

New Patient Information

Name: _____

Day Time Phone Number: _____

Email Address: _____

Primary Care Physician: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Cardiologist: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Pain Management Specialist: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Pharmacy: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

		time								
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Arm or Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Arm or Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Hip, Buttock or Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Hip, Buttock or Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What causes your symptoms to come on? *May choose more than one*

Which Treatments have you tried? *May choose more than one*

- Over-the-counter Medications (eg. Tylenol, Advil, Motrin, Aleve, etc.)
- Narcotic Medications (eg. Vicodin, Codine, etc.)
- Physical Therapy
- Chiropractic Therapy
- Chiropractic Care
- Massage
- Acupuncture
- Epidural Injections
- Facet Injections
- Other Injections
- Muscle Relaxants

Please let us know the following information of the MEDICATIONS that you are currently on: (fill in as much as you can)

(Example: Name of the Medication – Baclofen, Dose – 40mg, Frequency – 3/day)

Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency

What other medical problems do you have or have you had with your Heart or Blood?

May choose more than one

- Heart Attack
- Stroke

- Blood Clots
- DVT – Deep Vein Thrombosis
- PE – Pulmonary Embolus
- Coronary Artery Disease
- CHF – Congestive Heart Failure
- Angina
- Arrhythmia
- High Cholesterol
- Other Heart Problems

What other medical problems do you have or have you had with your Lungs?
May choose more than one

- PE – Pulmonary Embolus
- Asthma
- COPD – Chronic Obstructive Lung Disease
- Pneumonias
- Other Lung Problems

What other medical problems do you have or have you had with your Stomach or Intestines?
May choose more than one

- IBD – Irritable Bowel Disease
- GERD – Gastroesophageal Reflux Disease
- Reflux
- Ulcers
- Other

What other medical problems do you have or have you had with your Nervous System or Mental Health?
May choose more than one

- Stroke
- Anxiety

- Depression
- Parkinson's Disease
- Other

What other medical problems do you or have you had?

May choose more than one

- Sugar Diabetes
- Blood Clots
- DVT – Deep Vein Thrombosis
- PE – Pulmonary Embolis
- Rheumatoid Arthritis
- Osteoarthritis
- Arthritis
- Low Thyroid
- High Thyroid
- Kidney Disease
- Fibromyalgia
- Gout
- Renal Failure
- Cirrhosis
- Hepatitis
- Osteomyelitis
- Other

Please write any additional medical problems not mentioned previously:

What surgeries have you had on your Heart or Blood Vessels?

May choose more than one

- Heart Surgery
- CAB – Coronary Artery Bypass
- Heart Valve replacement or Repair
- Pacemaker
- Defibrillator
- Vascular Surgery
- Vein Removal
- Bypass Grafting
- Aneurysm Repair
- AAA – Abdominal Aortic Aneurysm

What surgeries have you had on your Lungs, Chest, or Breasts?

May choose more than one

- Chest Surgery
- Removal of Lung
- Chest Tube
- Breast Surgery
- Breast Biopsy
- Mastectomy
- Cosmetic Surgery

What surgeries have you had on your Stomach, Abdomen, or Pelvis?

May choose more than one

- Cosmetic Surgery
- Abdominal Surgery
- Appendix Removal – Appendectomy

- Gall Bladder Removal – Cholesystectomy
- Hysterectomy
- Laparoscopy
- C-Section
- Bladder Repair
- Prostate Removal – Prostatectomy
- Vasectomy
- “Tubes Tied”
- Colon Surgery
- Liver Surgery
- Hernia
- Small Bowel Obstruction
- Spleen Removal – Splenectomy

What surgeries have you had on your Head, Face, Neck, or Brain?

May choose more than one

- Neurosurgery
- Brain Tumor Surgery
- Spine Tumor Surgery
- Brain Aneurism Surgery
- VP Shunt
- Cosmetic Surgery
- Tonsils Removed – Tonsillectomy
- Sinus or Nose Surgery
- Tracheostomy
- Vocal Cord Surgery

Please let us know something about your previous spine surgery/surgeries:

Fill in as much as you can

	What type of surgery was performed? (ALIF, PLIF, Lumbar Fusion, Scoliosis Surgery, Tumor	Which Levels were Operated upon? (L45, L5S1, C6, C34,	What was the date of the surgery?	Who was the Operating Physician?	Was a Fusion performed?	Were there any complications?

