LAS VEGAS
SPINE&PAIN
CENTER

PATIENT INFORMATION

Name:	Date of Birth:	Age:	Sex:
Address: (City, State, Zip)			
Billing Address:	SSN:	Marital Status:	
Primary Phone #:	Work Phone #:	Secondary Phone #:	
Email:	Employment: Full/Part/None	Employer:	
Referring Physician:	Primary Care Physician:		
How did you hear about us? (Referring doctor, friend, family, self referral, internet, magazine, newspaper, advertisement other)			

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Cell Phone #:
Relationship:	Home Phone #:

INSURANCE INFORMATION

Primary Insurance: Copay:	Secondary Insurance: Copay:
Certificate#/Policy ID:	Certificate #:
Group Number:	Group Number
Subscriber Name:	Subscriber Name:
Subscriber DOB/Relationship:	Subscriber DOB:

Please circle the best option listed that describes your race and ethnicity.

Race: Asian, Native Hawaiian, Other pacific Islander, Black/African American, American Indian/Alaska Native, White, More than 1 race	Ethnicity: Hispanic/Latino, Not Hispanic/Latino, unreported/refuse to report	Primary Language:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my provider when they accept assignment.
Authorization To Release Medical Information: I hereby authorize my Provider to release any information necessary for my course of treatment.
I certify that the above information is correct as of the date signed.

_____ _____

Signed (patient of parent if minor) Date

Patient Name:_____

DOB:_____

LAS VEGAS SPINE&PAIN CENTER

Please mark the correct box if the question applies to you, and circle the score based upon your gender. If not applicable, please circle N/A.

1. Has anyone in your family ever had a history of substance abuse?

		F Score	M Score	
Alcohol	[ ]	1	3	N/A
Illegal Drugs	[ ]	2	3	
Prescription Drugs	[ ]	4	4	

2. Have you ever had a personal history of substance abuse?

Alcohol	[ ]	3	3	N/A
Illegal Drugs	[ ]	4	4	
Prescription Drugs	[ ]	5	5	

3. Mark box if your age is between 16-45.

[ ]	1	1	N/A

4. Have you had a history of preadolescent Sexual Abuse?

[ ]	3	0	N/A

5. Have you ever been diagnosed with Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, or Schizophrenia?

[ ]	2	2	N/A

6. Have you ever been diagnosed with Depression?

[ ]	1	1	N/A

Total _____

I certify that the above information is correct to the best of my knowledge.

_____ _____

Patient Signature Date

Please identify your main pain area

0 **Abdominal Pain**
- 0 Radiates into Pelvis
- 0 Radiates into Lower back
- 0 Radiates into Legs 0 L 0 R

0 **Lower Back Pain**
- 0 Radiates into legs 0 L 0 R
- 0 Buttock Pain 0 L 0 R
- 0 Hip Pain 0 L 0 R

0 **Upper Back Pain**
- 0 Radiates into Ribs 0 L 0 R

0 **Neck Pain**
- 0 Causes headaches
- 0 Radiates into Arms 0 L 0 R
- 0 Radiates into Mid-Back

0 **Upper Body Pain**
- 0 Shoulders 0 L 0 R
- 0 Arms 0 L 0 R
- 0 Hands 0 L 0 R

0 **Headaches**
- 0 Frontal Area 0 L 0 R
- 0 Temples 0 L 0 R
- 0 Back of Head 0 L 0 R

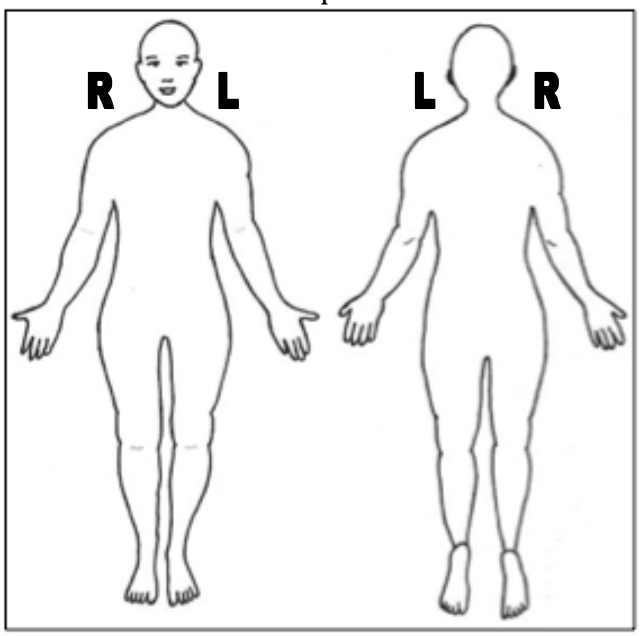
0 **Lower Body Pain**
- 0 Groin 0 L 0 R
- 0 Pelvis 0 L 0 R
- 0 Hips 0 L 0 R
- 0 Buttocks 0 L 0 R
- 0 Knees 0 L 0 R
- 0 Feet 0 L 0 R

