DESERT SPINE INSTITUTE REGISTRATION FORM

PATIENT'S LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____AGE: _____SEX: M____ F ____MOTHER'S MAIDEN NAME_____

MARITAL STATUS: ____ SINGLE ____ MARRIED _____ DIVORCED____ SEPARATED ____ WIDOWED

SOCIAL SECURITY NO.: _____EMAIL:_____

STREET ADDRESS: _____ PO BOX: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER NAME: _____ EMPLOYER PHONE NUMBER: _____

REFERRING PROVIDER: DR. _____ PRIMARY CARE PHYSICIAN: _____

PREFERRED LANGUAGE: _____INTERPRETER NEEDED: _____

*IF AN INTERPRETER IS NEEDED FOR THE PATIENT PLEASE BE SURE ONE ACCOMPANIES THE PATIENT ON THE DAY OF THE APPOINTMENT OTHERWISE THE APPOINTMENT MAY BE RESCHEDULED

ETHNICITY: _____ RELIGION: _____

IS THIS APPOINTMENT WORK RELATED: YES_____ NO_____

IS THIS APPOINTMENT MOTOR VEHICLE ACCIDENT RELATED: YES_____ NO_____

GUARANTOR NAME: _____ DATE OF BIRTH _____

ADDRESS (IF DIFFERENT): _____ CITY: _____

STATE: _____ ZIP CODE: _____ HOME PHONE: _____

CELL PHONE: _____ SOCIAL SECURITY NO: _____

PATIENT'S RELATIONSHIP: _____ SELF _____ SPOUSE _____ CHILD _____ OTHER

NAME OF PRIMARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

NAME OF SECONDARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____CELL PHONE: _____WORK PHONE: _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCES. I ALSO AUTHORIZE DESERT SPINE INSTITUTE OR INSURANCE COMPANY TO RELEASE ANY INFORMATION NEEDED TO PROCESS MY CLAIMS.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

Desert Spine Institute

Yuma, AZ
Phone 928-247-9714
Fax 928-247-9718

ADULT New Patient Evaluation Form

Name: _____ **Age:** _____ **Date of visit:** _____

Consultation from: _____ **Primary physician:** _____
City, State: _____ City, State: _____

Handedness: □ right, □ left

Presenting symptoms:
□ Neck pain only □ Back pain only □ Scoliosis
□ Neck and arm pain □ Back and leg pain □ Other _____

What is the nature of your problems?
_____
_____
_____

What activities increase your pain? (check all that apply)
□ Sitting, □ Standing, □ Lying, □ Walking, □ Bending, □ Coughing, □ Bearing down
□ Other _____

How long have you had this problems?
□ Less than 1 month , □ 1- 3 months, □ 3-6 months,
□ Greater than 6 months, How long? _____

Are you out of work because of this problem? □ No, □ Yes. If yes, how long? _____

Prior treatments:
Medicines: _____
Therapy: _____
Injections: _____
Other: _____

Social history:
What is your occupation? _____
Habits:
Do you smoke? □ No, □ Yes (____pack/day, ____ years)
Do you drink? □ No, □ Yes (____ drinks / week)
Do you participate in any sports / activities on a regular basis? _____
Do any medical problems run in your family? _____

Medical History:
Do you have? (check all that apply):

□ high blood pressure	□ osteoporosis	□ arthritis	□ anemia
□ heart disease	□ cataract/glaucoma	□ drug /alcohol abuse	□ inflam bowel
□ emphysema	□ peptic ulcer	□stroke	□ skin condition
□ asthma	□ depression	□ multiple sclerosis	□ phlebitis
□ diabetes	□ headaches	□ parkinson's	□ hepatitis
□ cancer	□ seizure disorder	□ thyroid disease	□ hay fever/sinus

□ Other _____

List all medicines you take:

Medicine	Reason	Medicine	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any allergies? □ No, □ Yes. If so, to what _____
Do you have any allergies to Iodine / Shellfish / Latex

List all prior surgeries:	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What prior imaging studies have you had done?

Study	Date (as accurately as you recall)
X-Rays	_____
MRI	_____
CT	_____
Myelogram	_____
Bone scan	_____
EMG	_____
Other	_____

Nursing evaluation:
Height: _____ Weight: _____
Support system: _____ Assist devices_____

PAIN SCALE
ESCALA DE DOLOR

Select the number on the scale that indicates your pain level 0=None 10=Max
Seleccione el numero en la escala que indique su nivel de dolor. 0=Ninguno 10=Maximo

Back Pain
> 0__.__1__.__2__.__3__.__4__.__5__.__6__.__7__.__8__.__9__.__10
Dolor de
Espalda

Neck Pain
> 0__.__1__.__2__.__3__.__4__.__5__.__6__.__7__.__8__.__9__.__10
Dolor de
Cuello

Leg Pain
> 0__.__1__.__2__.__3__.__4__.__5__.__6__.__7__.__8__.__9__.__10
Dolor en
la pierna

