

# PIONEER SPINE AND SPORTS PHYSICIANS – PATIENT REGISTRATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M ( ) F ( )

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cellphone: ( ) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_

Workers Compensation Case ( )

M.V.A./Auto Accident ( )

Date of Injury: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

## BILLING INFORMATION

Primary Insurance: \_\_\_\_\_ I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Please fill out the following by placing a check next the correct answer ( )**

**Are You Participating In Physically Handicapped Childrens Program:** Yes ( ), No ( )

**Student Status:** Full Time ( ), Part Time ( ), Not A Student ( )

**Race:** American Indian/Alaska Native ( ), Asian ( ), Black/African American ( ),  
Native Hawaiian/Other Pacific Islander ( ), White ( ), Other ( ),  
Patient Declined/Unknown ( )

**Ethnicity:** Hispanic/Latino ( ), Not Hispanic/Latino ( ), Patient Declined/Unknown ( )

**Patient's Primary Language:** English ( ), Spanish ( ), Arabic ( ), Polish ( ), Portuguese ( ),

Russian ( ), Vietnamese ( ), Patient Declined/Unknown ( ), None ( ) Other: \_\_\_\_\_

(Continued On Back)

**CONSENT FOR TREATMENT**

I authorize PIONEER SPINE & SPORTS PHYSICIANS and/or their designee to examine, treat and perform any diagnostic testing or certain procedures in the office deemed necessary to properly evaluate my condition.

\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Empowered Representative

**ASSIGNMENT OF BENEFITS**

I authorize release of medical information necessary to process any and all claims for services rendered to me by PIONEER SPINE & SPORTS PHYSICIANS. This assignment will remain in effect until revoked by me in writing. I authorize payment of any and all benefits to be made on my behalf to the office of PIONEER SPINE & SPORTS PHYSICIANS. I understand that I am financially responsible for all charges. I have read this information and I understand its contents.

\_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Empowered Representative

**MISSED APPOINTMENT POLICY**

If you miss an appointment and do not cancel the appointment ahead of time, this may be considered a "no show." Any missed appointment may be subject to a \$20.00 missed appointment fee.

\_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Empowered Representative

Attorney's Name (if applicable)

\_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

# Comprehensive Adult New Patient Health Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Right Handed \_\_\_\_\_ Left Handed \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Why are you here today?  Low Back,  Neck,  Scoliosis,  Sports Injury,  Other, If so, please

provide details: \_\_\_\_\_

Was this an: Auto Accident?  Work Injury?  If yes, is there a claim open? Yes  No

**Medical History:** Check Here If All Are Negative

Cancer  High Blood Pressure  Diabetes  Kidney Stones

Emphysema  Treatment for Alcohol Addiction  Ulcer Disease

Overweight

H.I.V.  Treatment for Drug Addiction  Asthma  Arthritis

Heart Disease  Heart Arrhythmia  Heart Attack

Stroke

Thyroid Disease  Prostate Disease  Multiple Sclerosis  Blood Clots

Other: \_\_\_\_\_

**Accidents/Injuries,** Check Here If None

Fracture,  M.V.A.,  Sprain,  Strain,  Sports Related Injury,  Head Injury

**Surgical History,** Check Here If None

Appendectomy \_\_\_\_\_ year  Heart Surgery \_\_\_\_\_ year  Low Back Surgery \_\_\_\_\_ year

Cancer Surgery \_\_\_\_\_ year  Hernia Repair \_\_\_\_\_ year  Neck Surgery \_\_\_\_\_ year

Fracture Surgery \_\_\_\_\_ year  Hysterectomy \_\_\_\_\_ year  Prostate Surgery \_\_\_\_\_ year

Gallbladder Surgery \_\_\_\_\_ year  Joint Replacement - Please Be Specific:

Other: \_\_\_\_\_

**Hospitalizations:** \_\_\_\_\_

**Adaptive Devices:** Check Here if None ,  Foot Support/Orthotic,  Ankle brace/A.F.O.,

Corset,  Spine Brace,  Crutches,  Walker,  Wheelchair,

Other \_\_\_\_\_

Allergies: Check Here If None

Latex  Iodine  Shellfish  Sulfa  Penicillin  Adhesive Tape  Other Medication  
Allergies:

