



SPINE & JOINT
PHYSICIANS
of Frisco

WELCOME PACKET

YOUR APPOINTMENT HAS BEEN SCHEDULED ON:

DATE: _____ TIME: _____

Should you need to cancel, please call the office at: 972-219-8400

PLEASE READ THE BELOW LISTED INFORMATION

**It is very important that you bring your MRI or CT reports to your appointment
The physician needs this information to best help you at the time of your visit**

**If you are relying on the facility or another office to send these directly to our practice we
ask that you call 2 days in advance of your scheduled appointment to confirm that the
office has received them.**

Thank you for your cooperation

Thank you for choosing us to serve your health care needs

Every effort will be made to honor your appointment time.

Please note, however, that due to the nature of our practice, occasionally there are delays with appointments.

We apologize in advance for any inconvenience this may cause you.



**SPINE & JOINT
PHYSICIANS**
of Frisco

DEMOGRAPHIC INFORMATION

Name: _____ **DOB:** ____/____/____ **AGE:** _____ **Social Security:** _____
Last First Middle Initial

Address: _____
Number Street City State Zip

Cell Phone: _____ **Home Phone:** _____ **EMAIL:** _____

Who referred you to our office? _____ **Phone Number:** _____

Who is your primary care doctor? _____ **Phone Number:** _____ **Location:** _____

Emergency Contact: _____ **Phone Number:** _____ **Relationship:** _____

ADDITIONAL INFORMATION

☐ **Male** ☐ **Female** **Marital Status:** ☐ Married ☐ Single ☐ Other: _____

Languages Spoken: ☐ English ☐ Spanish ☐ Other: _____

Occupation: _____

Employer: _____

PLEASE TELL US THE REASON FOR YOUR VISIT: _____

PHARMACY INFORMATION

PREFERRED PHARMACY: _____ PHONE #: _____

PHARMACY ADDRESS: _____

MEDICATION ALLERGIES

- ☐ **No Known Drug Allergies**
- ☐ **No Other Allergies (latex, contrast or adhesives..)**
- ☐ **Yes I have known Drug Allergies (Please list name and symptoms)**

1. _____

2. _____

- ☐ **Yes I have Other Allergies to things like latex, contrast or adhesives (Please list name and symptoms)**

1. _____

2. _____

CURRENT MEDICATIONS

LIST ALL THE CURRENT MEDICATIONS YOU ARE TAKING

NAME: <i>Example: Benadryl</i>	DOSE <i>40 mg</i>	FREQUENCY <i>one tab a day</i>	REASON PRESCRIBED: <i>Allergies</i>
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1. _____	_____	_____	_____
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2. _____	_____	_____	_____
----------	-------	-------	-------

3. _____	_____	_____	_____
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4. _____	_____	_____	_____
----------	-------	-------	-------

5. _____	_____	_____	_____
----------	-------	-------	-------

6. _____	_____	_____	_____
----------	-------	-------	-------

7. _____	_____	_____	_____
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8. _____	_____	_____	_____
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9. _____	_____	_____	_____
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Signature of Patient/Guardian

Date

PATIENT NAME:

DATE:

REVIEW OF SYSTEMS

ROS. Does the patient currently have any of these issues? *Please circle yes or no*

Constitutional	Fatigue	No	Yes	Fever	No	Yes	Weight Loss	No	Yes
	Seizures	No	Yes	Dizziness	No	Yes	Headaches	No	Yes
Neurologic	Muscle Pain	No	Yes	Back Pain	No	Yes	Weight Gain	No	Yes
	Joint Pain	No	Yes	Neck Pain	No	Yes	Morning Stiffness	No	Yes
Musculoskeletal	Rash	No	Yes	Ulcers	No	Yes			
	Short of Breath	No	Yes	Wheezing	No	Yes	Cough	No	Yes
Skin	Difficulty Breathing	No	Yes						
	Chest Pain	No	Yes	Palpitations	No	Yes	Irregular Heart Beat	No	Yes
Pulmonary	Diarrhea	No	Yes	Vomiting	No	Yes			
	Constipation	No	Yes	Nausea	No	Yes	Abdominal Pain	No	Yes
Cardiology	Freq Urine	No	Yes	Pain Urinating	No	Yes	Burning with Urination	No	Yes
	Nasal Drainage	No	Yes	Change of Vision	No	Yes	Loss Of Hearing	No	Yes
Gastrointestinal	Sore Throat	No	Yes	Tooth Ache	No	Yes			
	Easy Bleeding	No	Yes	Easy Bruising	No	Yes			
Genitourinary	Anxiety	No	Yes	Depression	No	Yes			
Eyes/Ears/Nose									
Mouth and Throat									
Hematologic									
Psychiatric									

Has the patient or family member ever been diagnosed with any of the following medical conditions?

