



HORIZON
SPINE & PAIN
OF UTAH

Dr. Devan Partridge, DO

Today's Date: _____

Name: _____

Preferred Name: _____

Date of Birth (MM/DD/YYYY): ____ / ____ / ____

Email Address: _____

Social Security Number: _____

Street Address: _____

City & State: _____

Zip Code: _____

Cell Phone #: _____

Gender: Male Female

Height: _____ Weight: _____

Marital Status: Single Married Domestic Partner Separated Divorced Widowed

Who Referred You?
 Referring Physician: _____

Race: American/Indian/Alaska Native Asian
 Black/African American More than one race
 Native American Pacific Islander
 Unreported White

Self
 Google Referral
 Patient/Family Referral
 Instagram/Facebook
 Employee Referral
 Workers Comp/VA
 Other

Ethnicity:
 Hispanic/Latino
 Non- Hispanic/Latino
 Unreported

Pharmacy Details:

Pharmacy Name and Location/Address:

Allergies:

Please list any known allergies (medications, foods, environmental):

Imaging:

Have You Completed Any of the Following Diagnostic Imaging Studies in the Past 3 Years?

MRI CT Scan X-Ray No Recent Imaging

Area of Body: _____ Facility: _____

Responsible Party Information:

***Minors or Power of Attorney only**

Name: _____ Relationship to patient: _____

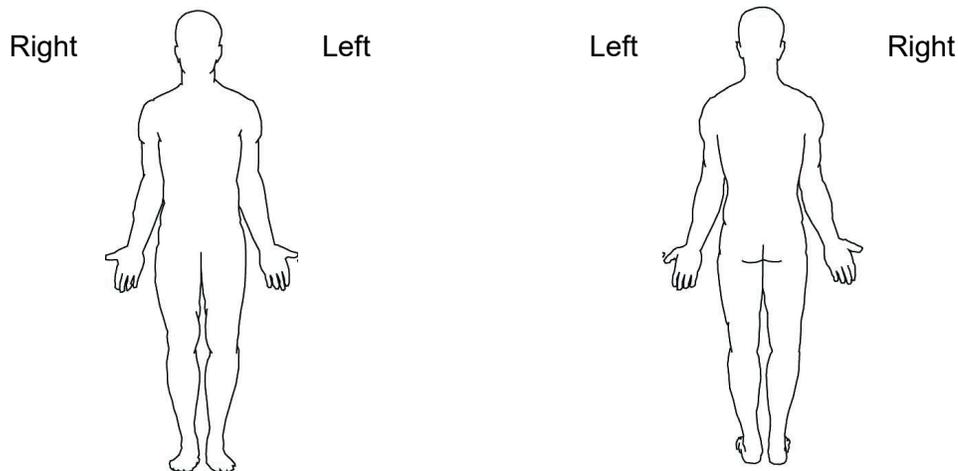
Date of Birth: ____/____/____ Primary Phone: _____ Social Sec. # _____

Pain Description:

Approximately, when did this pain begin (days, months, weeks, years):

Does Your Pain Radiate? If so, where? _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now: _____ At Its Best: _____ At Its Worst: _____

Please List Any Additional Areas of Pain:

How did your current pain episode begin?

Suddenly

Gradually

Since your pain began, how has it changed?

Improved

Worsened

Stayed the same

When is Your Pain the Worst?

Morning

Afternoon

Evening

Night

How Would You Describe Your Pain?

Aching

Burning

Deep

Dull

Numb

Sharp

Stabbing

Shooting

Tight

Tingling

What factors worsen or affect your pain?

What other factors relieve your pain?

Are there any associated symptoms (Ex: numbness/tingling/weakness/incontinence):

Please list the names of other Pain Physicians you have seen in the past, as well as treatment received:

Current Medications

Please list all current medications, including prescriptions, over-the-counter drugs, and supplements.

Medication Name	Dosage (mg, etc.)	Frequency (e.g., once daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which of the following treatments have you tried for your current pain?

	Excellent Relief	Moderate Relief	No Relief
Anti-Inflammatory / NSAIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot/Cold Packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tens Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Surgical History

Surgery

Approximate Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have NEVER had any surgical procedures performed

Medical History – Pain Management

Do you currently have or have you ever been diagnosed with any of the following?

(Please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Heart Attack/Cardiac | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Hepatitis (Type: ____) | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Cancer (Type: ____) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other Chronic Pain |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Cholesterol | (Specify: _____) |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid Arthritis |

Please list any other significant medical conditions or diagnoses relevant to your pain care:

Family Medical History

Mark all appropriate diagnoses as they pertain to your parents and siblings:

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other: _____ |

I have no significant family medical history

Occupation:

Are you a current or previous tobacco user?

Are you a current or previous alcohol user?

Are you a current or previous recreational drug user?

Horizon Spine & Pain of Utah

Patient Authorization & Financial Agreement

Authorization & Consent

I authorize Horizon Spine & Pain of Utah to use and share my health information for treatment, payment, and healthcare operations. I understand my rights under HIPAA and may request a copy of the clinic's **Notice of Privacy Practices** at any time.

I consent to receive healthcare communications by phone, email, and mail. I may request limits on use of my information or revoke this consent in writing.

I authorize my provider to perform evaluation, testing, and treatment as needed.

Financial Agreement

I authorize direct payment of insurance benefits to Horizon Spine & Pain of Utah. I am responsible for any co-pays, deductibles, or balances not covered by insurance. I may receive separate bills for labs or imaging.

Fees may apply for:

- Missed appointments (\$50 fee if not canceled with 24-hour notice for clinic appointments, \$100 fee for procedure appointments)
- Returned checks
- Medical records
- Late payments

I consent to be contacted regarding my account and agree to pay all collection costs if applicable.

Prescription Refills

I understand regular visits are required for long-term medications and will allow **48 hours** for refill requests. I authorize the clinic to access my medication history electronically.

By signing below, I acknowledge and agree to these terms.

Patient Signature: _____

Date: _____