

**NEW YORK SPINE & PAIN PHYSICIANS  
 NEW PATIENT QUESTIONNAIRE**

**\*\*Office use** Provider \_\_\_\_\_  
 Appt time \_\_\_\_\_ Entered \_\_\_\_\_  
 Ht \_\_\_\_\_ Wt \_\_\_\_\_  
 BP \_\_\_\_\_

**DEMOGRAPHICS-** *To be completed by all patients*

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
                     ☐ Preferred                      ☐ Preferred                      ☐ Preferred  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Gender: ☐ Male ☐ Female Preferred Language: \_\_\_\_\_  
 Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to Report  
 Race: ☐ American Indian, Alaska Native ☐ Asian ☐ Native Hawaiian  
       ☐ African American ☐ White  
       ☐ Other Pacific Islander ☐ Other Race ☐ Refuse to Report  
 \*Email Address: \_\_\_\_\_

**HEALTH INSURANCE COVERAGE-** *To be completed by all patients. (In the case of Workers' Compensation or No Fault, this information will only be used if coverage is denied).*

Health Insurance Company Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security #: \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_ Group #: \_\_\_\_\_  
 ID #: \_\_\_\_\_ Medicare ID #: \_\_\_\_\_  
 Do you have secondary insurance? ☐ Yes ☐ No Carrier Name: \_\_\_\_\_ ID#: \_\_\_\_\_  
 My Visit is NOT related to an accident (*Please Initial*): \_\_\_\_\_

**NO FAULT/LIABILITY-** *Please complete this section if your illness/injury is the result of an accident (auto or otherwise- but NOT related).*

Insurance Company Name: \_\_\_\_\_ Date of Accident: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_ Claims Adjuster: \_\_\_\_\_  
 Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Location of Accident (State): \_\_\_\_\_

**WORKERS' COMPENSATION-** *Please complete this section if your illness/injury is work related.*

Insurance Company Name: \_\_\_\_\_ Date of Accident: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Claim #: \_\_\_\_\_ Claims Adjuster: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
 WCB Case #: \_\_\_\_\_ Employer at the time of the accident: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
 Patient's usual work activities on date of illness/injury?  
 \_\_\_\_\_

**DISABILITY-** *To be completed by all patients*

Are you, or have you been disabled? ☐ YES ☐ NO Date: \_\_\_\_\_

Are you out of work? ☐ YES ☐ NO

Are you partially or totally disabled? \_\_\_\_\_

Name of physician who placed you on disability: \_\_\_\_\_

Are you receiving disability payments? ☐ YES ☐ NO If yes, for how long? \_\_\_\_\_

Are you currently involved in a lawsuit? ☐ YES ☐ NO If yes, please explain below:

Attorney Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**EMPLOYMENT-** *To be completed by all patients.*

Are You Currently Employed: YES- FULL TIME YES- PART-TIME ☐ NO ☐ RETIRED

Patient's Employer: ☐ \_\_\_\_\_ ☐ \_\_\_\_\_ Employer Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Patient's Employer's Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

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**PHYSICIANS-** *Please list all of your providers. If you do not have a particular physician, enter N/A.*

Primary Care Provider: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Referring Provider: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Cardiologist: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Neurologist: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Pulmonologist: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Endocrinologist: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Other: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

➤ **AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON**

It is often difficult to reach a patient to discuss appointments, medications, and other information that is pertinent to our patients' care. In this event, we would discuss such information with the person whom you sign authorization and designate below. Please complete the following section:

I hereby authorize New York Spine & Pain Physician to discuss any information required in the course of my examination or treatment when I cannot be reached by phone to the following designated person(s):

Name of Designee: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Name of Designee: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

This individual will be considered your emergency contact.

☐ None

I agree to all of the above information.

