PATIENT INFORMATION

Account#_____
FOR OFFICE USE ONLY

THE SPINE CENTER

Have you been a patient here before? ☐ Yes ☐ No

Which doctor are you here to see? _____

Patient Name: _____
First MI Last

Mailing Address: _____
Street Apt.

_____
City State Zip

_____
Home Phone Cell/Alternate Phone

Age: _____ Date of Birth: _____ Social Security #: _____ Gender: ☐ F ☐ M

Email: _____ Would you like our FREE *Doctor's Orders e-newsletter?* ☐ Y ☐ N

Marital Status: *(Choose One)* ☐Married ☐Single ☐Divorced ☐Widowed Spouse's Name:_____

Employer:_____

Race Choices: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Type-Unknown ☐ White

Ethnicity Choices: ☐ Hispanic Origin ☐ Non-Hispanic ☐ Type-Unknown

Language: _____

Student: Parent(s) or Legal Guardian(s) Name: _____

Address (if different from primary): _____
Street Apt.

_____
City State Zip

_____
Home Phone Cell/Alternate Phone

Emergency Contact Name: _____
Need different address Relationship to Patient Home Phone Cell/Alternate Phone

Medical Insurance Information:

1. **Will you be filing today's visit through your personal health insurance?** **If so, present card to front desk.**
2. **Is this a job related injury?** **If so, complete section II.**
3. **Is your visit today part of a legal, disability or liability related issue?** **If so, complete section III.**

I. REFERRED BY:

Name: _____ Primary Dr.? ☐ YES ☐ NO

Other: Please explain: _____

II. Workmen's Compensation Claims: (Please complete if your visit is the result of a work related injury.)

DATE OF INJURY/ACCIDENT : _____ **DID YOU REPORT THIS TO YOUR EMPLOYER?** ☐ **YES** ☐ **NO**

_____
Employer Work Compensation Contact Person Contact's Phone

_____
Employer Address City State Zip Code

_____
Work Compensation Carrier Phone Claim Number Adjuster

III. Legal/disability/Liability Claims: (Please complete if your visit is the result of legal, disability or liability issue.)

DATE OF INJURY/ACCIDENT :_____

_____
Law Office/Disability/Liability Office Name Lawyer's/Agent's Name Phone

_____
Address City State Zip Code

I agree that The Spine Center of Louisiana may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

I Hereby Authorize The Spine Center of Louisiana to release any medical information and/or medical records maintained at this clinic as needed to my insurance company, to the social security administration or carriers, to my attorney as listed above, or to the attorney responsible for the payment for medical services or evaluation to be provided. I permit a copy of this authorization to be used in place of the original. I hereby assign to the facility listed above all Insurance Company or Medicare reimbursements for medical and/or surgical expenses. Regulations pertaining to Medicare assignment of benefits apply. I have been given a copy of the Notice of Private Practices of The Spine Center of Louisiana.

_____ _____
Date Signature (Patient or Responsible Party)

_____ _____
Name of Person Completing Form Relationship to Patient

MEDICAL HISTORY FORM

PATIENT NAME: First _____ MI _____ Last _____

Age: _____ Height: _____ Weight: _____ Date of Birth: _____

Gender: ☐ Female ☐ Male I am: ☐ Left Hand Dominant ☐ Right Hand Dominant

Primary Care Physician: _____

WHO RECOMMENDED YOU TO SEE US:

Name: _____ Primary Dr.? ☐ Yes ☐ No

If other, please explain: _____

CHIEF COMPLAINT: Why are you here? _____

_____

Date of Injury or Onset of Symptoms: _____ **Body Part to be Examined:** _____ ☐ **Left** ☐ **Right**

(Check all that apply)

Main Problem: ☐ pain ☐ numbness ☐ weakness ☐ stiffness ☐ unstable ☐ swelling ☐ popping/grinding ☐ other: _____

Where complaint/injury occurred: ☐ work ☐ at home ☐ sports/recreational ☐ car accident ☐ at school ☐ other: _____