	Surgery, Laminectomy, Discectomy, ACDF, etc.)	etc)				
#1						
#2						
#3						
#4						

Others?:

Have you ever had a problem with anesthesia? _____ If yes, please explain. _____

Have you ever had a blood transfusion? _____ If yes, please explain. _____

Please list any surgeries not mentioned previously:

Do you experience any of these symptoms? *(Please check ALL that apply)*

Heart Symptoms

- Palpitations
- Chest Pain

Head or Neurologic

- Headaches
- Dizziness

Abdomen and Stomach

- Heartburn
- Indigestion

Excessive Sweating

Breathing Problems

- Difficulty Breathing while lying flat
- Shortness of Breath
- Chronic Cough
- Bronchitis
- Night Sweats
- Pneumonias

Blood Problems

- Anemia
- Easy Bleeding
- Frequent Infections

Psychiatric

- Depression
- Anxiety
- Being seen by a Psychiatrist

Blackouts

Paralysis

Seizures

Kidney, Bladder & Sexual

- Burning on Urination
- Frequent Urination
- Nighttime Urination
- Difficulty Starting Urination
- Blood in Your Urine
- Sexual Difficulties

Overall Health

- Heart Attacks
- Heart Failure
- High Blood Pressure
- Swelling in the Legs – Edema
- Legs cramp when walking
- Recent Weight Gain
- Recent Weight Loss

Difficulty Swallowing

Ulcers

Abdominal Pain

Nausea/Vomiting

Diarrhea

Hemorrhoids

Rectal Bleeding

Change in Bowel Habits

Jaundice

Bone and Joints

- Joint Pain
- Joint Swelling
- Joint Stiffness
- Muscle Pain
- Weakness

<p>Do you Drink? If so, How Much?</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> 1-4 Drinks per week<input type="radio"/> About a drink per day<input type="radio"/> Several drinks per day	<p>Do you Smoke? If so, How Much?</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Less than 1 pack per week<input type="radio"/> 1-3 packs per week<input type="radio"/> About a pack per day
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	<input type="radio"/> More than a pack per day <input type="radio"/> Not currently, but I did smoke a pack or more in the past
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Do you do any drugs not listed in the medications? If so, How much?

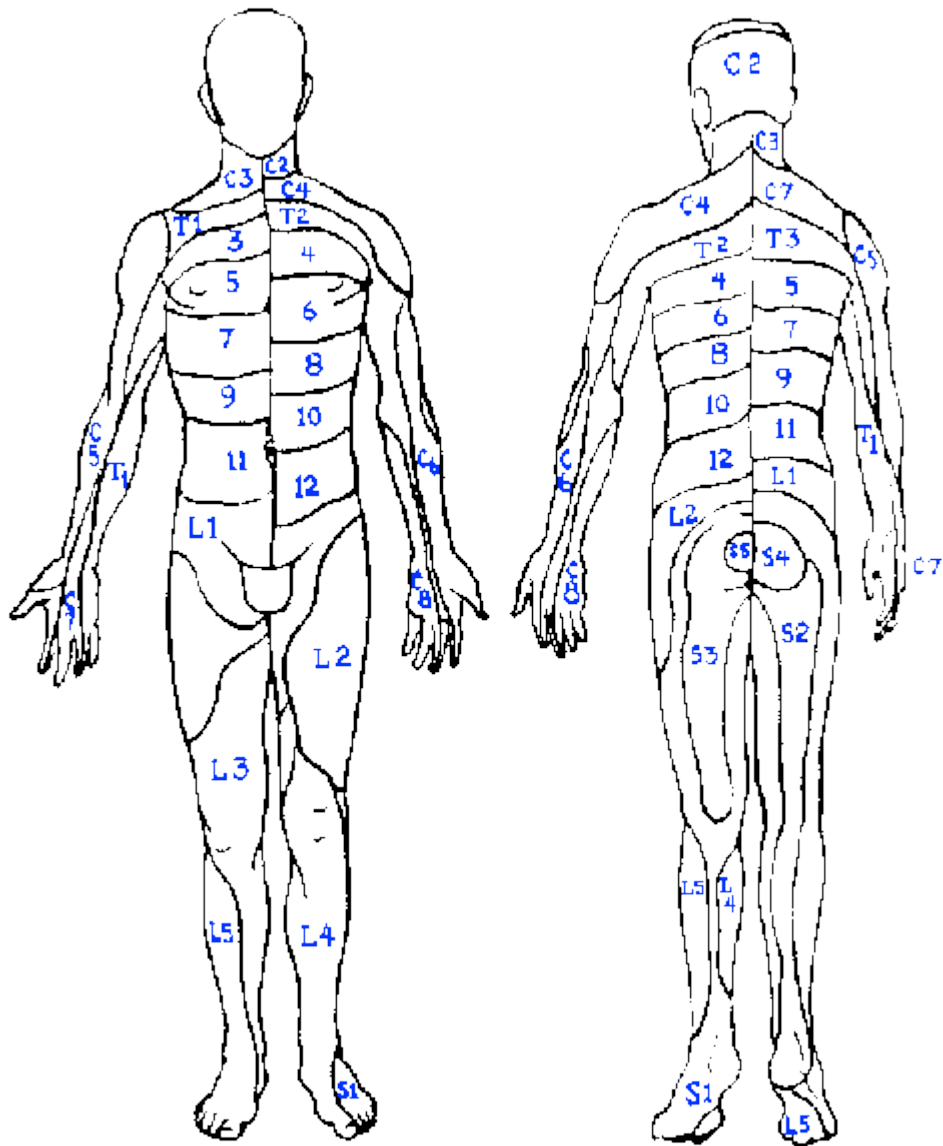
- None
- Marijuana
- Cocaine
- Injectable Drugs

