



## SPINE INSTITUTE OF ARIZONA

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### Acknowledgment of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_, acknowledge that I have received a copy of Spine Institute of Arizona's 'Notice of Privacy Practices'. This Notice described how Spine Institute of Arizona may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative, etc.)



**SPINE INSTITUTE OF ARIZONA**

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**Documentation of Good Faith Efforts  
To Obtain Acknowledgment of Receipt of Notice of Privacy Practices**

Patient Name: \_\_\_\_\_

Date of Patient Encounter: \_\_\_\_\_

The patient presented to the office and was provided with a copy of the office's Notice of Privacy Practices. A good faith effort was made to obtain from the patient or patient's representative, if applicable, a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

- Patient refused to sign.
- Patient Representative refused to sign.
- Patient was unable to sign or initial because:

\_\_\_\_\_  
\_\_\_\_\_

- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe below):

\_\_\_\_\_  
\_\_\_\_\_

Signature of Employee Completing Form: \_\_\_\_\_

Date: \_\_\_\_\_



## SPINE INSTITUTE OF ARIZONA

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### PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Spine Institute of Arizona may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Spine Institute of Arizona's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Spine Institute of Arizona reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Spine Institute of Arizona's Privacy Officer at 9735 North 90<sup>th</sup> Place, Scottsdale, Arizona 85258.

With my consent, Spine Institute of Arizona may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Spine Institute of Arizona may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Spine Institute of Arizona may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Spine Institute of Arizona restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Spine Institute of Arizona's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Spine Institute of Arizona may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Patient's Printed Name

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Date

---

Print Name of Patient or Legal Guardian



**SPINE  
INSTITUTE  
OF ARIZONA**

9735 North 90th Place  
Scottsdale, Arizona 85258  
TEL 602/953.9500  
FAX 602/953.1782

**Authorization for Disclosure of My Health Information to  
My Spouse / Significant Other / Parent / Family Member**

I, \_\_\_\_\_, hereby authorize that my Spouse / Significant Other / Parent / Family Member(s) may obtain or receive copies of my Protected Health Information to include, but is not limited to; office notes, prescriptions, imaging films.

Unless I revoke this authorization earlier, this authorization will expire six years from the date signed.

Name(s) of Spouse/Significant Other/Parent/Family Member(s)

Relationship

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**PLEASE NOTE:** *Your Spouse/Significant Other/Parent/Family Member(s) will be required to show legal I.D. prior to being able to obtain your Protected Health Information.*

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Legal Guardian's Printed Name



# Spine Institute of Arizona

Edward J. Dohring, M.D.  
*Board Certified Orthopaedic Surgeon  
Fellowship Trained Spine Surgeon*

Paul R. Gause, M.D.  
*Board Certified Orthopaedic Surgeon  
Fellowship Trained Spine Surgeon*

Mark J. Wang, M.D.  
*Board Certified Orthopaedic Surgeon  
Fellowship Trained Spine Surgeon*

John H. Faryna, M.D.  
*Board Eligible Orthopaedic Surgeon  
Fellowship Trained Spine Surgeon*

Allan L. Rowley, M.D.  
*Board Certified  
Physical Medicine and Rehabilitation  
Interventional Pain Management*

Vibhooti H. Dave, D.O.  
*Board Certified  
Physical Medicine and Rehabilitation  
Electrodiagnostic Medicine (EMG's)*

Brock P. Auten, D.C.  
*Board Certified Chiropractic Physician  
Board Certified Physiotherapist*

Bill Balogh, P.A.  
*Physician Assistant*

Donna M. Lahey, R.N.F.A.  
*CEO  
Registered Nurse First Assist*

Megan E. Ashby, CMPE  
*Practice Administrator*

Main Office  
9735 North 90<sup>th</sup> Place  
Scottsdale, Arizona 85258

West Valley Office  
18700 N. 64<sup>th</sup> Dr, Suite 202  
Glendale, Arizona

East Valley Office  
16515 South 40<sup>th</sup> Street, Suite 119  
Ahwatukee, Arizona

