

INSURANCE

Primary Insurance _____ Effective Date _____

Policy Number _____ Group Number _____

Insurance provided through your employer your spouse=s employer other

If other than your employer, list the following information for the primary card holder.

Name _____ Social Security Number _____

Date of Birth _____ Employer Name _____

Secondary Insurance _____ Effective Date _____

Policy Number _____ Group Number _____

Insurance provided through your employer your spouse=s employer other

If other than your employer, list the following information for the primary card holder.

Name _____ Social Security Number _____

Date of Birth _____ Employer Name _____

Third Insurance _____ Effective Date _____

Policy Number _____ Group Number _____

Insurance provided through your employer your spouse=s employer other

If other than your employer, list the following information for the primary card holder.

Name _____ Social Security Number _____

Date of Birth _____ Employer Name _____

Is this a WORK related injury? Yes No Not sure

If yes, Date of injury _____ Employer you worked for when injured _____ Last date of work _____

Is this an AUTO related injury? Yes No Not sure

If yes, Date of injury _____ Last date of work _____

Is this another type injury? Yes No Not sure

If yes, how were you injured? _____

Date of injury _____ Where did injury take place? _____ Last date of work _____

For WORK, AUTO or other related injury, please complete the following:

Claim Number _____

Send Bill To _____

Name _____

Address _____

City/State/Zip _____

Telephone (____) _____

Adjuster=s Name _____

Telephone (____) _____

Is there a lawsuit involved? Yes No

Your Caseworker=s Name and Address

(____) _____

GENERAL INFORMATION

CHIEF COMPLAINT

State clearly why you are here to see a neurosurgical specialist.

Note: If your main problem is one of PAIN in the neck, back, arms or legs, go directly to pages 5 & 6, the PAIN QUESTIONNAIRE; skip the remainder of this page. If not, continue on this page.

HISTORY OF PRESENT ILLNESS

When did your problem start? _____

Suddenly or gradually? _____

In what part of your body is it located? _____

What was your health status preceding the onset of the current symptoms? _____

When did you feel well last? _____

In your best judgment, what brought on this problem? _____

Try to give an orderly sequence of events that have occurred since the onset of the current problem.

Are your symptoms constant or fluctuating? _____

If your symptoms are episodic, describe a typical episode: _____

How frequent are the episodes? _____

What is the duration of a typical episode? _____

What factor(s) seem to make it worse? _____

What factor(s) seem to make it better? _____

Do medications help? _____

What treatment have you received so far? _____

What tests have you undergone so far? X-ray CT Scan MRI EEG Other

How is your lifestyle affected by this illness? _____

CHIEF COMPLAINT & HISTORY OF PRESENT ILLNESS

Note: Answer the pain questionnaire ONLY if your primary symptom is PAIN in the neck, back, arm or leg. If not, proceed directly to page 6, PAST MEDICAL HISTORY.

When did the pain start? (Specify date if you know) _____

What were you doing when it started? _____

Did it occur: Suddenly Gradually

Where is the pain worse? Back Neck Hips Legs

Is the pain: On the surface Deep inside Hard to tell

Does the pain go anywhere? (Example: Does it shoot down arms or legs?) Yes No

If YES, describe the path of the pain _____

Is your pain: Getting better Getting worse Comes and goes Always there

What time of day is your pain worse? _____

How long does it last? _____

What makes your pain BETTER? Lying down Manipulation Muscle relaxants
 Sitting Physical therapy Heat
 Standing Aspirin Cold
 Walking Pain pills
 Other _____

What makes your pain WORSE? Exercise Walking Bending forward
 Sitting Coughing Bending backward
 Standing Sneezing Lying down
 Other _____

Does your pain keep you from doing any of the following?

Working Exercising Having sex
 Sports Sleeping Driving
 Showering Dressing Shopping
 Having fun Leaving the house
 Does not stop activities

Do you need to rest during the day because of your pain?

No A little Half the day Over half the day

Do you have any numbness?

No Yes

If YES, where? _____

Do you have any weakness?

No Yes

If YES, where? _____

Do you have any problems with: Bowel function Bladder function Sexual function

Have you received any of the following treatments?

Physical therapy Chiropractic manipulations Epidural steroids Other

If yes, how often? _____ and for how long? _____

PAIN QUESTIONNAIRE

Using the patterns below, show exactly where on the body you are having problems.