How complaint/injury occurred: ☐ gradual ☐ onset ☐ sudden/traumatic ☐ unknown ☐ other: _____

Severity of Pain: ☐ mild ☐ moderate ☐ severe ☐ extremely severe

Quality of Pain: ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning

PREVIOUS AND/OR CURRENT TREATMENTS FOR THIS CONDITION: *(Check all that apply)* ☐ **None**

X-rays/Tests: ☐ Regular x-rays ☐ MRI scan ☐ CAT scan ☐ Myelogram ☐ Nerve tests (EMG, NCV) ☐ Other: _____ Did you bring your X-rays with you? _____

Medications: ☐ Anti-inflammatories ☐ Muscle relaxants ☐ Pain medication ☐ Other: _____

Therapies: ☐ Physical therapy ☐ Chiropractic care ☐ Injections ☐ Other: _____

ARE YOU PREGNANT? ☐ **YES** ☐ **NO**

GENERAL MEDICAL HISTORY:

Are you affected by any of the following? *(Check all that apply)* ☐ **No medical problems**

☐ Abnormal heart rhythm ☐ Bleeding disorders ☐ Depression ☐ Heart attack ☐ High blood pressure ☐ Lung Problems
☐ Sleep apnea ☐ Acid Reflux ☐ Blood clots ☐ Diabetes ☐ Heart failure ☐ HIV
☐ Osteoporosis ☐ Stomach ulcers ☐ Asthma ☐ Cancer ☐ Gout ☐ Hepatitis
☐ Kidney problems ☐ Rheumatoid arthritis ☐ Stroke

If you checked any of the above, please explain: _____

SOCIAL HISTORY: *(Check all that apply)*

A. Occupation: _____

B. Are you on: ☐ Full Duty ☐ Light Duty (since: _____) ☐ Disabled (since: _____)

C. Do you use tobacco products? ☐ no ☐ less than 1 pack ☐ 1 pack ☐ more than 1 pack

D. Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown ☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked

E. Do you use alcohol? ☐ no ☐ occasionally ☐ daily

F. What is your living status? ☐ alone ☐ with spouse ☐ with parents ☐ with roommate ☐ assisted living/nursing home

PREVIOUS SURGERIES: ☐ **None**
Please list the type and date the surgery was performed.

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

Have you ever had a problem with a general anesthetic? *(Check one)* ☐ Yes, explain below ☐ No
If yes, describe any problems:_____

CURRENT MEDICATION: ☐ **None**
Pharmacy Preference and Phone #:_____
Please list any prescriptions, drugs, and/or non-prescription medications, including vitamins, nutritional supplements, or anything taken orally.

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

ALLERGIES: Do you have any known drug allergies? *(Check one)* ☐ Yes, explain below ☐ No

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

FAMILY HISTORY: Please indicate if anyone in your family has had the following: *(Check all that apply)*

☐ Cancer (Type): _____ ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Scoliosis ☐ Heart Disease
☐ Other: _____ ☐ None apply

REVIEW OF SYMPTOMS:
Are you experiencing any of the following? *(Check all that apply)*

☐ Blackouts/fainting	☐ Difficulty with balance	☐ Joint Pain	☐ Stomach pain or ulcers
☐ Burning with urination	☐ Fevers, chills, sweats	☐ Nausea or vomiting	☐ Stress
☐ Back Pain	☐ Frequent rashes	☐ Neck or Shoulder Pain	☐ Unexplained weight loss
☐ Cough	☐ Heart or chest pain	☐ Seizures	☐ Urinary incontinence, frequency, urgency
☐ Depression	☐ Heartburn	☐ Shortness of breath	☐ None apply

_____ _____
Signature of patient, parent, or guardian Date Physician's signature Date

_____ _____ _____ _____ _____ _____ _____ _____
REVIEWED BY MD DATE INIT DATE INIT DATE INIT DATE

_____
NAME OF PERSON COMPLETING THIS FORM