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

\_\_\_\_\_  
Date

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➤ **HIPAA ACKNOWLEDGEMENT-**

THE PURPOSE OF THIS DOCUMENT IS TO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE "HIPAA PRIVACY ACT" FROM THIS OFFICE. I AM AWARE THAT IF I HAVE ANY QUESTIONS REGARDING THIS I CAN CONTACT THE OFFICE MANAGER.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

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➤ **MEDICAL INFORMATION RELEASE-**

I, \_\_\_\_\_ GIVE NEW YORK SPINE & PAIN PHYSICIANS PERMISSION TO OBTAIN MY PAST MEDICAL HISTORY FROM MY REFERRING PHYSICIAN OR PRIMARY CARE PHYSICIAN.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

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➤ I hereby authorize payment directly to New York Spine & Pain Physicians for services rendered to me and paid by my carrier. I understand that if my insurance carrier does not make payment for these charges I am financially responsible for the charges for services rendered.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE



Our goal is to provide and maintain a positive physician-patient relationship. Providing you with our financial policy in advance allows for a good flow of communication and enables us to operate efficiently. To prevent misunderstanding between patients and our practice, New York Spine Physicians (the 'Practice') adheres to the following patient financial policy. Your complete understanding of your financial responsibilities is an essential element of the physician- patient relationship and continued medical management. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

- The Practice must collect copays at the time of service and is required to report to the carrier any enrollees failing to pay the co-pay. For your convenience we accept cash, personal check, credit cards (Visa, MasterCard or Discover), and money orders. The Practice is required to collect these based on your benefit contract and the Practice's contractual agreement with your insurance carrier.
- It is your responsibility to provide the Practice with current, accurate insurance information at the time of check in and to notify the Practice of any changes in this information. A valid insurance card(s) and picture ID must be presented at the time of service
- It is the patient's responsibility to obtain insurance carrier coverage limitations.
- If the Practice does not participate with your insurance, you are expected to pay in full for our services at the time of visit. The Practice may provide assistance in filing the charges to your insurance company; however payment is expected up front.
- If you do not have medical insurance, payment for services is required at the time of the visit.
- It is the patient's responsibility to ensure that an authorization and/or referral is obtained prior to your appointment if required by your insurance.
- Patients are billed for any patient responsibility (co-insurance /deductibles/non-covered services) as determined on the Explanation of Benefits (EOB) from your carrier. Patients will receive two (2) statements for any patient balance due after insurance payment. Patients that have not made payment prior to the second statement being mailed are placed in a collection status. Patients with a delinquent balance may be sent to an outside collection service.
- Patients will receive a separate bill from third party laboratories for processing of any laboratory services. Questions about these bills should be directed to the respective lab.
- The Practice does not accept post-dated checks. Checks written to the Practice that are canceled or returned for non-sufficient funds results are assessed a \$35.00 fee. To rectify your account, you will be required to pay with cash, money order, cashier's check, or credit card.
- Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.
- We request that **you please give our office 24 hour notice in the event that you are unable to keep your appointment.** This courtesy allows us to be of service to other patients. **Failure to comply with this policy will result in a \$25 fee for office visits and \$100 fee for procedures.**
- Please be advised that **failure to request medications within four (4) business days before your medication runs out will result in a \$15 fee to cover the cost of processing the refill request prior to your next scheduled appointment.**

I agree to provide information regarding health insurance, workers' compensation, automobile, and other health care benefits which the patient may be entitled. Patient assigns payment(s), if any, from insurance carriers(s)/health benefit(s) plan to New York Spine & Pain Physicians for services rendered. The direct payment assigned and authorized includes any medical insurance benefits entitled, including any Major Medical benefits otherwise payable to patient under the terms of the policy, but not to exceed the balance due for services rendered.

I understand that if my insurance company or health maintenance organization does not consider the services received as covered or has not authorized the services, then I will be fully responsible for the service provided

Our practice believes that a good provider-patient relationship is based upon effective communications. If you have any questions, please feel welcome to call 914-873-8313.

**By signing below I certify that I have read and understand the Patient Billing Policy, have had the opportunity to ask questions and have them answered and accept the above conditions and terms. I further certify that I am the patient or guardian, duly authorized representative, parent or other family member of the patient.**

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed by Practice Representative

\_\_\_\_\_  
Date



**In addition to the enclosed paperwork, please bring the following with you to your appointment:**

Babylon  
500 West Main Street Suite 116  
Babylon, NY 11702

Babylon Village  
100 West Main Street Suite C  
Babylon Village, NY 11702

Bay Shore  
8 Saxon Avenue  
Suite E  
Bay Shore, NY 11706

Westchester  
550 Mamaroneck Ave Suite  
503 Harrison, NY 10528

- ✓ A picture ID
- ✓ Insurance cards
- ✓ Your co-pay (if required by your insurance)
- ✓ Your referral (if required by your insurance)
- ✓ Any report, film, or disc of radiology relating to your pain and treatment
- ✓ Any medical records relating to your pain and treatment
- ✓ A list of medications you are currently taking or their medication bottles