ACHE
////
///
/

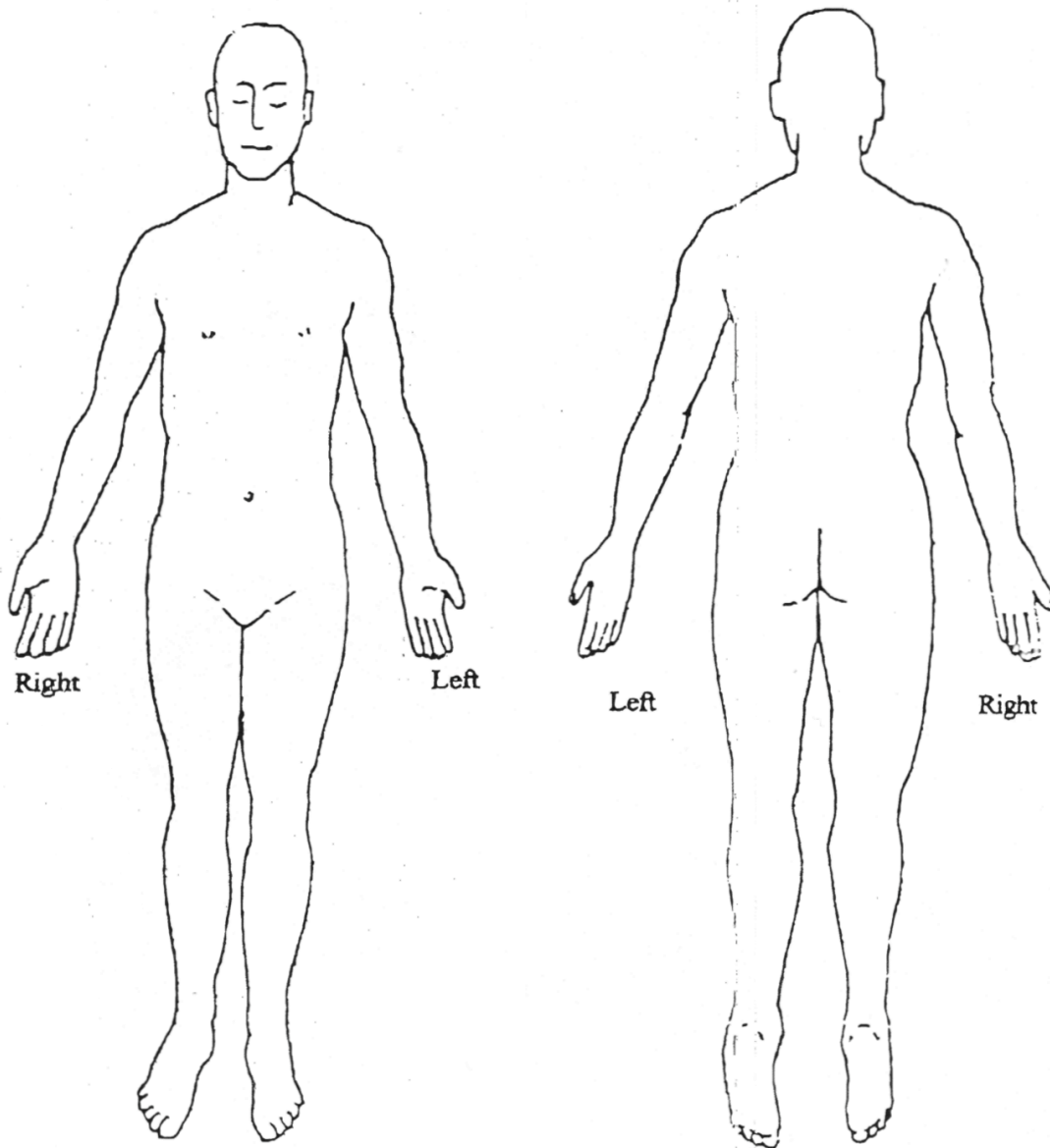
BURNING
BBBBB
BBB
B

NUMBNESS
XXXXX
XXX
X

PINS & NEEDLES
=====

STABBING
ZZZZZ
ZZZ
Z

OTHER
OOOOO
OOO
O



How would you rate your pain now?

(Circle the number you would give it if A1" is no pain and A10" is the worst pain ever.)