0 **Facial Pain** 0 L 0 R

0 **Pelvic Pain**
- 0 Coccyx
- 0 Radiates into Legs 0 L 0 R

0 **Diffused Body Pain**
- 0 Chest
- 0 Back
- 0 Neck
- 0 Arms 0 L 0 R
- 0 Legs 0 L 0 R
- 0 Face
- 0 Head

Please shade the area where you feel the worst pain



Height _____ **Weight** _____

Quality of pain:

0 Burning	0 Deep
0 Cramping	0 Shooting
0 Sharp	0 Aching
0 Stabbing	0 Dull
0 Throbbing	0 Pins and Needles

Severity of Pain:

0 Mild	0 Mild to Moderate
0 Moderate	0 Moderate to Severe
0 Severe	

Onset of Pain:

0 Acute 0 Sudden 0 Gradual
0 Sudden, following incident
0 Gradual, following incident
0 Following trauma
0 Following a vehicle accident

Pain Pattern:

0 Intermittent 0 Episodic 0 Persistent

Duration of Pain:

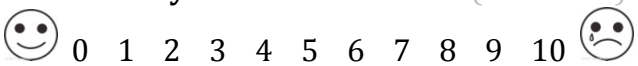
- 0 Years (How many?_____)
- 0 Months (How many? _____)
- 0 Weeks (How many? _____)
- 0 Other _____

Course of Pain:

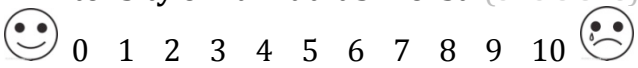
(Select only one)

0 Increasing	0 Rapidly Improving
0 Worsening	0 Constant
0 Gradual worsening	0 Without Change
0 Rapidly worsening	0 Recurrent
0 Decreasing	0 Night Pain
0 Gradually improving	0 No Night Pain

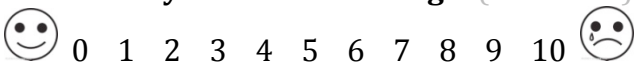
Intensity of Pain at it's Best: (circle one)



Intensity of Pain at it's Worst: (circle one)



Intensity of Pain on Average: (circle one)



Pain Aggravated By:

0 Sneezing	0 Lifting
0 Coughing	0 Sitting
0 Bowel Movements	0 Standing
0 Bending	0 Walking
0 Twisting	0 Lying Down
0 Other:_____	0 None

Pain Relieved By:

0 Rest	0 Ice
0 Change in Position	0 Sitting
0 Exercise	0 Standing
0 Pain Medication	0 Bending Forward
0 Heat	0 Physical Therapy
0 Other:_____	0 None

Associated Factors:

0 Abdominal Pain	0 Incontinence of Stool
0 Arthritis	0 Urinary Retention
0 Chills	0 Leg Weakness 0 L 0 R
0 Dysuria	0 Arm Weakness 0 L 0 R
0 Fever	0 Numbness _____
0 Flank Pain	0 Tingling _____
0 Hip Pain	0 History of Malignancy
0 None	0 Unintentional weight loss

Daily Activities Impaired by Pain:

0 Work	0 Intimacy
0 Sleeping	0 Dressing
0 Shopping	0 Chores
0 Leisure	0 Bathing
0 None	0 Exercise

Previous Evaluations:

0 Primary Care	0 Psychologist
0 Urgent Care	0 Pain Management
0 Emergency Room	0 Orthopedic Surgeon
0 Chiropractor	0 Neurologist
0 Rheumatologist	0 Neurosurgeon
0 Physiatrist	0 None

Previous Imaging:

Please include date of image and of what part of the body image was taken

- 0 Bone Scan_____
- 0 EMG _____
- 0 X-ray _____
- 0 CT _____
- 0 MRI _____

Physical Therapy:

0 None 0 Yes (Dates_____)

- 0 Stretching exercises
- 0 Strengthening exercises
- 0 TEN's Unit 0 Heat
- 0 Massage 0 Ice
- 0 Other: _____

Previous Injections:

0 None	0 Epidural injection
0 Hip Injection	0 Vertebroplasty
0 Facet Injection	0 Kyphoplasty
0 Other : _____	

Previous Spine Surgery:

0 None 0 Yes- please indicate:

Type_____

Date_____ Surgeon_____

Type_____

Date_____ Surgeon_____

Assisted Devices:

0 None	0 Cane	0 Walker
0 Corset	0 Brace	0 Wheelchair

Previous Pain Medications:
(Please list dose and frequency)

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Accident/Injury:

1. Are you currently involved in **litigation** regarding your injury? Y/N
2. Is your pain a **work related** injury? Y/N
3. Is **workman's compensation** involved? Y/N
4. **Date** of Accident/Injury? _____

Past Medical History:

0 Anemia
0 Anxiety
0 Arthritis
0 Asthma
0 Atrial Fibrillation
0 Bipolar Disorder
0 Bleeding Disorder
0 BPH
0 Breast Cancer
0 Bronchitis
0 CHF
0 Clotting Disorder
0 COPD
0 Coronary Artery Disease
0 Depression
0 Diabetes
0 Emphysema
0 GI Ulcer
0 Heart Attack
0 Hepatitis
0 HIV/AIDS
0 Hypertension
0 Kidney Disease
0 Liver Disease
0 Osteoporosis
0 Other Cancer
0 Prostate Cancer
0 Seizures
0 Shingles
0 Stroke
0 Thyroid Disease
0 Other: _____

Allergies:

0 Shell Fish 0 Contrast Dye 0 Iodine
0 Sulfa Drugs 0 Codeine 0 Latex
0 Seasonal Allergies 0 Penicillin 0 None
0 Other:_____

Family History:
(Please specify who if applicable)

0 Adopted_____ 0 Heart Disease_____
0 Alzheimer's_____ 0 High Blood Pressure_____
0 Cancer_____ 0 Migraine_____
0 Diabetes_____ 0 Osteoporosis_____
0 Mental Illness_____ 0 Stroke_____

Social History: (please explain if applicable)

0 History of Drug Abuse_____
0 Current Drug Abuse_____

Alcohol Use:
Do you drink? Y/N Drinks per Day? _____

Tobacco Use:
0 Never Smoked 0 Former Smoker
0 Recently Quit 0 Remotely Quit
0 Current Smoker 0 Every day Smoker

Seatbelt Use:
0 Always 0 Almost Always 0 Never

Work Status:
0 Employed 0 Retired 0 Unemployed
0 Disabled 0 Self employed

ORT Score:
(See first page) Score: _____

Current Medications:

Medication	Dose(mg)	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Are you taking blood thinners? Y/N

Past Surgical History:

0 Adenoidectomy
0 Appendectomy
0 Knee Arthroscopy
0 Back Surgery
0 Cervical
0 Thoracic
0 Lumbar
0 Brain Surgery
0 Carpal Tunnel
0 L 0 R
0 Cataract Surgery
0 CABG
0 Coronary artery dilation
0 Detached retina repair
0 Gallbladder
0 Hemorrhoidectomy
0 Hernia repair
0 Other: _____
0 Hysterectomy
0 Lumpectomy
0 Large Bowel res.
0 Mastectomy
0 Prostate surgery
0 Plastic surgery
0 Shoulder surgery
0 L 0 R
0 Small Bowel res.
0 Thyroidectomy
0 Tonsillectomy
0 Hip Replacement
0 L 0 R
0 Knee Replace
0 L 0 R
0 Tubal Ligation
0 Vasectomy
0 Pace Maker

Review of Systems

Please mark all that are present

General:

- 0 Appetite Loss
- 0 Dietary changes
- 0 Fatigue
- 0 Weight Gain > 10lbs
- 0 Weight Loss < 10lbs

Skin:

- 0 Brittle Nails
- 0 Bruising
- 0 Open Wound
- 0 Excessive Sweating
- 0 Itching
- 0 Rash
- 0 Ulcer

HEENT:

- 0 Headache
- 0 Blurred Vision
- 0 Double Vision
- 0 Glaucoma
- 0 Visual Loss
- 0 Hearing Loss
- 0 Vertigo
- 0 Sleep Apnea
- 0 Seasonal Allergies

Endocrine:

- 0 Appetite Changes
- 0 Thyroid Problems

Neck:

- 0 Neck Mass
- 0 Swollen Glands
- 0 Neck Pain

Respiratory:

- 0 Chronic Cough
- 0 Difficulty Breathing
- 0 Shortness of Breath
- 0 Stop breathing in sleep

Cardiovascular:

- 0 Chest Pain
- 0 Edema
- 0 Heart Stent
- 0 Irregular heart
- 0 Difficult to breath lying down
- 0 Irregular heart beat
- 0 Leg Pain
- 0 Leg Swelling
- 0 Rapid heart beat

Gastrointestinal:

- 0 Abdominal pain
- 0 Black tarry stool
- 0 Bloody Stool
- 0 Vomiting
- 0 Constipation
- 0 Diarrhea
- 0 Incontinence of stool
- 0 Nausea

Hematology:

- 0 Blood clots
- 0 Easy bruising
- 0 Spontaneous bleeding
- 0 Nose bleeds

Musculoskeletal:

- 0 Back Pain
- 0 Joint Pain
- 0 Leg Cramps
- 0 Muscle Atrophy
- 0 Muscle Weakness
- 0 Muscle Spasms

Neurological:

- 0 Difficulty Speaking
- 0 Trouble Walking
- 0 Incontinence stool
- 0 Incontinence Urine
- 0 Leg Weakness
- 0 Numbness
- 0 Seizures
- 0 Stroke
- 0 Headaches

Psychiatric:

- 0 Anger
- 0 Anxiety
- 0 Depression
- 0 Hallucinations
- 0 Hearing Voices
- 0 Mood changes
- 0 Panic Attacks

Thank you for your time!!

Please give completed paperwork to the front desk receptionists