Gilbert Office  
3483 S. Mercy Road, Suite 102  
Gilbert, Arizona

Prescott Office  
3655 Crossings Drive  
Prescott, Arizona

Tel. 602/953.9500  
Fax 602/953.1782  
www.spineaz.com

## CAUTIONS REGARDING THE USE OF LONG TERM NARCOTICS

1. Narcotics are drugs that act like morphine. These include drugs: Lortab, Percocet, Demerol, Darcon, Ultram, Tylenol #3, and others.
2. The drug you have been prescribed is extremely dangerous, capable of being abused, and an over-dose can be lethal
3. When taken in excess, the individual will first become sleepy, fall asleep, will be difficult or unable to arouse and finally, will stop breathing. The level of sedation depends upon the amount of drug ingested.
4. Keep these drugs in a locked box.
5. Be responsible for the drug. No early refill will be given.
6. These drugs can cause physical dependence. This means when you stop taking the drug you will experience a withdrawal reaction. Physical dependence occurs after approximately one week on the drug. This does not mean the drug cannot be stopped, however, it usually must be tapered in order to avoid withdrawal symptoms. A withdrawal reaction can be characterized by severe nausea, vomiting, diarrhea, abdominal pain, muscle aches, low-grade fever, tremor, rapid heart rate, sweating, and chills.
7. Physical dependence is not the same as addiction. Physical dependence means that if you stop the drug suddenly, you will develop a withdrawal reaction (nausea, diarrhea, sweats, shaky, and flu-like symptoms). Addiction is a psychological diagnosis characterized by cravings for the drug, uncontrollable use of the drug even when it causes harm to you and others.
8. There are numerous side effects, which can occur as a consequence of the use of these medications. These include:
  - A. Sedation. If you experience this side effect, even slightly, you should not be driving an automobile until the effect wears off. It generally takes one to two weeks for this side effect to wear off. You should then be safe to operate an automobile. If confusion, mental changes or excessive sleepiness occur, report this to your physician or present to the nearest emergency room immediately.
  - B. Constipation. If this occurs you will not adapt to this effect. You should drink eight 8 ounce glasses of water per day, take daily doses of Senokot S or Dulcolax, use milk of Magnesia no more than every third day for no bowel movement and notify your physician that you are experiencing this complication. People over the age of 60 are especially at risk for this complication.
  - C. Urinary retention. This means it is difficult to start your stream. Males over the age of 60 are especially at risk for this complication.
  - D. Itching. These drugs can cause itching in some patients.
  - E. Sweating. Profuse sweating can occur at any time with the use of these medications.
  - F. Nausea and vomiting. If this occurs, notify your physician.
  - G. Decreased sex drive.
  - H. Mild suppression of the immune response.

I understand these cautions and am willing to take the drugs as prescribed by my doctor.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



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# Spine Institute of Arizona

## AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTION

As a patient at the Spine Institute of Arizona, you may or may not be prescribed a controlled substance. If you are prescribed a controlled substance, we ask that you agree to our controlled substance protocol. If you will not accept our protocol, we cannot treat you and you will need to work with another physician.

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but they have high potential for misuse and are therefore closely controlled by the local state and federal government. They are intended to relieve pain, to improve function and/or ability to work, not simply to feel good. If I am prescribed such medication, I agree to the following:

1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from the Spine Institute of Arizona physicians.
3. Refills of controlled substance medication:
  - A. Will be made only during regular office hours Monday through Friday 9 am to 4 pm. Refills will not be made at night, on holidays, or weekends. I will call at least seventy-two (72) hours ahead for all prescription refill requests. Refill calls made on Friday will be filled the following week.
  - B. Will not be made if I "run out early." I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
  - C. Will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow."
4. If requested, I will bring in the containers of all medications prescribed by my physician, even if there is no medication remaining. These will be the original containers from the pharmacy for each medication.
5. Upon request from my physician, if narcotic abuse is suspected, I may be asked to submit to a urine drug screen. If I decline, it will be the sole discretion of the Spine Institute of Arizona to discontinue my narcotic pain medication.
6. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following my doctor's instructions regarding my health care.

Controlled substances are known to cause psychological dependence (addiction), which I understand is real. I know that some persons may develop a tolerance to medications in which my body does not respond as well to the medication, and I feel the need to have more or a higher dose of the medication. I know that I can become physically dependent on the medication. This will occur if I am on the medication several weeks, and when I stop the medication I must do so under medical supervision or I may have withdrawal symptoms.

