DESERT SPINE™
AND SCOLIOSIS CENTER
ORTHOPAEDIC SPINAL SURGERY

NEW PATIENT INTAKE FORM

1. PERSONAL INFORMATION

Today's Date:

Name:_____ Height: _____ Weight: _____
First Middle Last

Gender: ☐ Male ☐ Female Age: _____ Date of Birth: _____ Place of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Live with Partner ☐ Widowed Social Security #:_____-_____-_____

Spouse Name(Parent if Minor):_____ Phone #: _____ Date of Birth: _____

Handedness: ☐ Left ☐ Right ☐ Ambidextrous Do you use Alcohol?☐ No ☐Yes – Avg Daily Amt: _____

Smoker: ☐ No ☐ Yes ☐ Previous (if yes/previous, how long?:_____) How much per day?:_____) If previous, year quit: _____

Do you use (check all that apply): ☐ Chewing Tobacco/Dip ☐ Pipes ☐ Cigars ☐ Recreational Drugs

Your Mailing Address: _____ City: _____ State: _____ ZIP:_____

Primary Number: _____ ☐ C ☐ W ☐ H Alternate Number: _____ ☐ C ☐ W ☐ H

Email: _____ Occupation: _____

Your Preferred Pharmacy Name: _____ Pharmacy Phone: _____

Primary Care Physician: _____ Primary Care Phone #:_____

Who Referred you to Our Office?: _____ Referring Phone #: _____

- Are you currently on disability? ☐No ☐FMLA ☐Short Term ☐Permanent If Yes, Why? :_____
- Is this related to a Motor Vehicle Accident?☐ No ☐ Yes Date:_____
- Is this a work-related injury?☐ No ☐ Yes Date:_____
- Due to my current condition, I have filed or plan to file: ☐ A Lawsuit ☐ A Worker's Comp claim ☐ Neither

2. INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____
Policy #: _____ Group #: _____
Policy Holder's Name: _____ Date of Birth: _____ Relationship to Patient: _____
Policy Holder's Address (if other than patient's): _____ City:_____ State:_____ ZIP:_____
Policy Holder's Employer Address: _____ City:_____ State: _____ ZIP: _____

Secondary Insurance: _____ ID #: _____
Policy #: _____ Group #: _____
Policy Holder's Name: _____ Date of Birth: _____ Relationship to Patient: _____
Policy Holder's Address (if other than patient's): _____ City:_____ State:_____ ZIP:_____
Policy Holder's Employer Address: _____ City:_____ State: _____ ZIP: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize all payments of medical benefits to the providers for all services, rendered or to be rendered in the future, without obtaining my signature on each claim. I also authorize the release of any medical information necessary to handle such claims. I UNDERSTAND I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES incurred while I am a patient at Desert Spine and Scoliosis Center, if not covered by my insurance. I hereby confirm that I have read and understand this form.

• **Please Sign Here**: X_____ **Date**: _____

3. INFORMATION RELATED TO YOUR CONDITION AND REASON FOR VISITING OUR OFFICE

Please help us to understand your chief complaint:

What is your primary reason(s) for visiting our clinic, today? Please select all symptoms that apply:
☐ Neck Pain: Arm: ☐ Pain ☐ Numbness ☐ Tingling ☐ Loss of Sensation ☐ Weakness ☐ Other: _____
☐ Back Pain: Leg: ☐ Pain ☐ Numbness ☐ Tingling ☐ Loss of Sensation ☐ Weakness ☐ Other: _____
☐ I don't like the appearance of my back/body
☐ Other:
☐ Spinal Deformity (Scoliosis, Kyphosis, etc.)
- Who discovered your spinal deformity? _____ How was it discovered? _____

- Do you know your present curve measurement(s)? ☐ No ☐ Yes (please list): _____

When did the symptoms first begin? _____ When did the symptoms worsen significantly? (if at all): _____

I feel like my symptoms are: ☐ Getting Worse Fast ☐ Getting Worse Gradually ☐ Not Changing (stable) ☐ Improving

