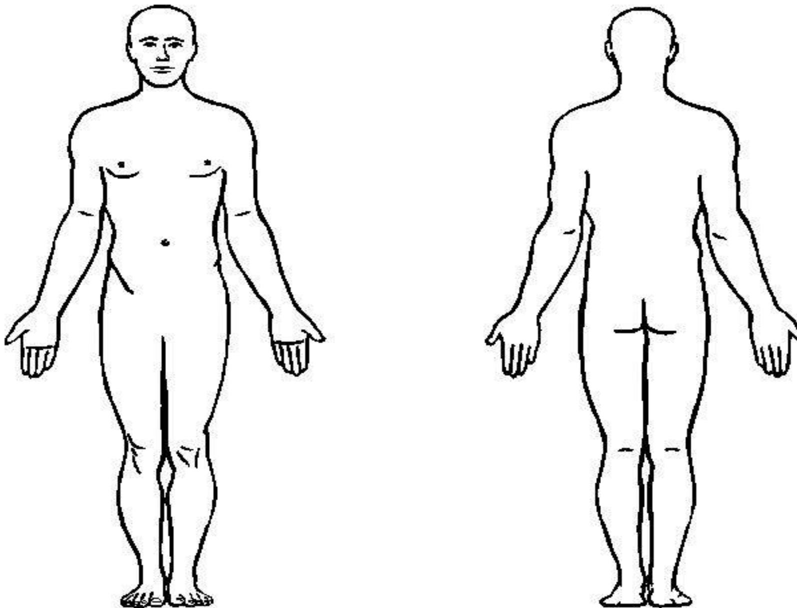
NEW PATIENT SPINE FORM FOR DR. STAGGS

Please print all information. All blanks must be filled to allow us to serve you quickly and efficiently. If you already completed this form in the last 2 months, please fill out just the first 2 pages and only items on other pages that have changed since your initial visit. Thank you for your cooperation.

Date: ___________ Last Name: ____________________________ First: ______________________ MI: _____
Address: ____________________________Apt#:______City:________________State:______Zip code:______
❑ Male ❑ Female Date of Birth: ________________ Age: _______ Height: ________ Weight: _________
SSN:___________________________
Phone: Home: ( ) __________________ Work: ( ) __________________ Cell: ( ) __________________
Email: ______________________________
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Partner
Race: ❑African American ❑ Asian ❑ Hispanic/Latino ❑ American Indian ❑ Caucasian
❑ Other___________ ❑ Refused Ethnicity: ❑Hispanic ❑Non-Hispanic
Current Work Status: ❑ Full time ❑ Part time ❑ Retired ❑ Disabled (Since________)
❑ Student ❑ Homemaker ❑ Unemployed Company Name: ______________________________
Occupation: _____________________ Title:________________ How long have you worked there?_________
Referring Physician: _________________ Phone: ( )___________ Primary Care Physician: _______________

Please indicate where your pain is on the illustrations below.



Please indicate your current pain level by placing a line below with "0" = no pain and "10" = worst pain imaginable. **Example:** Pain [I]
0 10

Pain at its Worst [ ]
0 10

Pain at its Best [ ]
(lying down, resting) 0 10

Current Pain [ ]
0 10

History of Present Complaint

1. How long have you had this problem? ___________________________ Since? _______/________/_________
Month Day Year

2. Briefly, please give the details of your main problem: ____

____

____

3. Was this injury from ❑ Auto ❑ Work ❑ Other **If work related, please fill out questions below, if not, skip to #4.**

❑ Full time ❑ Part time Have you missed any work because of this problem? ❑ Yes ❑ No How much?_________

Date of Injury: _____________ Claim Number: ______________________ Allowed Conditions______________________

Name of Managed Care Organization (MCO): _________________________________Phone:_______________________

Address: ____ Contact___________________________

Employer at time of injury _______________________________________Contact: _____________Phone: ___________

Is there a C-9/prior authorization to see one of our doctors? ❑ Yes ❑ No Do you have an attorney? ❑ Yes ❑ No

