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: __________________________________

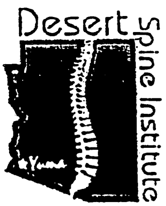
POLICY NUMBER: ___________________ GROUP NUMBER: _____________________

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:__________________

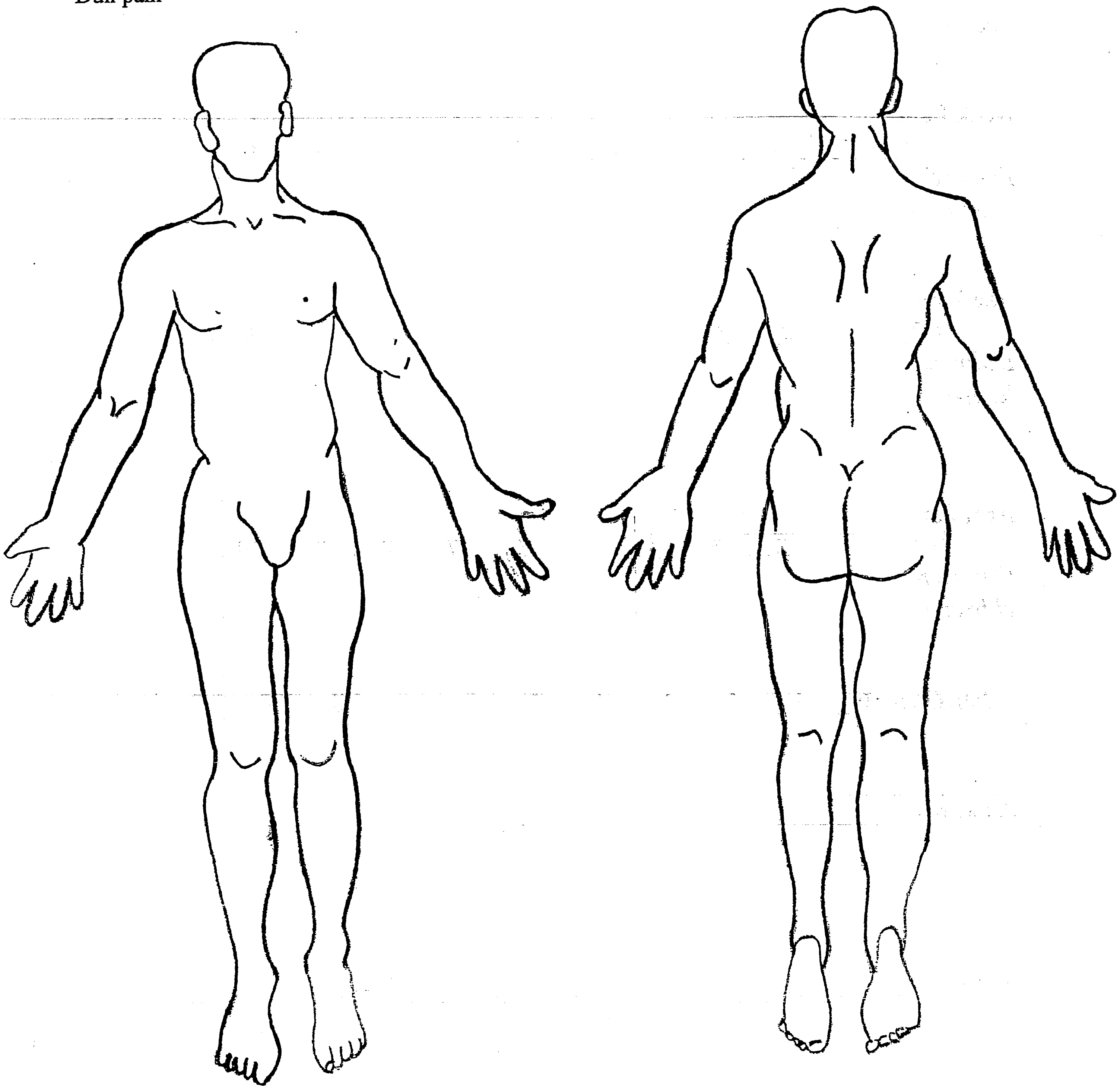
Please complete the following drawing to show where your pain is. You do not need to use all of the symbols, just those that apply. I understand the difficulty with pain descriptions, but please do the best that you can.

Sharp pain= XXXXXXXX

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

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

Numbness= OOOOOOO



Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

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 manage most of my personal care.
- ☐ I need help every day in most aspects of self -care.
- ☐ I do not get dressed. I 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 from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

Section 6 – Concentration

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

Section 7 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

Section 8 – Driving

- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my care at all because of neck pain.

Section 9 – Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

Section 10 – Recreation

- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

Patient Name ______________________ Date ______________

Score ____________ [50] Benchmark -5 = ____________

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