## PAIN COMPREHENSIVE QUESTIONNAIRE

\*Office use \* Provider \_\_\_\_\_

Appt time \_\_\_\_\_ Entered \_\_\_\_\_

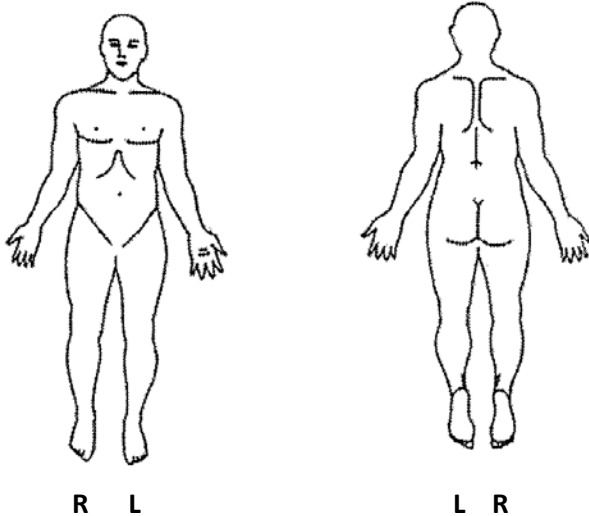
Vitals \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physicians \_\_\_\_\_

Chief Complaint (main problem seeking treatment) \_\_\_\_\_ Side ☐ right ☐ left

On the Diagram, shade in or circle the area where you feel pain:



The onset of your pain was:

- ☐ Motor vehicle accident  
Date of Accident \_\_\_\_\_  
Were you wearing a seatbelt: ☐ Yes ☐ No  
Position during the accident:  
☐ Driver ☐ Passenger in front seat ☐ Passenger in back seat
- ☐ Falling from a height
- ☐ Injury at work  
Date of injury \_\_\_\_\_  
What injury occurred? \_\_\_\_\_

☐ Insidious onset ☐ Lifting an object ☐ Playing a sport ☐ Slipping and falling ☐ Trauma ☐ Tripping/uneven surface

Your pain occurs: ☐ Constantly ☐ Intermittent ☐ Worse after activity ☐ Worse at the end of the day ☐ Worse during activity ☐ Worse during cold seasons ☐ Worse during the day ☐ Worse during the night ☐ Worse in the morning

Describe your pain: ☐ aching ☐ burning ☐ cramp-like ☐ dull ☐ in a glove distribution ☐ in a stocking distribution  
☐ pins & needles-like ☐ sharp ☐ shooting ☐ stabbing

Your pain has been occurring for: \_\_\_\_\_ ☐ days ☐ weeks ☐ months ☐ years

Preferred Pharmacy Name/Address:

Preferred Pharmacy Phone:

Are you pregnant or possibly pregnant?

☐ Yes ☐ No ☐ N/A

---- (0 = no pain 10 = unbearable pain) ----

Pain level today

0 1 2 3 4 5 6 7 8 9 10

Over the last 4 weeks, please identify your pain levels below:

Severe pain level (on a bad day)

0 1 2 3 4 5 6 7 8 9 10

Average pain level (on an average day)

0 1 2 3 4 5 6 7 8 9 10

Allergies \_\_\_\_\_

Email \_\_\_\_\_

Symptoms	Associated with your pain	Symptoms	Associated with your pain
Arm numbness		Insomnia	
Awakens you from sleep		Leg numbness	
Changes in bladder function		Perineal numbness	
Changes in bowel function		Sexual Dysfunction	
Changes in temperature in the affected area		Shoulder numbness	
Depression		Suicidal ideation	
Finger numbness		Sweating in affected area	
Flushing in affected area		Toe numbness	
Hand numbness		Hand numbness	

