



Please PRINT and complete ALL sections

Is your condition the result of a work injury? YES NO Auto accident? YES NO Date of Injury: _____

PATIENT INFORMATION

Name: _____
Street Address: _____ Apt # _____ City: _____ State: _____ Zip: _____
E-mail address: _____
Home Phone: () _____-_____ Work Phone: () _____-_____ Mobile Phone: () _____-_____
Date of Birth: _____/_____/_____ Age: _____ Driver's License: _____/_____ Social Security No.: _____/_____/_____
Mo. Day Year State Lic. #

Employer Name: _____
Occupation: _____ [] Full Time [] Part Time
Employer Address: _____ Employer Phone: () _____-_____
Marital Status: [] Single [] Married [] Divorced [] Widowed
Spouse's Name: _____ Spouse DOB: _____/_____/_____
Spouse's Social Security No.: _____/_____/_____
Spouse's Employer: _____ Spouse's Work Phone: () _____-_____

Emergency Contact: _____ Relationship: _____
Street Address: _____ Apt # _____ City: _____ State: _____ Zip: _____
Home Phone: () _____-_____ Work Phone: () _____-_____ Mobile Phone: () _____-_____

REFERRAL INFORMATION

* Important! This information allows us to keep your physicians updated regarding your spine care.

Referring Physician Name and Address: _____

PCP Name and Address (if different from referring physician): _____

- [] Self
If self, how did you find out about us?
[] Website, or internet search engine If so, which one? _____
[] TV
[] Newspaper
[] Magazine
[] Billboard
[] Other _____

INSURANCE INFORMATION

PRIMARY Insurance Company: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____

Relationship to Insured: Self Spouse Child Other: _____

Insurance ID Number: _____ Group Number: _____

SECONDARY Insurance Company: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____

Relationship to Insured: Self Spouse Child Other: _____

Insurance ID Number: _____ Group Number: _____

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

Method of Payment: Cash Credit Card Check

I hereby give authorization for payment of insurance benefits to be made directly to the Minimally Invasive Spine Institute (MISI) and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

PREFERRED PHARMACY

Name: _____ Phone Number: () _____ - _____

ACKNOWLEDGEMENT FORM

I have received and reviewed the Notice of Privacy Practices.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

MISI FACSIMILE AUTHORIZATION FORM

I, the undersigned, authorize MISI to send/receive confidential healthcare information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below.

I may revoke this authorization by giving MISI five (5) days written notice. **This revocation may be by facsimile transmission; however, a written copy of the revocation must be mailed to MISI as well.**

Patient Signature: _____ Date: _____

Patient Name: _____

CONTACT AUTHORIZATION

Check where you can be reached during business hours: Home Work Mobile

May we contact you at home? Yes No

Leave message with: _____

Voicemail / Answering Machine: Yes No

Mobile Phone: Yes No

Family Member: Yes No

May we contact you at work? Yes No

Leave message with: _____

Voicemail / Answering Machine: Yes No

Mobile Phone: Yes No

Co-worker: Yes No

May we contact you by email? Yes No If yes, email address: _____

I hereby give permission to the Minimally Invasive Spine Institute to disclose and discuss any information related to my medical conditions to/with the following (relatives, or close personal friends):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OR

_____ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical conditions

EMERGENCY CONTACT/ LEGAL GUARDIAN

Name: _____ Phone #: _____

Address: _____

Relation: _____

Patient Signature: _____

PAIN DIAGRAM

Is your condition the result of a work injury? YES NO Auto accident? YES NO Date of Injury: _____

Please indicate in table below the percentage of pain you currently feel in your neck, arm, back and legs. Example (0%, 25%, 75%, 100%)

* Total of percentages should equal 100%.