If yes please provide Attorney's Name and Phone:____

4. Have you had spinal surgery in the past: (Check one) ❑ Yes ❑ No If so, what surgery was performed and when (date):____

Did you improve from your spine surgery procedure? ❑ Yes ❑ No

5. Which of the following best describes your ratio for neck & arm or back & leg discomfort (if appropriate)

A. 100% back pain and 0% leg pain
B. 90% back pain and 10% leg pain
C. 75% back pain and 25% leg pain
D. 50% back pain and 50% leg pain
E. 25% back pain and 75% leg pain
F. 10% back pain and 90% leg pain
G. 0% back pain and 100% leg pain

A. 100% neck pain and 0% arm pain
B. 90% neck pain and 10% arm pain
C. 75% neck pain and 25% arm pain
D. 50% neck pain and 50% arm pain
E. 25% neck pain and 75% arm pain
F. 10% neck pain and 90% arm pain
G. 0% neck pain and 100% arm pain

6. For any pain/ numbness in your arm(s) or leg(s), which side is worse? (Choose one if appropriate)

Leg Symptoms

A. 100% left leg pain and 0% right leg pain
B. 75% left leg pain and 25% right leg pain
C. 50% left leg pain and 50% right leg pain
D. 25% left leg pain and 75% right leg pain
E. 0% left leg pain and 100% right leg pain

Arm Symptoms

A. 100% left arm pain and 0% right arm pain
B. 75% left arm pain and 25% right arm pain
C. 50% left arm pain and 50% right arm pain
D. 25% left arm pain and 75% right arm pain
E. 0% left arm pain and 100% right arm pain

Current Pain Profile

7. Please choose letter A – F (in first column) to answer the questions in column two.

A. Unable to tolerate	How long can you sit? ____
B. About 15 minutes only	
C. About 30 minutes only	How long can you stand?______________________________________
D. About 45 minutes	
E. About 1 hour	How long can you walk? _______________________________________
F. Indefinitely	

8. Which of the following activities change the nature of your pain?

	Aggravates Pain	**Relieves Pain**	**Neither**
Sitting	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Leaning forward (brushing teeth)	❑	❑	❑
Bending forward	❑	❑	❑
Lying on your side	❑	❑	❑
Lying on your back	❑	❑	❑
Lying on your stomach	❑	❑	❑
Rising from sitting	❑	❑	❑
Changing positions	❑	❑	❑
Coughing / Sneezing	❑	❑	❑
Driving	❑	❑	❑

Now go back and Circle the box to indicate **<u>the most aggravating activity</u>** and the **<u>most relieving activity</u>.**

9. If the symptoms of your present pain have changed, please indicate the most appropriate statement: (Circle One)

A. My symptoms have remained the same since the time of onset.

B. My symptoms are more severe since the time of onset.

C. My symptoms are less severe since the time of onset.

10. How have the symptoms of your present pain changed: (Circle One)

A. No change in symptoms

B. Increased aggravation in one arm or leg

C. Increased aggravation in both arms or legs

D. Increased aggravation in the back or neck

E. Increased aggravation in both arms/legs and back/neck

Past Back History

11. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury? (Check one of each)

	Which Type	Helpful	No Help	Not Used
Anti-inflammatory	________________	❑	❑	❑
Muscle Relaxants	________________	❑	❑	❑
Narcotic Pain Medications	________________	❑	❑	❑
Hot Packs	________________	❑	❑	❑
Ice	________________	❑	❑	❑
Ultrasound	________________	❑	❑	❑
TENS Unit/Muscle Stim (Circle)	________________	❑	❑	❑
Physical Therapy Treatment	________________	❑	❑	❑
Back/Neck Exercises	________________	❑	❑	❑
Chiropractor	________________	❑	❑	❑
Epidural Block/injection	________________	❑	❑	❑
Facet Block/Injection	________________	❑	❑	❑
SI Joint Block/Injection	________________	❑	❑	❑
Trigger Point Injection	________________	❑	❑	❑
Acupuncture	________________	❑	❑	❑
Traction/VAX-D(Circle)	________________	❑	❑	❑
Other:_______________	________________	❑	❑	❑