Do you work? If so, please write in your job title: _____

	Living	Deceased	No Medical Problems	Heart Disease	Lung Disease	Cancer	Stroke	Heart Attack	Diabetes	Bleeding Problems	Other
Father	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brother/Sister #1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brother/Sister #2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brother/Sister #3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brother/Sister #4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other things that run in family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please list an allergies you have to medicines: _____

Shade areas where you have pain



Surgery Risk Factor Screening Questionnaire:

Do you have a cardiologist?

Date last seen by your cardiologist? _____

Cardiac:

- Heart Attack
- Chest Pain
- Arrhythmia/palpitations
- Syncope/fainting/blackouts
- Congestive Heart Failure
- Heart murmur, congenital heart disease, or valve disease
- Cardiomyopathy/weak or enlarged heart
- Hospitalizations/evaluations for heart disease _____
- Stroke/TIA

Cardiac Procedures:

- Most recent cardiac catheterization/angiogram _____
- Angioplasty/Stents
- Cardiac Bypass surgery
- Heart valve or arrhythmia surgery
- Most recent echocardiogram
- Most recent stress test
 - Stress Echo: _____
 - Stress Nuclear: _____
- Holter Monitor
- Pacemaker/ICD/implantable loop recorder
- Electrophysiologic study or ablation

Pulmonary:

- Asthma
- COPD/Emphysema
- Smoking history
- Shortness of breath
- Sleep apnea
 - CPAP
 - biPAP
- Cough
- Wheezing
- PND/orthopnea (shortness of breath while lying flat)
- Current symptoms that may prompt cardiac clearance:
 - Any chest pain or discomfort
 - Location _____
 - Character (pressure, burning, knife-like, ache, other) _____

How long _____

Frequency _____

Duration of each episode _____

What makes it worse _____

What makes it better _____

- Heartburn or indigestion
- Shortness of breath
 - *At rest
 - *With exertion
 - *PND/Orthopnea (SOB while lying flat)
 - *How far can you walk without stopping? _____
- Palpitations, missed or skipped heartbeat, or racing heartbeat
- Dizziness, light headedness or fainting
- Known blockage of blood vessels outside the heart
- Aneurysm
- Pain in legs with walking (if so where/why) _____

Cardiac Risk Factors:

- Any tobacco use (smoking or chewing tobacco)
 - Current: Amount per day? _____
 - Past: Date Quit: _____ Length of Use: _____
- Hypertension
- Diabetes
- High Cholesterol
- Family history of heart disease
- Exercise ability
 - Regular Exercise program? _____
 - What is the most exercise you currently can do? _____
- Alcohol Use

Oswestry Disability Index

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking *one* circle in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just shade out the spot that indicates the statement *which most clearly describes your problem*.