\_\_\_\_\_, Food Allergies: \_\_\_\_\_  Dust  Pollen  Cats   
Dogs

Family History: Medical Problems:  Diabetes,  Heart Disease  Cancer  Spine Problems  
Father:  Alive  Deceased, Cause: \_\_\_\_\_ Mother:  Alive  Deceased, Cause:  
\_\_\_\_\_

Number of Children \_\_\_\_\_ Number of Brothers/Sisters \_\_\_\_\_

### Comprehensive Adult New Patient Health Information

#### Social History

Single  Married  Committed  Widowed  Divorced,   
Other: \_\_\_\_\_

Lives With  Alone  Spouse  Son  Daughter   
Other: \_\_\_\_\_

Education:  G.E.D.  Currently Attending Grade: \_\_\_\_\_, Highest Grade Completed:  Associates  
 Bachelor's  Masters  Doctorate  Vocational School

Occupation: \_\_\_\_\_  Homemaker  Retired  Disabled  Unemployed

Personal Habits: Tobacco:  Never,  Stopped \_\_\_\_\_ Years Ago,  Smokes \_\_\_\_\_ packs per day.

How often do you have drinks containing alcohol:  None,  Once/Month,  Few Per Month,   
Once A Week,  Few Per Week,  Daily

How many drinks containing alcohol do you have on a typical day:  None,  1 or 2,  3 or 4,  5  
or 6,  
 7 to 9,  10 or more.

What is the greatest number of drinks you have had on a single day in the past month: \_\_\_\_\_

Recreational Drug Use/Street Drugs:  None,  Other: \_\_\_\_\_

Exercise:  None,  Once A Month,  Once A Week,  Few Times A Week,  Daily

#### Review of Systems

Please rate your overall health:  Excellent  Good  Fair  Poor

Do you have any of the following symptoms? Those items marked with none or not marked at all will be considered a negative finding.

None. Constitutional:  fatigue  fever  weight loss

None. Eyes:  blurred vision  double vision  corrective lenses

None. Ears, Nose, Throat:  hearing loss  ringing  sinus infection  hoarseness   
difficulty  
swallowing

None. Heart:  chest discomfort  chest pain  irregular heartbeat

- None. Lungs:  cough  cough up blood  shortness of breath  wheezing
- None. G.I.:  abdominal pain  loss of appetite  constipation  diarrhea  
 bloody bowel movements  blood in stool
- None. Urinary:  difficulty voiding  loss of urine  burning  infection
- None. Musculoskeletal:  arthritis  stiffness  swelling  muscle spasms
- None. Skin/Breast:  birthmarks  lumps  masses  rash  sores  skin ulcers
- None. Neurologic:  dizziness  balance problems  memory lapses  memory loss
- None. Psychological:  anxiety  claustrophobia  depression  hallucinations  sleep disturbance
- None. Endocrine:  crave food  hair loss  crave fluids
- None. Blood/Lymphatics:  anemia  easy bruising  enlarged glands
- None. Immunologic:  frequent colds  frequent infections  itching

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATION LIST**

**Patients Name:** \_\_\_\_\_

**Curent Medications: Check here if none**

<b>Name of Drug</b>	<b>Dosage (mg)</b>	<b># of times per day</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____