**Effective April 26, 2018 all medical prescribers must comply with the 2018 Arizona Opioid Epidemic Act. This means that any medication that you are prescribed must meet the requirements of this new law. If you have been receiving medication from the Spine Institute of Arizona the quantity, dosage, or frequency of your prescription may be adjusted to meet these new requirements.**

I have read this agreement. I understand that if I do not follow the rules of this agreement, I will no longer be able to obtain medications from the Spine Institute of Arizona.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## **FINANCIAL STATEMENT**

It is the policy of the Spine Institute of Arizona to collect co-pays and any outstanding patient balances before each visit. If you cannot pay your co-pay and any outstanding balance your appointment will be rescheduled.

Our business office will bill your medical insurance for the services rendered in our office. Payment is not guaranteed by your insurance. You are ultimately responsible for all charges. The insurance process normally takes approximately 60-90 days. You will receive monthly financial statements to include any outstanding charges on your account. Once insurance has processed payment, your financial statement will reflect any deductibles and/or co-insurance due from you as per your insurance.

It is your responsibility to know and understand your insurance policy and benefits. We will bill secondary insurance as a courtesy.

Our providers are not contracted with any AHCCCS / Medicaid insurance programs. You will be responsible for outstanding balances.

If your insurance has lapsed, is inactive, or for any reason does not cover the expenses that you have incurred at the Spine Institute of Arizona, you will be responsible for the full charges that have been billed to your insurance company. Payment for these charges must be received within 30 days from receipt of your bill.

If you choose to pay by check and your check does not clear, you will be responsible for paying the bank administrative charge of \$25.00 plus the amount of your original check.

If we have had no response or contact from you within 60 days to pay off your balance, the Business Office will turn your account over to our collection agency. The collection agency will assess a 25% collection fee due in addition to your original balance.

### **SELF-PAY PATIENT POLICY:**

We do see patients on a self-pay basis. The charge for services will be collected prior to the service being rendered. Cash, debit card with VISA/MasterCard guarantee, or credit card payment is the only accepted form of payment for self-pay patients. Sorry, no personal checks are accepted.

### **INJECTIONS/SURGICAL PROCEDURE POLICY:**

**If you become a candidate for injections or surgery, it is our policy to collect any deductible or co-insurance that may be due in advance.** Cash, debit card with VISA/MasterCard guarantee, or credit card payment are the only accepted forms of pre-payment for these services. Sorry, no personal checks are accepted. Payment must be received no later than 48 hours prior to the injection or one (1) week prior to surgery or your procedure will be cancelled. To determine any financial responsibility to the facility, please contact the facility prior to your procedure.

### **DISABILITY / MEDICAL LEAVE FORM POLICY:**

If you need a disability / medical leave form filled out there will be a \$20.00 charge for each form. By signing this agreement, you understand that you will need to prepay the \$20.00 charge for this form to be completed and subsequently released.

Thank you for your understanding of our financial policies at the Spine Institute of Arizona. If you have any questions, please do not hesitate to give our Business Office a call at 602-953-9500.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# PATIENT REGISTRATION FORM

IF FORM IS NOT COMPLETE WE CANNOT BILL YOUR INSURANCE

ACCOUNT # \_\_\_\_\_

Billing Code: \_\_\_\_\_ Resp Dr. # \_\_\_\_\_  New Pt.  Update

PATIENT NAME: \_\_\_\_\_ RESPONSIBLE PARTY FOR MINOR: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT # \_\_\_\_\_ CITY, ST, ZIP: \_\_\_\_\_

HOME PH: \_\_\_\_\_ CELL / ALT PH: \_\_\_\_\_ EMAIL: \_\_\_\_\_ SEX:  Male  Female

PT. SS # \_\_\_\_\_ RESP PARTY SS #: \_\_\_\_\_ RELATIONSHIP TO PT:  Self  Spouse  Parent  Other

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

PRIMARY CARE PHYSICIAN & ADDRESS: \_\_\_\_\_

IF INJURY IS RELATED TO AN ACCIDENT, Was it an:  Auto Accident  Job Related Injury DATE OF INJURY: \_\_\_\_\_

IS PATIENT:  SINGLE  MARRIED  OTHER IS PATIENT:  EMPLOYED  STUDENT  RETIRED

PT. EMPLOYER NAME AND ADDRESS: \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_

PHONE / ADDRESS OF PERSON ABOVE: \_\_\_\_\_

WHAT ARE YOU BEING SEEN FOR: \_\_\_\_\_ FIRST DATE OF SYMPTOMS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ ARE YOU PREGNANT?  Yes  No