## PAIN COMPREHENSIVE QUESTIONNAIRE

**What activities aggravate/relieve your symptoms?**

ACTIVITIES	AGGRAVATES YOUR PAIN	RELIEVES YOUR PAIN
All Movements		
Bending Forward		
Exercise		
Lifting Objects		
Lying Flat		
Rest		
Rotating the neck		
Sitting		
Standing for long periods		
Walking long distances		

**What treatments have you used to treat the symptoms?**

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF																																													
ACTIVITY MODIFICATION																																																
ACUPUNCTURE																																																
BRACE																																																
What type of Brace?	<input type="checkbox"/> Back Brace <input type="checkbox"/> Neck Brace <input type="checkbox"/> Cervical traction <input type="checkbox"/> TENS unit <input type="checkbox"/> Ankle Brace (R or L) <input type="checkbox"/> Wrist Brace (R or L) <input type="checkbox"/> Knee Brace (R or L)																																															
How long have you had the product?																																																
Are you obtaining relief?																																																
Are your products in good condition?																																																
CHIROPRACTIC MANIPULATION																																																
HEAT TREATMENT																																																
ICE TREATMENT																																																
PHYSICAL THERAPY																																																
PILATES																																																
WEIGHT REDUCTION																																																
YOGA																																																
MEDICATIONS	<b>Check mark all medication that apply below</b>																																															
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## PAIN COMPREHESIVE QUESTIONNAIRE

**Do you have any adverse effects since starting any treatment?**

☐ Constipation   ☐ Drowsiness   ☐ Mental slowness   ☐ Other

**What procedures have you had to treat the pain?**

PROCEDURE	Mark if applicable
No Procedure	
Epidural Steroid Injection	
Facet Joint Injection	
Medial Branch Block Trial	
Peripheral Nerve Injection	
Rhizotomy	
Fusion, anterior	
Fusion, posterior	
Fusion, combined anterior and posterior	
Laminectomy	
Microdiscectomy	
Other	

**What imaging studies have you had for the pain?**

- ☐ Bone scan  
☐ CT Scan  
☐ EMG  
☐ MRI  
☐ Radiographs

**How has the pain limited you?** (check mark all that apply)

Activities	Limit Pain	Activities	Limit Pain
No limitations		Inability to attend school	
Attending school on a limited basis		Inability to perform daily activities (ADL's)	
Difficulty getting up from chair		Inability to work	
Difficulty sitting		Requiring constant assistance	
Difficulty standing		Requiring occasional assistance	
Difficulty walking		Working on a limited basis	
Difficulty with daily activities (ADL's)		Working light duty	
Difficulty with recreational sports		Other	
Functional limitations			

**Who have you seen for this problem?**   ☐ Chiropractor   ☐ Emergency Room   ☐ General Surgeon   ☐ Internist

☐ Orthopedic Doctor   ☐ Pediatrician   ☐ Primary care   ☐ Therapist   ☐ Trainer   ☐ Urgent Care Center   ☐ Walk in clinic

## INTAKE AND HISTORIES

### Past Medical History (please check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia, Chronic             | <input type="checkbox"/> Diabetes, Non-Insulin Dependent | <input type="checkbox"/> Lymphoma          |
| <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> End Stage Renal Disease         | <input type="checkbox"/> Multiple Myeloma  |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> GERD                            | <input type="checkbox"/> Obesity, Morbid   |
| <input type="checkbox"/> Atrial fibrillation         | <input type="checkbox"/> Hepatitis                       | <input type="checkbox"/> Obesity           |
| <input type="checkbox"/> Bipolar Disorder            | <input type="checkbox"/> HIV/AIDS                        | <input type="checkbox"/> PBPH              |
| <input type="checkbox"/> Breast Cancer               | <input type="checkbox"/> High Cholesterol                | <input type="checkbox"/> Prostate Cancer   |
| <input type="checkbox"/> Chronic Pain                | <input type="checkbox"/> Hyperparathyroidism             | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Colon Cancer                | <input type="checkbox"/> Hypertension                    | <input type="checkbox"/> Fibromyalgia      |
| <input type="checkbox"/> COPD                        | <input type="checkbox"/> Hyperthyroidism                 | <input type="checkbox"/> Sleep Apnea       |
| <input type="checkbox"/> Coronary Artery Disease     | <input type="checkbox"/> Hypothyroidism                  | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Deep Venous Thrombosis      | <input type="checkbox"/> Leukemia                        | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Lung Cancer                     | <input type="checkbox"/> <b>None</b>       |
| <input type="checkbox"/> Diabetes, Insulin Dependent |  | <input type="checkbox"/> Other _____       |