Name: _____ Email: _____ Date: _____

<p>1. Pain Intensity (<i>Mark only one</i>)</p> <ul style="list-style-type: none"> ○ I can tolerate the pain I have without having to use pain killers ○ The pain is bad, but I manage without taking pain killers ○ Pain killers give me complete relief from pain ○ Pain killers give me moderate relief from pain ○ Pain killers give very little relief from pain ○ Pain killers have no effect on the pain, I do not use them 	<p>5. Sitting (<i>Mark only one</i>)</p> <ul style="list-style-type: none"> ○ I can sit in any chair as long as I like ○ I can only sit in my favorite chair as long as I like ○ Pain prevents me from sitting more than one hour ○ Pain prevents me from sitting more than 30 minutes ○ Pain prevents me from sitting more than 10 minutes ○ Pain prevents me from sitting at all
<p>2. Personal Care (<i>washing/dressing-mark only one</i>)</p> <ul style="list-style-type: none"> ○ I can look after myself normally without it causing extra pain ○ I can look after myself normally but it causes extra pain ○ It is painful to look after myself and I am slow and careful ○ I need some help, but manage most of my personal care ○ I need help in most aspects of self care ○ I do not get dressed, wash with difficulty, and stay in bed 	<p>6. Standing (<i>Mark only one</i>)</p> <ul style="list-style-type: none"> ○ I can stand as long as I want without extra pain ○ I can stand as long as I want, but it gives extra pain ○ Pain prevents me from standing more than one hour ○ Pain prevents me from standing more than 30 minutes ○ Pain prevents me from standing more than 10 minutes ○ Pain prevents me from standing at all
<p>3. Lifting (<i>Mark only one</i>)</p> <ul style="list-style-type: none"> ○ I can lift heavy weights without extra pain ○ I can lift heavy weights, but it gives extra pain ○ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table) ○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned ○ I can lift only very light weights ○ I cannot lift or carry anything at all 	<p>7. Sleeping (<i>Mark only one</i>)</p> <ul style="list-style-type: none"> ○ Pain does not prevent me from sleeping well ○ I can sleep well only by using tablets ○ Even when I take tablets, I have less than 6 hours of sleep ○ Even when I take tablets, I have less than 4 hours of sleep ○ Even when I take tablets, I have less than 2 hours of sleep ○ Pain prevents me from sleeping at all
<p>4. Walking (<i>Mark only one</i>)</p> <ul style="list-style-type: none"> ○ Pain does not prevent me from walking any distance ○ Pain prevents me walking more than 1 mile ○ Pain prevents me walking more than ½ mile ○ Pain prevents me walking more than ¼ mile ○ I can only walk using a stick or crutches ○ I am in bed most of the time and have to crawl to the toilet 	
<p>8. Employment/Homemaking (<i>Mark only one</i>)</p>	<p>10. Traveling (<i>Mark only one</i>)</p> <ul style="list-style-type: none"> ○ I can travel anywhere without extra pain

<ul style="list-style-type: none"> ○ My normal homemaking/job activities do not cause pain ○ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me ○ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities ○ Pain prevents me from doing anything but light duties ○ Pain prevents me from doing even light duties ○ Pain prevents me from performing any job or homemaking chores 	<ul style="list-style-type: none"> ○ I can travel anywhere, but it gives extra pain ○ Pain is bad, but I manage journeys over two hours ○ Pain restricts me to journeys less than one hour ○ Pain restricts me to short journeys under 30 minutes ○ Pain prevents me from traveling except to the doctor or hospital
<p>9. Social Life (<i>Mark only one</i>)</p> <ul style="list-style-type: none"> ○ My social life is normal and gives me no extra pain ○ My social life is normal, but increases the degree of pain ○ Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc) ○ Pain has restricted my social life and I do not go out as often ○ Pain has restricted my social life to home ○ I have no social life because of pain 	

1. In general, would you say your health is: *(mark only one)*

Excellent (1)

Very Good (2)

Good (3)

Fair (4)

Poor (5)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf: *(mark only one)*

Yes, limited a lot (1)

Yes, limited a little (2)

No, not limited at all (3)

3. Climbing SEVERAL flights of stairs: *(mark only one)*

Yes, limited a lot (1)

Yes, limited a little (2)

No, not limited at all (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like: *(mark only one)*

Yes (1)

No (2)

5. Were limited in the KIND of work or other activities: *(mark only one)*

Yes (1)

No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like: *(mark only one)*

Yes (1)

No (2)

7. Didn't do work or other activities as CAREFULLY as usual: *(mark only one)*

Yes (1)

No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)? *(mark only one)*

- Not at all (1)
- A little bit (2)
- Moderately (3)
- Quite a bit (4)
- Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful? *(mark only one)*

- All of the time (1)
- Most of the time (2)
- A good bit of the time (3)
- Some of the time (4)
- A little of the time (5)
- None of the time (6)

10. Did you have a lot of energy? *(mark only one)*

- All of the time (1)
- Most of the time (2)
- A good bit of the time (3)
- Some of the time (4)
- A little of the time (5)
- None of the time (6)

11. Have you felt downhearted and blue? *(mark only one)*

- All of the time (1)
- Most of the time (2)
- A good bit of the time (3)
- Some of the time (4)
- A little of the time (5)
- None of the time (6)

12. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

(mark only one)

- All of the time (1)
- Most of the time (2)
- Some of the time (3)
- A little of the time (4)
- None of the time (5)