## INSURANCE INFORMATION:

INDUSTRIAL / WORKMAN'S COMPENSATION

PRIMARY INSURANCE  
INSURANCE CO. NAME: \_\_\_\_\_

SECONDARY INSURANCE:  
INSURANCE CO. NAME: \_\_\_\_\_

INS CO. ADDRESS: \_\_\_\_\_

INS CO. ADDRESS: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_

RELATIONSHIP TO PT: \_\_\_\_\_

RELATIONSHIP TO PT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

POLICY NO. \_\_\_\_\_ GROUP/CLAIM NO.: \_\_\_\_\_

POLICY NO. \_\_\_\_\_ GROUP/CLAIM NO.: \_\_\_\_\_

POLICY HOLDER SEX:  F  M BIRTHDATE: \_\_\_\_\_

POLICY HOLDER SEX:  F  M BIRTHDATE: \_\_\_\_\_

**AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION AND RECORDS:** I hereby authorize this physician/clinic to release and/or obtain any information required in the course of my examination or treatment. This includes sending records by fax machine. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I also authorize records to be mailed to me upon my verbal request.

**SIGNED** (patient or parent, if minor): \_\_\_\_\_ **DATE:** \_\_\_\_\_

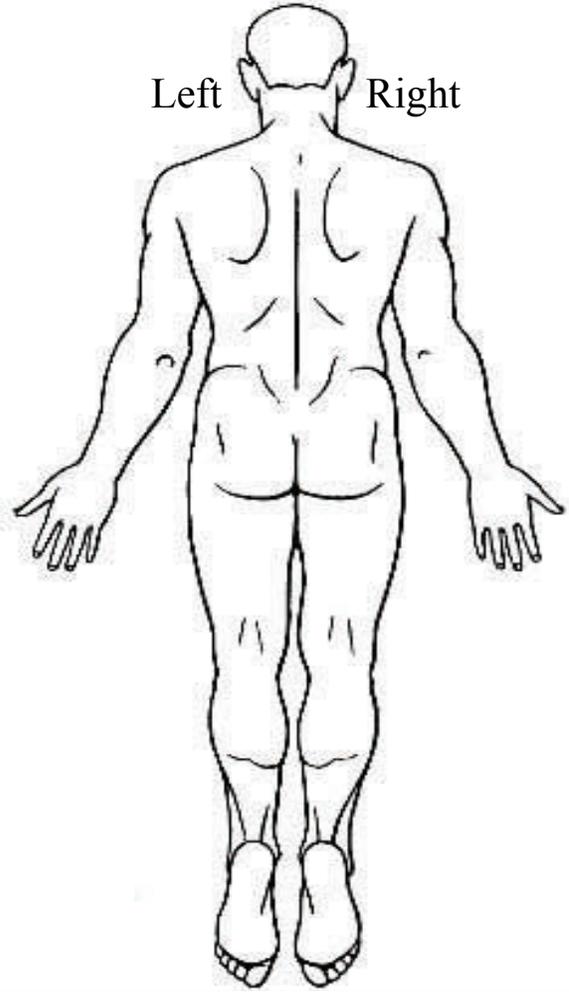
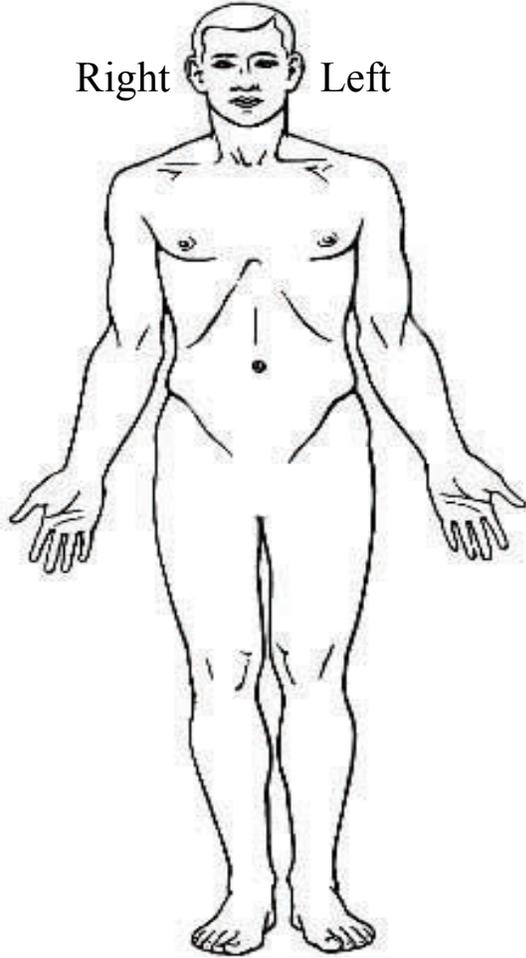
**AUTHORIZATION TO PAY:** I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered or paid by my insurance in a timely manner.