No Pain 1 2 3 4 5 6 7 8 9 10 (Worst Pain Ever)

What tests have you undergone so far? X-ray CT Scan MRI EMG Other

Where were the tests done and when? _____

PAIN QUESTIONNAIRE

PAST MEDICAL HISTORY

1. Major Medical Illnesses:

Check any major medical illnesses listed below that you have suffered from or currently have:

Asthma cancer diabetes heart attack heart disease hepatitis HIV
 High or low blood pressure stroke

Other major illnesses _____

List hospitalizations for surgery or major medical illnesses:

Hospital /Physician	Date/Year	Reason for admission

2. Transfusions, anesthesia:

Have you encountered any problems with transfusions or anesthesia in the past? Yes No

If yes, give details. _____

3. Serious Injuries: List any serious injuries you have sustained any time in the past.

(E.g. auto accident, falls, gunshot/stab wound, work injury) _____

4. Are you claustrophobic or feel 'panicky' or heart races when in confined spaces like an elevator? yes no

5. Do you have any metal anywhere in your body? yes no

If yes, where is it? _____

If yes, what is it? (metal filing, shrapnel, bullet etc) _____

6. Allergies to Medicines: yes no If yes, what medicines? _____

7. Do you have an allergy or a reaction to Latex? yes no

8. Allergies to substances other than medicines? yes no If yes, list what you are allergic to, (e.g. tape, pollen, bees, grass, etc.)

PAST MEDICAL HISTORY

PERSONAL AND SOCIAL HISTORY

1. Diet: Are you on any special diet? _____
2. Activity: Do you regularly exercise? _____
Do you participate in sports or athletic activity? _____
What are your hobbies and leisure activities? _____
3. Current weight: _____ Weight one year ago: _____ Height: _____
4. Handedness: Right handed Left handed Equally skilled in both hands
5. Tobacco use: Do you smoke? Yes No How much in a day? _____
6. Alcohol use: Do you drink? Yes No How much and how often? _____
7. Drugs: Have you ever used street drugs? Yes No
Do you still? Yes No (If no, go to next question)
What drugs? _____
Do you swallow smoke snort inject
How often? _____
8. Religious beliefs: Do you wish to express any of your personal religious beliefs that will impact on your health care? (e.g.: objection to blood transfusions) _____

9. Emotional status: How is your emotional health? _____

FAMILY HISTORY

Do you know of any genetic illness in your family? Yes No

1. List any of the following health problems in your near relatives in the table below:
diabetes, high blood pressure, high cholesterol, stroke, heart attack, tuberculosis, cancer, arthritis, kidney disease, anemia, allergies, asthma, headaches, epilepsy, mental illness, alcoholism, drug addiction

Relationship	IF LIVING		IF DECEASED	
	Age	Health Problems	Age at death	Cause of Death
Father				
Mother				
Grandparents				
Sister/ Brother				

PERSONAL, SOCIAL AND FAMILY HISTORY

Please quickly go over the following list of medical problems and circle only those that pertain to you.

HEAD AND NECK

frequent headaches
migraine
head injury
dizziness or fainting

EYES

impairment of eyesight
double vision
blurred vision
spots
flashing lights
cataracts

NECK

swollen glands
goiter
pain or stiffness

EARS

hearing difficulty
ringing/buzzing
earaches
discharge from ears
use of hearing aid(s)

NOSE AND SINUSES

frequent colds
nasal stuffiness
nose bleeds
sinus problems

MOUTH AND THROAT

bleeding gums
frequent sore throat
hoarseness

BREASTS

nipple discharge
lumps

RESPIRATORY

cough up phlegm
blood in sputum
shortness of breath
bronchitis
emphysema
tuberculosis (TB)

CARDIOVASCULAR

irregular heart beat
racing heart
heart murmur
chest pain
palpitations
cold feet
swollen feet/ankles

GASTROINTESTINAL

loss of appetite
nausea, vomiting
heartburn
recent change in bowel habits
black stools
rectal pain
rectal bleeding
jaundice
hepatitis
gall bladder trouble

URINARY

frequency of urination
burning
urgency
bloody urine
passage of stones
dribbling

GENITAL - MALE

discharge from penis
HIV
hernias
testicular swelling

GENITAL - FEMALE

irregular menses
painful menses
post-menopausal bleeding
use of birth control items

MUSCULOSKELETAL

aching muscles/joints
swollen joints
muscle weakness
fibromyalgia

SKIN

itching, scaling
rashes

ENDOCRINE

weight change
impotence
always feel hot
always feel cold
drink a lot of fluids
change in size of
gloves/shoes

NERVOUS SYSTEM

weakness
numbness
seizures
speech impairment
shaking
change in handwriting
difficulty walking

PSYCHIATRIC

depression
suicidal ideas
trouble sleeping
panic attacks
nervousness
memory impairment

REVIEW OF SYSTEMS