Arm Pain
> 0__.__1__.__2__.__3__.__4__.__5__.__6__.__7__.__8__.__9__.__10
Dolor en
el brazo

Other/*Otro* >0__.__1__.__2__.__3__.__4__.__5__.__6__.__7__.__8__.__9__.__10

_____
(Describe)

Name:_____ Date:_____

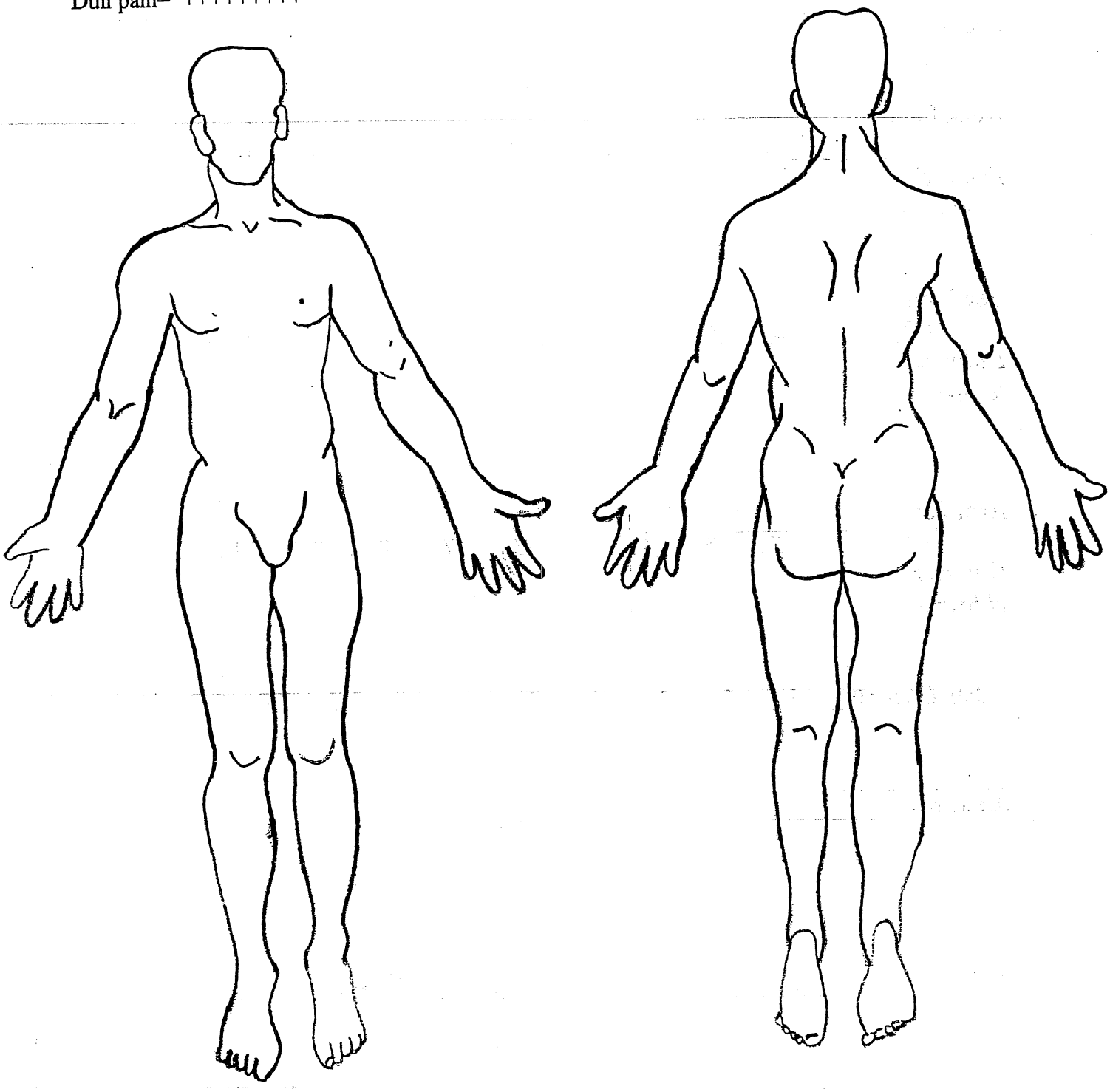
Please complete the following drawing to show where your pain is. You do not need to use all of the symbols, just those that apply. I understand the difficulty with pain descriptions, but please do the best that you can.

Sharp pain= XXXXXXX

Tingling=/ / / / / / / / / / / /

Dull pain= +++++++++

Numbness= OOOOOOO



Oswestry Disability Questionnaire

Please check ***ONE BOX IN EACH SECTION*** for the statement which best applies to you. 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.

Section 1: Pain Intensity
- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care
- ☐ I can look after myself normally without 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 can manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting
- ☐ I can lift heavy weights without causing extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (e.g. on a table)
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything at all.

Section 4: Walking
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting
- ☐ 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 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

Section 6: Standing
- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping
- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)
- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life
- ☐ 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 e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Traveling
- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Patient Name _____ Date _____

Score _____