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

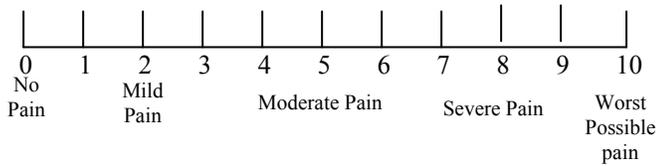
**AUTHORIZATION TO TREAT MINOR:** I hereby authorize the physician (s), physician assistants, technicians or other authorized medical personnel of Spine Institute of Arizona to treat the above patient.

**SIGNED** Patient (or Legal Guardian): \_\_\_\_\_ **DATE:** \_\_\_\_\_

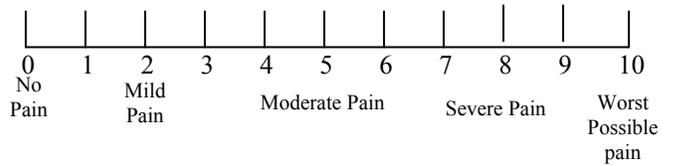
Please mark an "X" on the body part(s) where you have pain.  
Mark a "0" on the body parts where you have numbness.



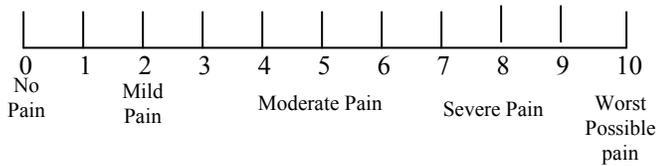
**NECK**



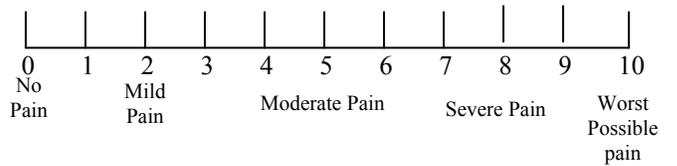
**BACK**



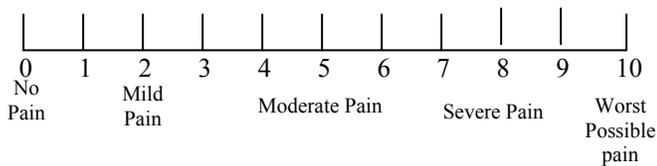
**RIGHT ARM**



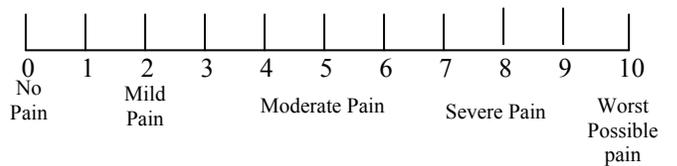
**RIGHT LEG**



**LEFT ARM**



**LEFT LEG**



# REVIEW OF SYMPTOMS

In the past month, have you experienced any of the following?

Please put a check mark in front of any/all of the following that you have experienced.

If you have experienced any of the symptoms, please be sure to notify your family doctor

## H.E.E.N.T.

- Blurred vision
- Dry Eyes
- Hard of hearing
- Nasal Congestion
- Sore Throat
- Cough
- Other \_\_\_\_\_

## INTEGUMENTARY

- Moles
- Skin Rash
- Other: \_\_\_\_\_

## GENERAL

- Fevers
- Chills
- Night Sweats
- Stress
- Poor sleep
- Swelling of feet
- Swollen glands
- Problems with blood clots
- Weight Loss
- Weight Gain
- Other \_\_\_\_\_

## NEUROLOGIC

- Tremors
- Other: \_\_\_\_\_

## PULMONARY

- Shortness of breath
- Other \_\_\_\_\_

## GASTROINTESTINAL

- Abdominal Pain
- Other

## ABDOMINAL

- Abdominal Pain
- Other \_\_\_\_\_

## CARDIOVASCULAR

- Chest Pain
- Other \_\_\_\_\_

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## WORK STATUS

- Full Time
- Regular Duty
- Other \_\_\_\_\_
- Restrictions: \_\_\_\_\_



# S PINE INSTITUTE of Arizona

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

This form must be filled out at each office visit.