### Past Surgical History (please check all that apply):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Appendix (Appendectomy)  | <input type="checkbox"/> Heart Transplant                    | <input type="checkbox"/> Rectum: Low Anterior Resection |
| <input type="checkbox"/> Bladder Removed  | <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Skin: Basal Cell Carcinoma     |
| <input type="checkbox"/> Breast: Mastectomy<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Heart: PTCA                         | <input type="checkbox"/> Skin: Melanoma                 |
| <input type="checkbox"/> Breast: Lumpectomy<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Kidney Stone Removal                | <input type="checkbox"/> Skin: Skin Biopsy              |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection  | <input type="checkbox"/> Kidney Transplant                   | <input type="checkbox"/> Skin: Squamous Cell Carcinoma  |
| <input type="checkbox"/> Colectomy: Diverticulitis  | <input type="checkbox"/> Liver: Liver Transplant             | <input type="checkbox"/> Tonsillectomy                  |
| <input type="checkbox"/> Colectomy: IBD   | <input type="checkbox"/> Liver: Shunt                        | <input type="checkbox"/> Hysterectomy: Caesarean        |
| <input type="checkbox"/> Colon: Colostomy   | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer     | <input type="checkbox"/> Hysterectomy: Uterine Cancer   |
| <input type="checkbox"/> Gallbladder Removal  | <input type="checkbox"/> Ovaries: Tubal Ligation             | <input type="checkbox"/> Hysterectomy: Cervical Cancer  |
| <input type="checkbox"/> Heart: Biological Valve Replacement  | <input type="checkbox"/> Pancreas: Pancreatectomy            | <input type="checkbox"/> <b>None</b>                    |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery  | <input type="checkbox"/> Prostate Removed: Prostate Cancer   | <input type="checkbox"/> Other _____                    |
|   | <input type="checkbox"/> Prostate Removed: TURP              |   |
|   | <input type="checkbox"/> Rectum: APR                         |   |

## INTAKE AND HISTORIES

### Interventional Pain History (please check all that apply):

- |   |                                      |                                   |                                   |
|---|--------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Epidural Injection(s)-             | <input type="checkbox"/> Lumbar      | <input type="checkbox"/> Thoracic | <input type="checkbox"/> Cervical |
| <input type="checkbox"/> Facet Injection(s)-                | <input type="checkbox"/> Lumbar      | <input type="checkbox"/> Thoracic | <input type="checkbox"/> Cervical |
| <input type="checkbox"/> Medial Branch Block- Injection(s)- | <input type="checkbox"/> Lumbar      | <input type="checkbox"/> Thoracic | <input type="checkbox"/> Cervical |
| <input type="checkbox"/> Rhizotomy-                         | <input type="checkbox"/> Lumbar      | <input type="checkbox"/> Thoracic | <input type="checkbox"/> Cervical |
| <input type="checkbox"/> Intrathecal Pump                   | <input type="checkbox"/> <b>None</b> |                                   |                                   |
| <input type="checkbox"/> Spinal Cord Stimulator             | <input type="checkbox"/> Other _____ |                                   |                                   |

