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: _____ **(Over 65 years of age) Pneumonia Vaccination ☐ Yes ☐ No, Date:** _____,
Women (Age 42 – 69 years of age) Mammogram ☐ Yes ☐ No, Date: _____

Accidents/Injuries: Check Here If None ☐
☐ Fracture, ☐ M.V.A., ☐ Sprain, ☐ Strain, ☐ Sports Related Injury, ☐ Head Injury

Have you fallen in the past year ☐ Yes ☐ No. If you answered Yes, how many times? _____

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 ☐, I.V.P. Dye ☐ , 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 _____

(PLEASE COMPLETE SIDE TWO)

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: ☐ High School, ☐ Associates, ☐ Bachelor's, ☐ Masters, ☐ Doctorate, ☐ Vocational School
Occupation: _____ ☐ Homemaker ☐ Retired ☐ Disabled ☐ Unemployed

Personal Habits: Do you smoke? ☐ Yes. ☐ No. If yes, how many packs per day_____
☐ Never smoked ☐ Quit _____ years ago.

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 <u>all</u> 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

Patient's Name: _____

Current Medications: **Check here if None** ☐

Name of Drug	Dosage (mg)	# Times a Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

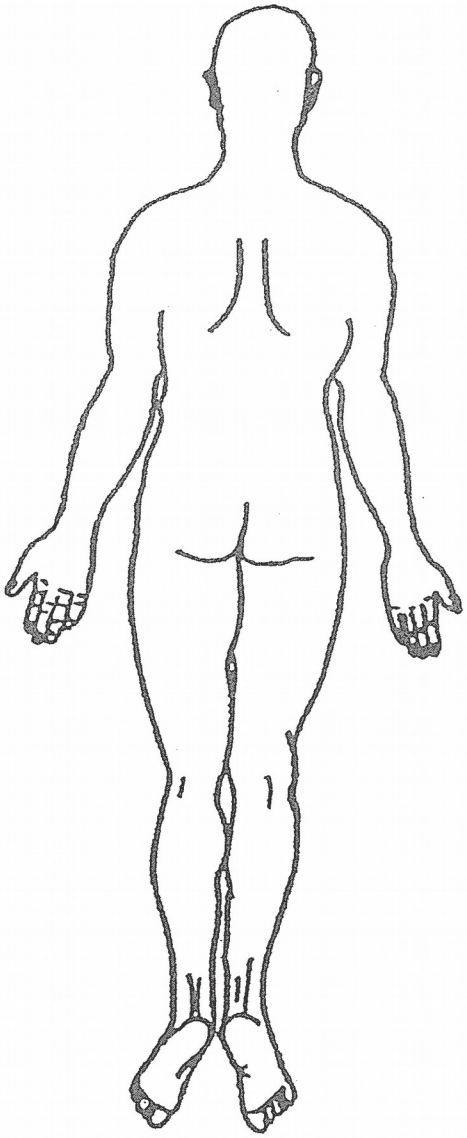
Over the Counter Medications:

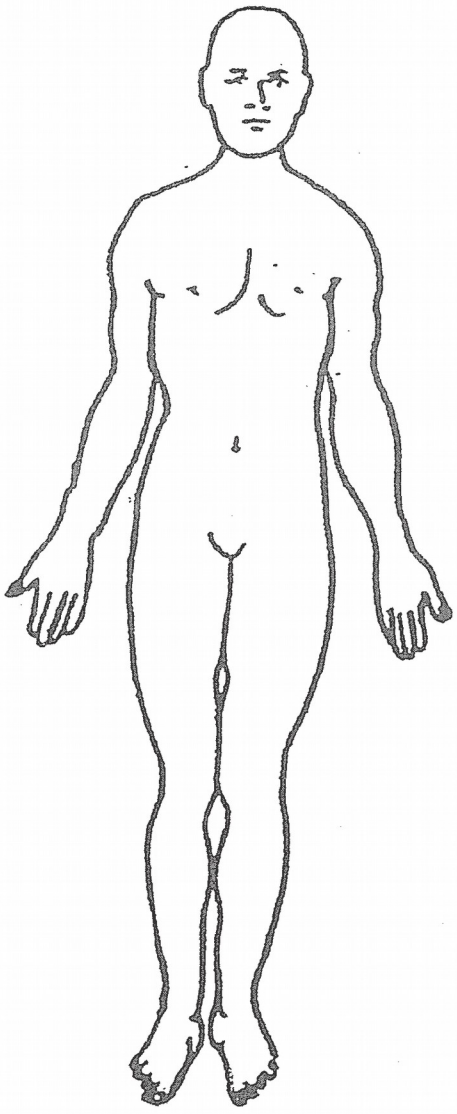
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Signature: _____ **Date:** _____

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

	====		o o o o		x x x x		/////		z z z z
Numbness	====	Pins and	o o o o	Burning	x x x x	Stabbing	/////	Chronic	z z z z
	====	Needles	o o o o		x x x x		/////	Ache	z z z z





OVER

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? Please Circle
   0 None 1 2 Mild 3 4 5 6 7 moderate 8 9 10 severe

If todays 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 he ceiling?	❑ no	❑ yes
t	❑ 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
    ❑ improved ❑ worse ❑ same ❑ improved temporarily

over ▸

Continued on the other side– Please turn

16. Have you received treatment for this problem? _____
If yes, please check all that apply

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

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?

❑ Prolonged sitting	❑ Lifting	❑ 0-10 lbs.
❑ Walking distances		❑ 10-20 lbs.
❑ Climbing		❑ 20-50 lbs.
❑ Bending		❑ over 50 lbs.
❑ Standing	❑ 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

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

Standing (in the last week)

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

Personal Care (Washing, Dressing)

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

Sleeping (in the last week)

0. ○ I sleep well.
1. ○ Pain occasionally interrupts my sleep.
2. ○ Pain interrupts my sleep half of the time.
3. ○ Pain often interrupts my sleep.
4. ○ Pain always interrupts my sleep.
5. ○ I never sleep well.

Lifting (in the last week)

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

Sex Life (in the last week)

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

(Please complete the next page)

Oswestry Pain Questionnaire

Walking (in the last week)

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

Sitting (in the last week)

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

Social and Recreational Life (in the last week)

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

Traveling (in the last week)

0. ○ I can travel anywhere without pain.
1. ○ I can travel anywhere but it gives me pain.
2. ○ Pain is bad but I can travel over 2 hours.
3. ○ Pain restricts me to trips of less than 1 hour.
4. ○ Pain restricts me to trips of less than 30 minutes.
5. ○ 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 heath 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