Do you know what caused your symptoms? ☐ No ☐ Yes – Please explain: _____

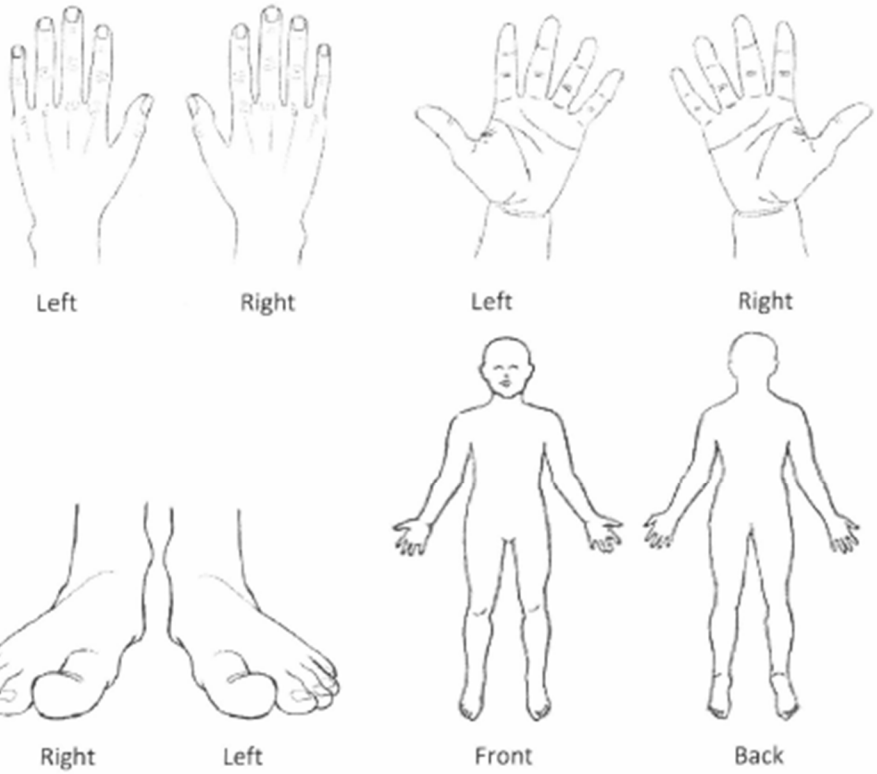
Pain Scale: Score 0 = No pain 10 = Most Severe

LOWER BODY	ON AVERAGE	AT ITS WORST	UPPER BODY	ON AVERAGE	AT ITS WORST
Lower Back	/10	/10	Mid Back	/10	/10
Right Hip	/10	/10			
RT Thigh(front)	/10	/10	Neck	/10	/10
RT Thigh(back)	/10	/10			
Right Calf	/10	/10	Right Shoulder	/10	/10
Right Foot	/10	/10	Right Arm	/10	/10
Left Hip	/10	/10	Right Hand	/10	/10
LT Thigh(front)	/10	/10			
LT Thigh(back)	/10	/10	Left Shoulder	/10	/10
Left Calf	/10	/10	Left Arm	/10	/10
Left Foot	/10	/10	Left Hand	/10	/10

↓ Lower back symptom sufferers- Check ALL that apply:	↓Upper Body/Neck symptom sufferers- Check ALL that apply:
My symptoms are worst with:☐Sitting ☐Standing ☐Lying Down	☐ I have difficulty handling small objects (e.g. coins, keys, etc.)
Bending forward (☐Worsens ☐Improves ☐No change) symptoms	☐ I have weakness in the arms: ☐ Right ☐ Left ☐ Both
Sitting (☐Worsens ☐Improves ☐No change) symptoms	☐ I have weakness in the hands: ☐ Right ☐ Left ☐ Both
Lying down (☐Worsens ☐Improves ☐No change) symptoms	☐ I have noticed that I fall and/or trips on objects
Without pain, I can stand ☐0-5 ☐5-10 ☐10-20 ☐20-30 ☐30-60 ☐60+ mins	☐ I have ☐ bladder or ☐ bowel retention issues (even if minimal)
Without pain, I can walk ☐0-5 ☐5-10 ☐10-20 ☐20-30 ☐30-60 ☐60+ mins	Raising my arm ☐ worsens ☐ improves ☐ doesn't change my pain
☐ I have noticed that I fall and/or trips on objects	Turning my neck ☐ worsens ☐ improves ☐ doesn't change my pain
☐ I have ☐ bladder or ☐ bowel retention issues (even if minimal)	☐ I have headaches at the back/bottom of my skull

ALL PATIENTS, please answer the following questions:
Tucking my chin to my chest causes jolts of pain/shooting sensations down: ☐ my arms ☐ my legs ☐ my spine ☐ none of these
Coughing or sneezing: ☐ Increases ☐ Sometimes increases ☐Does not increase my symptoms
My condition is preventing me from (please list daily activities that you can no longer perform):
_____

What makes your condition feel ***better***? _____ ☐ Nothing Helps
What makes your condition feel ***worse***? _____ ☐ Nothing



Where do you have symptoms?:

Please use these drawings to indicate ALL of your symptoms:

(Use the symbols below to describe the type of symptoms.)

S = Shooting pain
P = Stabbing pain
NT = Numbness and/or Tingling
X = Loss of sensation
C = Cramping
B = Burning
A = Aching
W = Weakness

What conservative treatments have you tried for your condition? (see below) ☐ I haven't tried anything yet.