**Patients Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name: \_\_\_\_\_

**SPINE AND SPORTS PHYSICIANS**

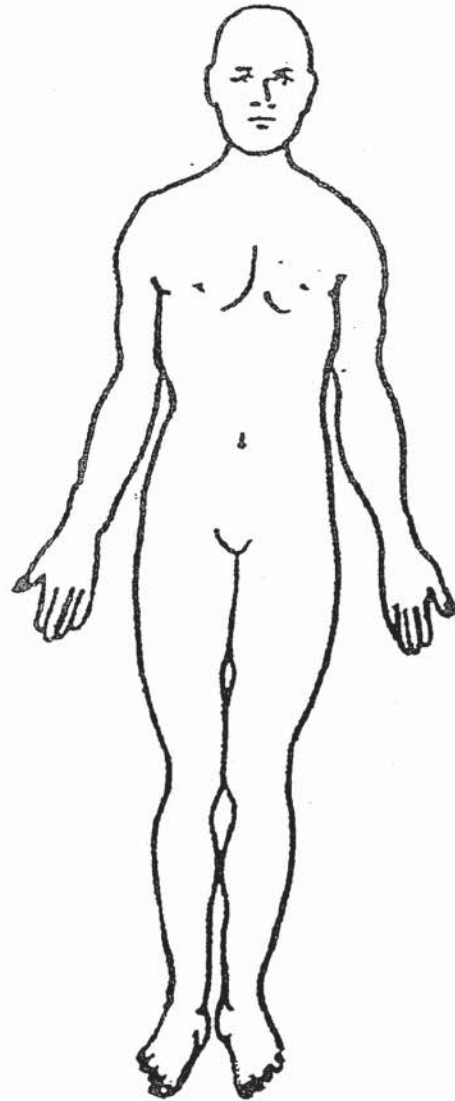
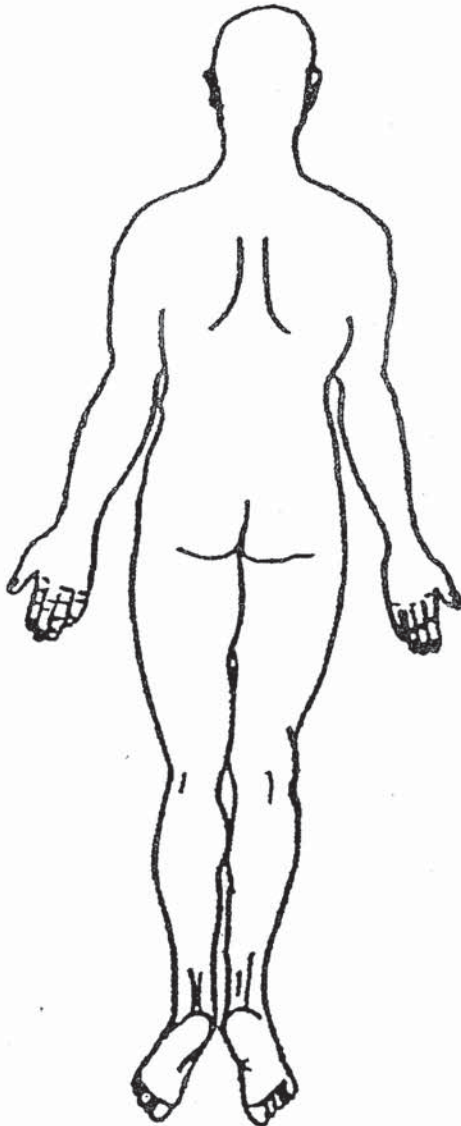
Date: \_\_\_\_\_

**PAIN EVALUATION - Patient Questionnaire**

**In order to obtain a complete picture of the problem you are having, please also answer the questions on the front and back of the attached form. Thank you.**

**Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.**

	=====	oooo	xxxx	/////	zzzz
Numbness	=====	Pins and	Burning	Stabbing	Chronic
	=====	Needles	xxxx	/////	Ache
	=====	oooo	xxxx	/////	zzzz



## Pain Evaluation - Patient Questionnaire

1. When was the very first time you ever had this problem?  
\_\_\_\_\_

2. Did your pain begin  gradually,  suddenly?

3. What were the circumstances of this first onset of pain?

- work injury,  car accident,  a fall,  lifting,  sports injury,  you don't remember anything specific,  
 other

4. Since the first episode has your pain been  continuous,  off and on?

5. How often do you have episodes of severe pain?

- all the time,  daily,  weekly,  monthly,  yearly,  less often than yearly

6. Are your episodes of pain becoming

- more frequent,  more severe,  staying the same,  getting better?

7. How severe is your pain now? 0 1 2 3 4 5 6 7 8 9 10  
None Mild moderate severe

Please Circle

**If today's visit is for neck or lower back pain please answer questions 8-15, otherwise please skip to question 16.**

8. Is the pain worse when you

- Stand for a long time?  no  yes  
 Walk?  no  yes  
 Lie down?  no  yes  
 Sneeze?  no  yes  
 In the morning?  no  yes  
 At night?  no  yes  
 Are active?  no  yes  
 Look at the ceiling?  no  yes  
 Sit?  no  yes