### Musculoskeletal History (please check all that apply):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Ankle Fracture             | <input type="checkbox"/> HNP, Lumbar             | <input type="checkbox"/> Scoliosis                 |
| <input type="checkbox"/> Ankylosing Spondylitis     | <input type="checkbox"/> Metastatic Bone Disease | <input type="checkbox"/> Shoulder Impingement      |
| <input type="checkbox"/> Adhesive Capsulitis        | <input type="checkbox"/> Osteoarthritis          | <input type="checkbox"/> Spine Fracture            |
| <input type="checkbox"/> Bursitis                   | <input type="checkbox"/> Osteopenia              | <input type="checkbox"/> Soft Tissue Sarcoma       |
| <input type="checkbox"/> Carpal Tunnel Syndrome     | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Spinal Stenosis, Cervical |
| <input type="checkbox"/> Chronic Low Back Pain      | <input type="checkbox"/> Polio                   | <input type="checkbox"/> Spinal Stenosis, Lumbar   |
| <input type="checkbox"/> DISH                       | <input type="checkbox"/> Primary Bone Sarcoma    | <input type="checkbox"/> Vertebral Body            |
| <input type="checkbox"/> Epidural Injections, Spine | <input type="checkbox"/> Psoriatic Arthritis     | <input type="checkbox"/> Compression Fracture      |
| <input type="checkbox"/> Fracture                   | <input type="checkbox"/> Rheumatoid Arthritis    | <input type="checkbox"/> Vitamin D Deficiency      |
| <input type="checkbox"/> Gout                       | <input type="checkbox"/> Ricketts                | <input type="checkbox"/> Wrist Fracture            |
| <input type="checkbox"/> Hip Fracture               | <input type="checkbox"/> RSD                     | <input type="checkbox"/> <b>None</b>               |
| <input type="checkbox"/> HNP, Cervical              | <input type="checkbox"/> Sciatica                | <input type="checkbox"/> Other _____               |

### Musculoskeletal Surgery (please check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Achilles Tendon Repair  | <input type="checkbox"/> Intramedullary Nailing Tibia                                      | <input type="checkbox"/> Lumbar Spine Surgery: Disc Replacement                            |
| <input type="checkbox"/> ACL Reconstruction  | <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Meniscus Repair   |
| <input type="checkbox"/> Ankle Fracture ORIF   | <input type="checkbox"/> Joint Replacement: Hip  | <input type="checkbox"/> Reverse Total Shoulder Replacement                                |
| <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Revision of Total Hip Arthroplasty                                |
| <input type="checkbox"/> Bunion Correction   | <input type="checkbox"/> Joint Replacement: Knee   | <input type="checkbox"/> Revision of Total Knee Arthroplasty                               |
| <input type="checkbox"/> Carpal Tunnel Decompression                                       | <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Revision of Total Shoulder Arthroplasty                           |
| <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Joint Replacement: Shoulder                                       | <input type="checkbox"/> Rotator Cuff Repair   |
| <input type="checkbox"/> Cervical Spine Surgery: ACDF                                      | <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Cervical Spine Surgery: Disc Replacement                          | <input type="checkbox"/> Knee Arthroscopy  | <input type="checkbox"/> Shoulder Arthroscopy  |
| <input type="checkbox"/> CMC Arthroplasty  | <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> <b>None</b>   |
| <input type="checkbox"/> Distal Radius ORIF  | <input type="checkbox"/> Kyphoplasty/Vertebroplasty  | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Lumbar Fusion   |  |
| <input type="checkbox"/> Ganglion Cyst Excision  | <input type="checkbox"/> Lumbar Laminectomy  |  |
| <input type="checkbox"/> Intramedullary Nailing Femur                                      | <input type="checkbox"/> Lumbar Spine Surgery: Decompression                               |  |
| <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Lumbar Spine Surgery: Decompression & Fusion                      |  |

## INTAKE AND HISTORIES

**Medications** (please list all current medications or check option, which applies):

- Complete the information below regarding all medications you are currently taking, have discontinued, or modified.
- Be certain to list both prescription and non-prescription medication, including any herbals or supplements you take.
- ☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
- ☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

**Allergies** (please list all known allergies or check option, which applies):

- ☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
- ☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

## INTAKE AND HISTORIES

### Social History (please check all that apply):

#### Cigarette Smoking

- ☐ Never Smoked  
☐ Quit: former smoker  
☐ Smokes less than daily  
☐ Smokes daily  
     ○ # packs per day \_\_\_\_\_

#### Alcohol Use

- ☐ Do not drink alcohol  
☐ Less than 1 drink a day  
☐ 1-2 drinks a day  
☐ 3 or more drinks a day

#### Exercise Frequency

- ☐ Several times a day  
☐ Once a day  
☐ Few times a week  
☐ Few times a month  
☐ Never  
☐ Other \_\_\_\_\_

#### Drug Use

- ☐ Drug Use  
☐ IV Drug Use  
     ○ \_\_\_\_\_

### Family History:

Please check appropriate box "Alive" or "Deceased" and list ages for the following Blood Family Members. If Parents or Grandparents are deceased, please write in Age and Cause of Death, if known.