For patients with neck and arm pain

Neck Pain _____ %
 Arm Pain _____ %
 Total Pain 100%

For patients with back and leg pain

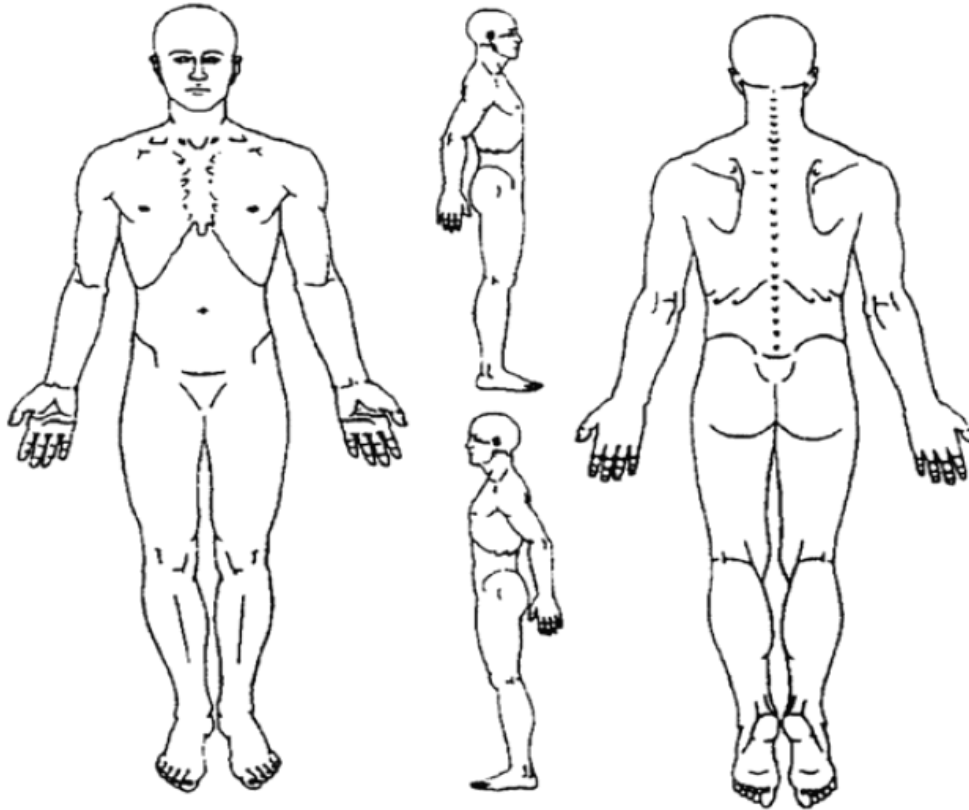
Back Pain _____ %
 Leg Pain _____ %
 Total Pain 100%

Please mark the area of discomfort on the diagram below using the appropriate symbols:

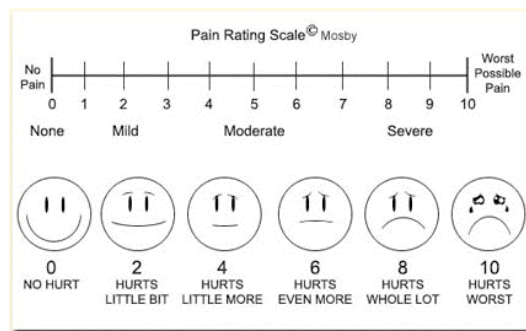
Pain or burning: x x x x x

Numbness: o o o o o

Pins and Needles: = = = = =



Grade your overall pain



Please place an X on the hash mark that most accurately describes your overall degree of pain now.

HISTORY

NAME: _____

DATE: _____

Age: _____ years Date of Birth: ____/____/____ Sex: Male Female Height: _____ Wt: _____

Chief Complaint: Neck pain Arm: Pain Numbness Weakness

(Check all that apply): Back pain Leg: Pain Numbness Weakness

How long has the pain (or your problem) been present?

Date of Injury? _____ OR: Less than 2 months 2-6 months 6-12 months Greater than 1 year

My pain is: Worsening Improving Same. Unchanged since it started

For patients with NECK or ARM pain, numbness or weakness:

There is: No weakness of the arms and hands Weakness of the (check following)

Right: Shoulder Upper Arm Forearm Hand/finger

Left: Shoulder Upper Arm Forearm Hand/finger

There is: No numbness of the arms and hands Numbness of the (check following)

Right: Shoulder Upper Arm Forearm Hand/finger

Left: Shoulder Upper Arm Forearm Hand/finger

Raising the arm: Improves the pain Worsens the pain Does not affect the pain

Moving the neck: Improves the pain Worsens the pain Does not affect the pain

Do you have difficulty picking up small objects like coins or buttoning buttons? YES NO

Do you have problems with balance or frequent tripping? YES NO

For patients with BACK or LEG pain, numbness or weakness:

Pain is present in the (check the following)

Right: Buttock Thigh - front Thigh - back Calf Foot

Left: Buttock Thigh- front Thigh- back Calf Foot

There is: No weakness of the legs Weakness of the (check following)

Right: Thigh Calf Ankle Foot Big toe

Left: Thigh Calf Ankle Foot Big toe

There is: No numbness of the legs Numbness of the (check following)

Right: Thigh Calf Ankle Foot Big toe

Left: Thigh Calf Ankle Foot Big toe

Worst position for pain is: Sitting Standing Walking

How many minutes can you stand/walk before you need to rest? 0-10 15-30 30-60 60+

Lying down: Eases the pain Does not ease the pain Sometimes eases the pain

Bending forward: Increases the pain Decreases the pain Does not affect the pain

There is: No loss of bowel or bladder control (incontinence) Loss of bowel and bladder control since:

I have: Not missed any work because of this problem How much work have you missed: -

Treatment has included: NO medication, physical therapy, chiropractic manipulations, injections, or bracing

Physical Therapy Epidural steroid injections Acupuncture

Muscle relaxants Facet injections Traction

Narcotic pain medication In-office injections without X-ray Braces

Anti-inflammatory medication Chiropractic manipulation

Other: _____

List pain medications and doses taken for your spine problem: NONE

Medication

Dose

Previous doctors seen for this problem: NONE

Doctor

Specialty

City

Treatment

Tests are done to evaluate your problem. Please list most recent for each category: NONE

Date of study

Where?