12. Please indicate whether you have had any of the following studies and write when/where the most recent was:

	Yes	No	When/Where				When/Where
Regular X-Ray of spine	❑	❑	________________________	Myelogram	❑	❑	______________________________
CT Scan of spine	❑	❑	________________________	Discogram	❑	❑	______________________________
EMG	❑	❑	________________________	MRI of spine	❑	❑	______________________________
Bone Scan	❑	❑	________________________	Bone Density	❑	❑	______________________________

13. Have you had any past episode of similar pain or injury? ❑ Yes ❑ No (please describe)

____

____

14. List all other physicians with whom you have consulted in the past year for this problem.

____

____

____

Medical / Surgical History

Please choose all current and past medical conditions

❑ No Medical problem
❑ High Blood Pressure
❑ Heart attack/❑Heart Disease
❑ Heart failure
❑ Abnormal heart rhythm
❑ Lung Disease
❑ Tuberculosis
❑ Asthma
❑Bronchitis
❑ Emphysema
❑ Liver disease
❑ Hepatitis

❑ Diabetes ❑ type I / ❑ type II
❑ Thyroid disease
❑Stomach Ulcers/❑GastricReflux
❑ Irritable Bowel
❑ Stroke
❑Seizures
❑ Cancer – where?__________
❑Kidney Failure
❑ Kidney stones
❑ Osteoporosis / q Osteopenia
❑ Osteo-Arthritis
❑ Rheumatoid Arthritis

❑ Bleeding disorders
❑ Anemia
❑ Blood clots in legs/lungs
❑ Endometriosis
❑Ovarian cysts
❑ Anxiety
❑ Depression
❑ Schizophrenia
❑ Anorexia/bulimia
❑ Alcoholism
❑ Seen a psychiatrist
❑ HIV

Are you under a doctor's care for any other medical condition? ❑ Yes ❑ No If yes, please explain

____

Please choose all surgeries you have had

❑ Spine-Neck
❑ Spine-lower back
❑ Brain
❑Heart/❑Pacemaker/❑IV Filter
❑Angioplasty/❑Stent/❑Bypass
❑ Lung
❑ Gallbladder/❑ Stomach

❑ Appendix/❑ Intestine
❑Hernia/❑Colon/❑Rectum
❑Hysterectomy/❑C-section/❑Female
❑Kidneys/❑Bladder/❑Urinary
❑ Prostate
❑Shoulders/❑Arms/❑Hands
❑Hips/❑Knees/❑Legs/❑Feet

❑ Eyes
❑ Ears
❑ Nose
❑ Throat/❑ Tonsils
❑Other:____________
____
____

Allergies	
Substance	**Reaction**

All Current Medications	
Name	**Dose**

Social History

15. Work status: ❑Full time ❑Part time ❑Retired ❑Disabled (due to ____________) Occupation ______________

16. I live: ❑Alone ❑With: ____

17. I live in a: ❑ House ❑ Apartment ❑ Assisted living ❑ Nursing home

18. Are you a cigarette smoker? ❑ Yes, now ❑ Never ❑ Quit – How long ago did you quit?_______________

If you answered "yes" or "quit", how much do or did you smoke per day? Check One.

❑ Less than ½ pack ❑ ½ pack ❑ ¾ pack ❑ 1 pack ❑ More (How many? ____

How old were you when you started smoking? ___

19. Do you drink any alcoholic beverages? (Check one) ❑ None ❑ Occasional ❑ 1 - 3 drinks per month

❑ 1- 2 drinks per week ❑ 1-2 drinks per day ❑ 3-5 drinks per day ❑ More than 5 drinks per day How many?____

20. Alcoholic in past? ❑ Yes ❑ No

21. Have you ever had a problem with drug dependence? ❑ Yes ❑ No

22. Are there any law suits pending or contemplated related to you problem? ❑ Yes ❑ No

If yes, please give your attorney's name and phone number:____

23. Please write any additional information that you feel is important for us to know...

____

____

____

____

Family History

What illnesses run in your close family (other than yourself)?