	FAMILY MEMBERS		PATIENT		IF YES FOR PATIENT, PLEASE COMMENT
Heart Disease (CAD)	No	Yes	No	Yes	
High Blood Pressure	No	Yes	No	Yes	
Stroke	No	Yes	No	Yes	
Cancer	No	Yes	No	Yes	
Osteoarthritis	No	Yes	No	Yes	
COPD	No	Yes	No	Yes	
Depression	No	Yes	No	Yes	
Coagulation Defects	No	Yes	No	Yes	
DVT (Blood Clots)	No	Yes	No	Yes	
Anemia	No	Yes	No	Yes	
Hepatitis	No	Yes	No	Yes	
Diabetes	No	Yes	No	Yes	
Kidney Disease	No	Yes	No	Yes	
Asthma	No	Yes	No	Yes	
Sleep Apnea	No	Yes	No	Yes	
Stomach Ulcers	No	Yes	No	Yes	
High Cholesterol	No	Yes	No	Yes	
Rheumatoid arthritis	No	Yes	No	Yes	
Lupus	No	Yes	No	Yes	
Seizures	No	Yes	No	Yes	
Anxiety	No	Yes	No	Yes	
Other Health Issues:					
	No	Yes	No	Yes	

If you checked yes to any of the above, are you under treatment for this issue with a physician? No Yes

If so, who is the physician treating you? _____

PATIENT NAME: _____ DATE: _____

PRIOR SURGERIES

Please list any surgeries you have ever had

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

PRIOR SURGERIES

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

SOCIAL HISTORY

Height _____ Weight _____

Alcohol Intake: Please circle the one that applies to you: Never Drink Drink Socially Drink Daily:
wine beer liquor

Do you have a history of alcohol abuse? ☐ Yes ☐ No

Smoking History: Have you ever smoked? ☐ Yes ☐ No If yes, How long? _____ How Many _____ packs/day
Have you quit smoking? ☐ Yes ☐ No If yes, When? _____ How Many _____ packs/day

Illicit Drug Use: Do you currently use any illicit substances? ☐ Yes ☐ No
Have you ever used any illicit substances? ☐ Yes ☐ No
If yes, which one(s)? _____

OTHER HEALTH RELATED ISSUES NOT COVERED ABOVE



SPINE & JOINT PHYSICIANS *of Frisco*

New Patient Questionnaire

Patient Name: _____ DOB: _____

Date: _____

Where is your pain located?

Did it start gradually or suddenly?

SEVERITY:

On a scale of 0 to 10, with **0** being no pain and **10** being the worst possible pain imaginable.

Please rate your pain. _____

History of Pain:

1. How long have you had this pain? _____

2. How did your pain start? _____

3. Check the one(s) that describe your pain:

- ☐ constant pain always present
☐ intermittent pain not present all the time

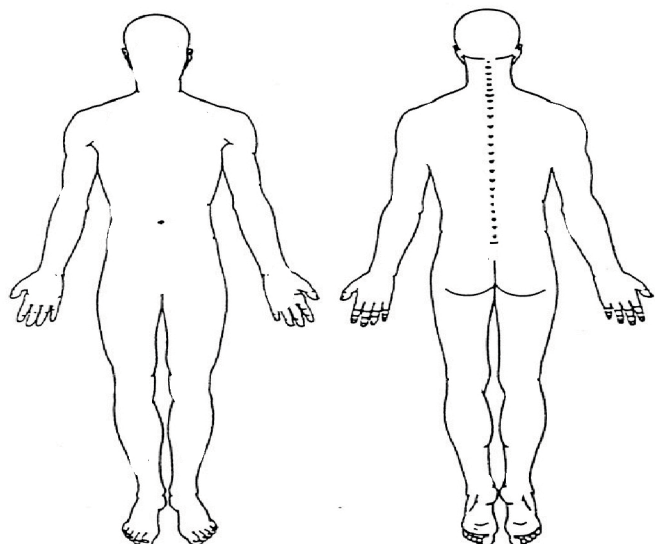
What tests have been done to try to diagnose your pain?

- ☐ X-rays ☐ MRI scan ☐ CT scan ☐ Myelogram
☐ Bone Scan ☐ Blood work ☐ Ultrasound ☐ Other: _____

Findings (if known): _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Ache ^ ^ ^ ^
Numbness o o o o
Pins and Needles = = = =
Burning X X X X
Stabbing / / / /



Does the pain travel, spread, or radiate from its primary location to another part of the body? _____

What **consistently** makes your pain worse?

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Stress | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Morning | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Night | <input type="checkbox"/> Touching Skin |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bending Backwards |
| <input type="checkbox"/> Damp Weather | <input type="checkbox"/> Cold Weather | |
| <input type="checkbox"/> Work | <input type="checkbox"/> Bending Forward | |
| <input type="checkbox"/> Other: _____ | | |

What makes your pain less?

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Pain Pills |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Anti-inflammatory agents |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Ice |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Other: _____ | |

Check sensations that most describe your pain:

- | | |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Deep |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Grinding |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Stinging |
| <input type="checkbox"/> Squeezing | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Cold |
| <input type="checkbox"/> Other: _____ | |

Have you had loss of control of your bladder or bowels associated with this condition?

- ☐ Yes ☐ No

Previous Treatments for this Condition?

Check Previous Treatments

Did it help or not?

- | | | |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Injections or Nerve Blocks | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Psychology Counseling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Biofeedback/relaxation Techniques | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

What medications have you taken for pain (please list any medicines you can remember trying for this pain)?

Did any of these treatments or medications seem to help your pain?

- ☐ No ☐ Yes, If so, which ones? _____