Plain x-rays: _____

CT scan: _____

MRI: _____

Myelogram: _____

EMG: _____

Bone scan: _____

PAST MEDICAL HISTORY

Check all that apply: None apply

- Heart attack Diabetes Lung disease Liver disease
- Heart failure (CHF) Stroke HIV Hepatitis
- High blood pressure Seizures AIDS Thyroid trouble
- Osteoarthritis Mental illness Tuberculosis Bleeding disorders
- Rheumatoid arthritis Kidney stones Asthma Anemia
- Ankylosing spondylitis Kidney failure Blood clot in leg Serious injury (explain)
- Gout Cancer Blood clot in lung
- Osteoporosis Alcoholism Stomach ulcers Other:

PAST SURGICAL HISTORY

List procedures, surgeon and date None apply

Operation	Surgeon	Date of Surgery

ALLERGIES: _____

MEDICATIONS

List all current medications and dose None

Medication	Dose

REVIEW OF SYSTEMS

Are you currently or have had problems with:

* Please explain and describe all YES answers below

Hematological / Bleeding problems Yes No Describe: _____

Reproductive / Sexual problems Yes No Describe: _____

Unexplained weight loss: Yes No Describe: _____

Skin: Yes No Describe: _____

Ear, Nose, Throat: Yes No Describe: _____

Stomach / Digestion: Yes No Describe: _____

Bladder / Bowel problems: Yes No Describe: _____

Musculoskeletal: Yes No Describe: _____

Neurological: Yes No Describe: _____

Psychiatric problems: Yes No Describe: _____

Fever / Chills: Yes No Describe: _____

Night sweats: Yes No Describe: _____

Night pain / Pain at rest: Yes No Describe: _____

SOCIAL HISTORY

Work Status: Homemaker Retired Disabled On leave
 Unemployed Employed: _____ Full time _____ Part time

Occupation: _____

Marital Status: Married Single Divorced Widowed

Number of living children: _____ None

I live: Alone With: _____

Do you smoke?: Yes No _____ packs per day for _____ years

Quit How long ago? _____

Drink alcohol? Daily 1-2 x/week 1-2 x/month Never

Alcoholic Recovering alcoholic

Illicit drug use: Never Currently In the past

Because of this spine problem, I have filed or plan to file:

A lawsuit A Worker's Compensation claim Neither

FAMILY HISTORY

Check all that apply: None apply

- Stroke Arthritis Mental illness Alcoholism
- Heart trouble Gout Kidney trouble or stones Cancer
- High blood pressure Seizures Diabetes Spine problems
- Bleeding disorders Other: _____

Patient Signature: _____ Date: _____ Reviewed: _____

PHYSICAL EXAM * to be completed by physician

Height: _____ Weight: _____ Respiration: _____

General: _____

Skin: _____

Range of Motion: Flex: _____ Ext: _____ Lat Bend: _____ Rotation: _____

Palpation: _____

Neurologic exam:

- | | | |
|--------|--------------|-------------------------------------|
| Motor: | Cervical | Lumbar |
| | R/L | R/L |
| | _____ Delt | _____ Iliopsoas |
| | _____ Bicep | _____ Quad |
| | _____ Tricep | _____ HS |
| | _____ WF | _____ DF |
| | _____ WE | _____ PF |
| | _____ Grip | _____ EHL |
| | _____ EPL | _____ Abductors |
| | | _____ Toe walk _____ Heel walk |

Sensation: _____

SLR: R _____ L _____ Troch/Burs: R _____ L _____

Fabers: R _____ L _____

SI joint: R _____ L _____

Spurling: _____ Lhermitte's: _____

Reflexes:

Biceps: _____ Triceps: _____ BR: _____

Patellar: _____ Achilles: _____

Clonus: R _____ L _____

Babinski: R _____ L _____

Hoffman: R _____ L _____ Phalens: R _____ L _____

W Tinels: R _____ L _____ E Tinels: R _____ L _____

IMPRESSION

- 1. _____
- 2. _____
- 3. _____
- 4. _____

PLAN

- 1. _____
- 2. _____
- 3. _____
- 4. _____

RTC: _____ weeks _____ months _____ yrs _____ PRN

_____ **Dictated** _____ **Not Dictated**