❑ Scoliosis
❑ Spine disease
❑ Arthritis
❑ Heart Disease
❑ High blood pressure

❑ Diabetes
❑ Cancer
❑ Bleeding disorder
❑ Mental illness
❑ Alcoholism

❑ Kidney disease
❑ Other_______________
____
____
____

Review of Systems

Please check off any <u>current or recent</u> problem you have

GENERAL

- ❑ Unexplained weight loss
- ❑ Appetite change
- ❑ Fevers or chills
- ❑ Night sweats
- ❑ Marked fatigue
- ❑ Difficulty sleeping

EAR, NOSE, THROAT

- ❑ Difficulty swallowing
- ❑ Hoarseness
- ❑Loss of hearing
- ❑ Ear pain
- ❑ Nosebleeds
- ❑ Gum trouble

EYES

- ❑ Glasses
- ❑Change of vision

CARDIOVASCULAR

- ❑Heart or chest pain
- ❑ Abnormal heartbeat
- ❑ Poor heart function

LUNG

- ❑ Morning cough
- ❑ Shortness of breath
- ❑ Productive cough or sputum

DIGESTIVE

- ❑ Nausea or vomiting
- ❑ Stomach pain or ulcers
- ❑ Heartburn/acid stomach
- ❑ Frequent diarrhea
- ❑ Frequent constipation
- ❑ Uncontrolled loss of stool
- ❑ Blood in stool
- ❑ Hemorrhoids

SKIN

- ❑ Frequent rashes
- ❑Frequent itchiness
- ❑Easy bruising
- ❑ Swollen ankles

NEUROLOGICAL

- ❑ Seizures
- ❑ Blackouts/fainting
- ❑ Tremor
- ❑ Headaches/migraines

MUSCULOSKELETAL

- ❑ Joint Pains/Swelling
- ❑ Back Pain
- ❑ Neck Pain
- ❑ Muscle Aches

GENITOURINARY

- ❑ Burning on urination
- ❑ Difficulty starting urination
- ❑ Incontinence
- ❑ Pelvic pain
- ❑ Urinate at night more than once
- ❑ Unable to completely empty bladder

PSYCHIATRIC

- ❑ Depression
- ❑ Nervous exhaustion
- ❑ Anxiety
- ❑ Paranoia
- ❑ Obsessive/compulsive behavior

Insurance Information

Primary Insurance:_____________________ ID#: ________________________ Grp#:___________________

Card Holder Name:_______________________ Date of Birth:________ Relationship to Cardholder:________

Secondary Insurance:______________________ ID#: ______________________Grp#:___________________

Card Holder Name:_______________________ Date of Birth:________ Relationship to Cardholder:________

HIPPA and Insurance Assignment

HIPPA Disclosure

Your signature below acknowledges that our **Notice of Privacy Practice** is available to you upon request. The document is provided to you as proof of our ongoing efforts to protect your medical information and to keep that information confidential. As outline in the act, we may disclose you protected health information to persons directly involved with your health care.

____________________________________ ___________________________ ___________

Signature of patient or representative *Relationship to patient* *Date*

May we leave a message on your recorder? ❑ Yes ❑ **No** **Cell Phone?** ❑ Yes ❑ No **Email?** ❑ Yes ❑ No

Please provide us with the names of your family/friends to which we are allowed to release your private medical information: ____________________________________ _________________________________

Name Relationship to patient

For Personal Injury Claims that have an attorney please supply the name and phone below:

____

Insurance Assignment and Release

The undersigned authorizes direct payment to Stephen D. Heis, M.D. & Associates, Inc. of my insurance benefits otherwise payable to or on behalf of the patient for all medical services. It is understood by the undersigned that ***he/she is financially responsible for the charges not covered*** by this assignment.

____ ______________________________ ___________

Signature of patient or representative *Relationship to patient* *Date*