9. Is the pain better when you

- Sit down?  no  yes  
 Lie down?  no  yes  
 Rest?  no  yes

10. Do you have pain in your arms?  no  yes

If yes,  right,  left,  both

Do you have pain in your legs?  no  yes

If yes,  right,  left,  both

11. How far down your arm/s and/or leg/s does the pain go?

To the:  buttock,  thigh,  calf,  foot,  toes,  shoulder,  elbow,  hand,  fingers

12. Is your (choose one - A, B, or C)

- A.  neck or back pain worse than your arm or leg pain?  If yes, a little worse, much worse  
 B.  arm or leg pain worse than your neck or back pain?  If yes, a little worse, much worse  
 C.  neck or back pain about equal to your arm or leg pain

13. Do you have any: Numbness?  no  yes, where  R arm,  L arm,  R leg,  L leg

Weakness?  no  yes, where  R arm,  L arm,  R leg,  L leg

Difficulty controlling your bladder or bowels?  no  yes

If yes, how long? \_\_\_\_\_

For men: Difficulty having an erection?  no  yes

If yes, how long? \_\_\_\_\_

14. If you have neck **and** lower back pain, choose one of the following

- Your neck pain is more than your lower back pain.  Much worse!  
 Your neck pain is about the same as your lower back pain  
 Your lower back pain is worse than your neck pain.  Much worse!

15. Have you had previous spine surgery?  no,  yes, please list

Type \_\_\_\_\_ Level \_\_\_\_\_ date \_\_\_\_\_

improved  worse  same  improved temporarily

Type \_\_\_\_\_ Level \_\_\_\_\_ date \_\_\_\_\_

improved  worse  same  improved temporarily

Continued on the other side— Please turn over

16. Have you received treatment for this problem? \_\_\_\_\_

If yes, please check all that apply

	Improved	Worse	Same	Improved Temporarily
<input type="checkbox"/> Rest/decreased activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arthritis medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Home exercise program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brace/corset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heat/ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Back school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TENS (nerve stimulation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cortisone injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain treatment center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Does your pain limit or prevent you from working?  no  yes

18. Are you currently on disability for this problem? \_\_\_\_\_

19. If working, are you working  full time,  part time,  full duty,  limited duty,  disabled

20. When did you last work? \_\_\_\_\_

21. Does your job require?

- |  |                                  |                                       |
|--|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Prolonged sitting | <input type="checkbox"/> Lifting | <input type="checkbox"/> 0-10 lbs.    |
| <input type="checkbox"/> Walking distances |                                  | <input type="checkbox"/> 10-20 lbs.   |
| <input type="checkbox"/> Climbing          |                                  | <input type="checkbox"/> 20-50 lbs.   |
| <input type="checkbox"/> Bending           |                                  | <input type="checkbox"/> over 50 lbs. |
| <input type="checkbox"/> Standing          | <input type="checkbox"/> Driving |                                       |

22. How long can you sit?  a few minutes,  15-30 minutes,  1/2 - 1 hour,  1-2 hours,  several hours

How far can you walk?  less than one block,  several blocks,  1/2 - 1 mile,  several miles

How long can you stand?  a few minutes,  15-30 minutes,  1/2 - 1 hour,  1-2 hours,  several hours

How much can you lift?  nothing,  1-10 lbs.,  10-20 lbs.,  20-50 lbs.,  over 50 lbs.

23. Is there a legal or compensation case pending?  no  yes

24. Pain causes stress. Are you under additional stress because of:

Family difficulties  no  yes

Marriage difficulties  no  yes

Work difficulties  no  yes

Financial difficulties  no  yes

Other \_\_\_\_\_

25. Do you feel (check all that apply)  happy,  concerned,  nervous,  worried,  anxious,  tense,  angry,  sad,  
 depressed,  at the end of your rope, none of the above, other \_\_\_\_\_

Additional Information:

Signature of Patient \_\_\_\_\_ Reviewed \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Name

\_\_\_\_\_ date

**OSWESTRY PAIN QUESTIONNAIRE:**

*In the last week, Please tell us how pain has affected your ability to perform the following daily activities. Mark the one statement that best describes your average ability.*

**Pain Intensity**

- ① I can tolerate the pain I have without using pain killers.
- ② The pain is bad but I manage without taking pain killers.
- ③ Pain killers give complete relief from pain.
- ④ Pain killers give moderate relief from pain.
- ⑤ Pain killers give very little relief from pain.
- ⑥ Pain killers have no effect on the pain, I do not use them.