We are required to have documentation of medications and allergies for each office visit; because of this we are unable to accept "no change" or "same as before" answers on this form.

Medications currently taking	Dosage	Frequency
------------------------------	--------	-----------

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

**Allergies:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

**Pharmacy:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

## PATIENT MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Reason you are being seen here:  Pain  Disability  Medication

Other: \_\_\_\_\_

Have you been seen here within the past 3 years?  YES  NO

Hand Dominance:  Left  Right

**PAST MEDICAL HISTORY:** (Please circle any/all of the following that you have experienced.)

- |                          |                   |                          |                                   |
|--------------------------|-------------------|--------------------------|-----------------------------------|
| AIDS                     | Depression        | Heart Attack/Angina      | Osteoporosis                      |
| Anemia                   | Diabetes          | Hepatitis C              | Peripheral Vascular Disease       |
| Anxiety Problem          | Diverticulosis    | High Blood Pressure      | Polio                             |
| Arthritis                | Ear Trouble       | HIV                      | Psychological/Psychiatric Problem |
| Asthma                   | Endometriosis     | Irregular Heart Beat     | Rheumatic Fever                   |
| Bipolar Disease          | Enlarged Prostate | Irritable Bowel Syndrome | Scoliosis                         |
| Cancer                   | Fibromyalgia      | Jaundice                 | Seizures                          |
| Colon Polyp              | Gastritis         | Kidney Disease           | Sexually Transmitted Disease      |
| Congestive Heart Failure | Glaucoma          | Kidney Stones            | Stroke                            |
| COPD/Emphysema           | Gout              | Liver Disease            | Thyroid Disease                   |
| Deep Venous Thrombosis   | Head Injury       | Lupus                    | Tuberculosis                      |
|                          |                   |                          | Ulcers                            |

Other Medical Problems: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Injuries:** Please list all fractures, injuries, and motor vehicles accidents.

Year Injured	Nature of Injury	Year Injured	Nature of Injury
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Hospitalizations/Surgeries:**

Year	Reason for Hospitalization/Surgery	Year	Reason for Hospitalization/Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please continue on the other side ♥

Have you ever had a blood transfusion?  YES  NO

**SOCIAL HISTORY:**

Do you smoke now?  NO  YES \_\_\_\_\_ packs/day \_\_\_\_\_ # of yrs.

Did you smoke in the past?  NO  YES \_\_\_\_\_ packs/day \_\_\_\_\_ # of yrs.

Do you drink alcohol?  NO  YES \_\_\_\_\_ number of drinks/wk.

Do you have a history of drug/alcohol abuse?  NO  YES

Your level of education:  Grade School  High School  Associate Degree  
 Bachelor Degree  Graduate School

**FAMILY HISTORY:**

Please check the box of any/all of the following problems that your blood relatives (e.g., parents, Brothers, sisters, grandparents, aunts, uncles, children), have had:

**Illness**

**Relative/Family Member (i.e., Mom, Grandfather)**

- Arthritis \_\_\_\_\_
- Back or Neck Surgery \_\_\_\_\_
- Back Pain/Sciatica \_\_\_\_\_
- Cancer \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Heart Attack/Heart Disease \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Mental Illness \_\_\_\_\_
- Muscle Disease \_\_\_\_\_
- Neck Pain \_\_\_\_\_
- Nerve Disease \_\_\_\_\_
- Stroke \_\_\_\_\_

Relation	Age	State Of Health/ Medical Problems	If Deceased, Cause Of Death	Age At Death
Father				
Mother				
Brothers and Sisters				
Spouse				
Children				

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

### JOB DESCRIPTION

Occupation: \_\_\_\_\_ Number of years at this job: \_\_\_\_\_

Are you currently working?  YES  NO If so...  Part-time  Full-time

Regular Duty  Modified Duty Working: \_\_\_\_\_ Hrs/Wk

What are your restrictions, if any? \_\_\_\_\_

Does your job require you to: (please check all that apply)

Lift or carry greater than 15 lbs.  Bend or twist repetitively.