Treatment Type	How did it help with your symptoms?	When did you try it?	Provider
☐ Prescribed Pain Medication	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	
☐Physical Therapy	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	
☐Chiropractic	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	
☐Spine Decompression	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	
☐Epidural Steroid Injections	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	
☐Facet Blocks	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	
☐Trigger Point Injections	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	
☐Bracing	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	
☐Other:	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	
☐Other:	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	
☐Other:	☐ No benefit ☐ Helped a little ☐ Helped a lot	From: To:	

Have you had previous Spine Surgery? ☐ I have **never** had spine surgery ☐ Yes: please circle the appropriate region and describe each surgery

☐ **Lumbar / Cervical** Spine Surgery: Year:_____ Procedure:_____ Surgeon:_____
How did that surgery help you? ☐ No benefit It helped: ☐ a little ☐ a lot and for how long?_____

☐ **Lumbar / Cervical** Spine Surgery: Year:_____ Procedure:_____ Surgeon:_____
How did that surgery help you? ☐ No benefit It helped: ☐ a little ☐ a lot and for how long?_____

Please list all other surgical procedures:

- _____: Year_____
- _____: Year_____
- _____: Year_____
- _____ Year:_____
- _____ Year:_____
- _____ Year:_____

4. PERSONAL/ FAMILY MEDICAL HISTORY- Check all that apply, add additional information if necessary.

MEDICAL CONDITION	YOU	MOTHER	FATHER	MEDICAL CONDITION	YOU	MOTHER	FATHER
HEAD, NECK AND NERVOUS SYSTEM				**HEAD, NECK AND NERVOUS SYSTEM**			
Alzheimer's / Dementia				Liver Problems - Please specify:			
☐ Anxiety / ☐ Panic Attacks				Pancreas Problems - Please specify:			
Depression				Diabetes			
☐ Dizziness / ☐Vertigo				Thyroid Problems☐Hypo(low) ☐Hyper(high)			
☐Frequent headaches / ☐ Migraines				Kidney Problems - Please specify:			
Multiple Sclerosis				☐Other:			
Seizures - when was your last?				**REPRODUCTIVE, URINARY AND BOWEL**			
Stroke - Please specify year:				Bladder issues (Including incontinence)			
Glaucoma				Difficulty starting urinary stream			
Changes in vision				Accidental "dribbling"			
☐ Other:				Frequent urination			
HEART AND CIRCULATORY SYSTEM				☐Burning / ☐Strong smelling urine			
Aneurysm				Bowel Issues (incl. retention problems)			
☐ Bleeding condition ☐ Bruise/Bleed Easily				Frequent constipation			
Chest Pain				Sexual Dysfunction (incl. erectile issues)			
☐ Hypertension/ ☐High Blood Pressure				☐Other:			
Heart Disease – Please Specify:				**OTHER**			
High Cholesterol				Calf cramps when walking			
Cardiac Stent – Please Specify year:				Cancer – Please Specify Type:			
Heart Attack – Please Specify year:				Fibromyalgia			
☐Other:				Osteo-arthritis			
CHEST AND LUNGS				☐Rheumatoid ☐Psoriatic Arthritis			
Asthma				Fever/Chills			
☐Emphysema/ ☐COPD				Recent weight change			
Morning Cough				Nausea/ Vomiting			
☐Other:				Other:			

5. Do you have any known allergies to medication? ☐ Yes (please describe below) ☐ No known drug allergies

Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____

Please mark ALL that apply: ☐ N/A ☐ Latex ☐ Adhesive Tape ☐X-Ray/Iodine Contrast Dye ☐Other:_____

6. CURRENT MEDICATIONS (please list prescribed and over the counter medication).

☐ I have attached a list of my medications to this form

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Name: (from label):_____ Dose:_____ Reason:_____

Are you currently taking Nutritional Supplements (e.g. Garlic, Gingko Biloba, Fish Oil, Vitamins)- If yes, please list them:

_____

_____

Are there any other important health issues that you feel we should be aware of: ☐ No ☐ Yes

If yes, please explain:_____

_____

6. ALL PATIENTS PLEASE READ AND SIGN THE FOLLOWING

I hereby certify that I have read each question contained on this form. I guarantee that I have answered each question honestly and to the best of my knowledge. I understand that any omission or misrepresentation on my part may seriously jeopardize the ability of my physicians to evaluate and appropriately treat me. I hereby give my permission to the staff of Desert Spine and Scoliosis Center to evaluate and appropriately treat me according to their findings. I hereby authorize all staff at desert Spine and Scoliosis Center to review my responses contained on this form.

Please sign here: X_____ Date:_____