please note most Cal Sports providers are NOT contracted with Medi-Cal therefore the patient is responsible for the amount that can not be billed to that Insurance.
If your insurance delays payment -If your insurance carrier does not make payment within 90 calendar days, the balance in full will be due from you.
Copays - will be collected when you check in for your appointment. A $20.00 fee will be applied if payment of the Copay is declined by the patient at check in.
We do not bill third-party insurance.
Self Pay - If a patient does not have insurance they are considered self pay. Payment for the appointment and any other services provided will be collected from the patient at the time of service.
Referrals - If your Insurance Plan requires a referral form from your Primary Care Physician it your responsibility to obtain the form prior to your appointment. If we have not received your referral and you do not have a copy, your appointment may be rescheduled.
Worker's Compensation - If you are seeing one of our physicians due to a work-related injury we must have written authorization from your adjuster before you arrive for your appointment.
Parental Consent - Our office cannot be involved in negotiating payment for divorce orders regarding medical bills. The parent that accompanies a patient under the age of 18 will be responsible for presenting current insurance information and will be required to issue any necessary Copays or balance due amounts.
Payment - We accept cash, MasterCard, Visa, debit cards and personal checks. Returned checks incur a $30.00 fee.
Delinquent accounts - balances present for 3 statement runs are considered delinquent. Those accounts are marked as "Bad Debt" and may be assigned to an outside collection agency. It is imperative that you update your address and contact information with us.

I have read and understand the above noted policies

Patient Name_____

Patient/Guardian Signature_____Date_____