Work overhead.  Repetitive motion of the arms or legs.

### HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

Date Problem/Symptoms Started: \_\_\_\_\_

Location of symptoms/pain when the problem started: \_\_\_\_\_

### HOW DID THE PROBLEM START?

Home/Leisure  At Work  Motor Vehicle Accident  Fall  Other: \_\_\_\_\_

Please briefly describe: \_\_\_\_\_

Location of symptoms/pain now: \_\_\_\_\_

Frequency of symptoms/pain: (please check one)

CONSTANT  INTERMITTENT  RARE

Since the onset of symptoms, has the problem: (please check one)

IMPROVED  WORSENER  STAYED THE SAME

Does coughing or sneezing cause any pain?  YES  NO

If so, where? \_\_\_\_\_

Do any of the following activities make your symptoms worse? (please check all that apply)

WALKING  LYING  BENDING/TWISTING  WORKING OVERHEAD

SITTING  KNEELING  LIFTING/CARRYING  OTHER: \_\_\_\_\_

STANDING  TYPING  PUSHING/PULLING

List anything (i.e. activities, positions, or treatments) that makes the pain better:

Do you have any weakness, if so, which arm, leg or muscle? \_\_\_\_\_

Have you had any new or recurrent problems with: Control of urination?  YES  NO

Bowel movements?  YES  NO

Have you experienced recent weight loss or fevers?  YES  NO

Please continue on the other side ➤

**HISTORY OF TREATMENT OF THIS PROBLEM**

**DIAGNOSTIC HISTORY**

<u>TEST</u>	<u>RECEIVED</u>	<u>DATE OF TEST/LOCATION</u>
X-ray	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
MRI Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
CT Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Bone Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
EMG	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

**MEDICATIONS**

**EXAMPLES**

**RECEIVED**

**DID THIS HELP?**

*(If yes, please circle the medication below.)*

<u>Anti-Inflammatories/ Cox-2 Inhibitors</u>	Naprosyn, Ibuprofen, Vioxx Voltaren, Celebrex, Bextra	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Muscle Relaxers</u>	Soma, Flexeril, Skelaxin, Zanaflex	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Pain Medication</u>	Tylenol w/ Codeine, Vicodin, Darvocet, Percocet	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Oral Steroid</u>	Prednisone, Medrol Dose Pak	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Neurontin, Zonegram, Paxil, Amitriptyline, Nortriptyline, Pamelor, Elavil, Prozac		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Other</u> <i>Please list:</i> _____		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

**TREATMENTS**

**RECEIVED**

**DID THIS HELP?**

Physical Therapy/ Exercise	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chiropractic Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Injections in Muscle or other injections in office	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epidural Steroid Injections	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Facet Blocks	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Braces/Corsets	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

**Back Surgery:**    Cervical    Thoracic    Lumbar      When: \_\_\_\_\_

Prior to the onset of your current problem, did you ever visit a health care provider for problems with your spine?    YES    NO    If yes, please list...

**PHYSICIAN NAME**

**MONTH/YEAR OF TREATMENT**

\_\_\_\_\_

\_\_\_\_\_

**LEGAL ADVICE**

Do you have an attorney regarding this injury/problem?    YES    NO

If yes, please list your attorney's name: \_\_\_\_\_

# C E R V I C A L

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Please read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE just circle the one which most closely describes your problem right now.**

## SECTION 1 – Pain Intensity

- A. I have no pain at the moment.
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

## SECTION 2 – Personal Care ( Washing, Dressing, etc.)

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

## SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very heavy weights.
- F. I cannot lift or carry anything at all.

## SECTION 4 – Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

## SECTION 5 – Headache

- A. I have no headaches at all.
- B. I have slight headaches which come frequently.
- C. I have moderate headaches which come in-frequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

## SECTION 6 – Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

## SECTION 7 – Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

## SECTION 8 – Driving

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my care at all because of severe pain in my neck.
- F. I cannot drive my car at all.

## SECTION 9 – Sleeping

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

## SECTION 10 - Recreation

- A. I am able to engage in all recreational activities with no pain in my neck at all.
- B. I am able to engage in all recreational activities with some pain in my neck.
- C. I am able to engage in most, but not all recreational activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.

**CERVICAL index score:** \_\_\_\_\_