	Alive	Age (if known)	Deceased	Age at Death	If deceased, cause of death	Unknown Status
Father						
Mother						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

	Number Alive	Age (if known)	Number Deceased	Age at Death	If deceased, cause of death	Unknown Status
Brothers						
Sisters						
Sons						
Daughters						

## INTAKE AND HISTORIES

### Family History (continued):

Please mark YES or NO if a Blood Family Member has ever had any of these conditions. If you mark YES, please mark the box under the relationship of the person to you

	Relationship of Person to you							
	YES	NO	DO NOT KNOW	Father	Mother	Grandparent	Brother /Sister	Son/ Daughter
Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Stroke/TIA								
Alcohol Abuse								
Drug Abuse								
Psychiatric Illness								
Seizures								
Depression/Suicide								
Osteoarthritis								
Osteoporosis								
Scoliosis								
Other Conditions								

## INTAKE AND HISTORIES

**Review of Systems\*** (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	Symptom	Yes	No
Joint pains			Wheezing		
Joint swelling			Pain w/ breathing		
Difficulty Walking			Palpitations		
Muscle Pain			Ankle Swelling		
Pain Radiating down to leg(s)			Labored breathing w/exertion		
Weakness			Nausea/ Vomiting		
Numbness			Diarrhea		
Tingling			Constipation		
Fever			Heartburn		
Weight Gain			Ulcers		
Rash			Blood in Stool		
Chest Pain			Urinary Incontinence		
Incontinence			Urinary hesitancy		
Shortness of Breath			Urinary retention		
Suicidal thoughts			Blood in urine		
Weight loss			Genital pain		
Chills			Excessive bruising		
Fatigue			Excessive bleeding		
Discoloration			Cancer		
Scarring			Excessive thirst		
Environmental Allergies			Heat/Cold intolerance		
Immunosuppression			Diabetes		
HIV/AIDS			Thyroid Disease		
Blurred Vision			Joint Stiffness		
Double Vision			Dizziness		
Glaucoma			Fainting		
Eye pain			Headaches		
Ringing in the Ears			Tremor		
Loss of hearing			Seizure		
Nose bleeds			Memory Loss		
Hoarseness			Depression		
Difficulty Swallowing			Anxiety		
Cough			Hallucinations		

**Other Medical Conditions\*** (check yes or no for the following):

\*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Symptom	Yes	No	Symptom	Yes	No
Blood Thinners			Rheumatoid Arthritis		
Pacemaker			Hepatitis B or C		
Defibrillator			Pregnancy or planning a pregnancy		
Premedicate Prior to Procedure			HIV/ADS		
Hepatitis B or C			Diabetes		

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

DOB \_\_\_\_\_ Date \_\_\_\_\_

Email \_\_\_\_\_

NSPC is dedicated to providing comprehensive care to patients and following the federal guidelines regarding important public health issues. Please answer the following questions.

### SECTION 1: TOBACCO USE

Please select the option that best describes your current tobacco use.

<input type="checkbox"/> Current every day smoker	<input type="checkbox"/> Current some day smoker (tobacco)	<input type="checkbox"/> Current some day smoker (cigarette)	<input type="checkbox"/> Former smoker	<input type="checkbox"/> Never smoker
---	--	--	--	---------------------------------------

### SECTION 2: OPIOID RISK TOOL

Do you have a family history of substance abuse?	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illegal Drugs <input type="checkbox"/> Prescription Drugs
Do you have a personal history of substance abuse?	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illegal Drugs <input type="checkbox"/> Prescription Drugs
Are you between 16 and 45 years of age?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a history of preadolescent sexual abuse?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you been diagnosed with any of the following?	<input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Bipolar <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Depression

### SECTION 3: BMI

*Office Use Only*

What is your height? \_\_\_\_\_ feet \_\_\_\_\_ inches

Weight: \_\_\_\_\_ lbs.

### SECTION 4: ADVANCE DIRECTIVE

*This section is for patients aged 65 years or older.*

Do you have a health care proxy in the event you are unable to make your own medical decisions?  
 Provide name, phone number, and relationship. If none assigned, leave blank.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_