**Personal care (washing, dressing):**

- ① I can look after myself normally without pain
- ② I can look after myself normally with some pain
- ③ It is painful to look after myself and I am slow
- ④ I need some help but manage most of my needs
- ⑤ I need help every day in most aspects of care
- ⑥ I do not get dressed and stay in bed

**Lifting (in the last week):**

- ① I can lift heavy objects without pain
- ② I can lift heavy objects but with pain
- ③ Pain prevents me from lifting heavy objects off the floor but I can manage if they are on a table
- ④ Pain prevents me from lifting heavy objects but can manage light to medium objects on a table
- ⑤ I can lift only light objects
- ⑥ I cannot lift anything

**Walking (in the last week):**

- ① Pain does not prevent me from walking
- ② Pain prevents me walking more than 1 hour
- ③ Pain prevents me walking more than 30 min.
- ④ Pain prevents me walking more than 10 min.
- ⑤ I can only walk a few steps at a time
- ⑥ I am unable to walk

**Sitting (in the last week):**

- ① I can sit in any chair as long as I like
- ② I can sit only in a special chair as long as I like
- ③ Pain prevents me sitting more than 1 hour
- ④ Pain prevents me sitting more than 30 min.
- ⑤ Pain prevents me sitting more than 10 min
- ⑥ Pain prevents me from sitting at all

**Standing (in the last week):**

- ① I can stand as long as I want
- ② I can stand as long as want but with pain
- ③ Pain prevents me standing more than 1 hour
- ④ Pain prevents me standing more than 30 min.
- ⑤ Pain prevents me standing for more than 10 min
- ⑥ Pain prevents me from standing at all

**Sleeping (in the last week):**

- ① I sleep well
- ② Pain occasionally interrupts my sleep
- ③ Pain interrupts my sleep half of the time
- ④ Pain often interrupts my sleep
- ⑤ Pain always interrupts my sleep
- ⑥ I never sleep well

**Sex Life (in the last week):**

- ① My sex life is unchanged
- ② My sex life is normal but it increases pain
- ③ My sex life is nearly normal but is very painful
- ④ My sex life is severely restricted by pain
- ⑤ My sex life is nearly absent because of pain
- ⑥ Pain prevents any sex life at all

**Social and Recreational Life (in the last week):**

- ① My social and recreational life is unchanged
- ② My social and recreational life is unchanged but it increases pain
- ③ My social and recreational life is unchanged but it severely increases pain
- ④ Pain has restricted my social and rec. life.
- ⑤ Pain has severely restricted my social life.
- ⑥ I have no social and recreational life

**Traveling (in the last week):**

- ① I can travel anywhere without pain
- ② I can travel anywhere but it gives me pain
- ③ Pain is bad but I can travel over 2 hours
- ④ Pain restricts me to trips of less than one hour
- ⑤ Pain restricts me to trips of less than 30 min
- ⑥ Pain prevents me from traveling

\_\_\_\_\_ Patient signature



**PIONEER SPINE AND SPORTS PHYSICIANS, P.C.**

**HIPAA CONSENT FOR PURPOSES OF TREATMENT, PAYMENT &  
HEALTHCARE OPERATIONS**

I consent to the use or disclosure of my protected health information by Pioneer Spine and Sports Physicians (PSSP) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Pioneer Spine and Sports Physicians (PSSP). I understand that diagnosis or treatment of me by Pioneer Spine and Sports Physicians (PSSP) may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations is not required to agree to the restrictions that I may request. However, if Pioneer Spine and Sports Physicians (PSSP) agrees to a restriction that I request, the restriction is binding on Pioneer Spine and Sports Physicians (PSSP) and its physicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that Pioneer Spine and Sports Physicians (PSSP) has taken action in reliance on this consent.

My “protected health information” means health information including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Pioneer Spine and Sports Physicians’ Notice of Privacy Practices prior to signing this document. The Pioneer Spine and Sports Physicians’ Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Pioneer Spine and Sports Physicians. The Notice of Privacy Practices (PSSP) is also provided in waiting rooms. This Notice of Privacy also describes my rights and the Pioneer Spine and Sports Physicians’ duties with respect to my protected health information.

Pioneer Spine and Sports Physicians (PSSP) reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Pioneer Spine and Sports Physicians’ office.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative’s Authority