NEW PATIENT HISTORY – Dr. Gabriel - NECK

Patient Name:_____ Age: _____ DOB: ___/___/_____ Date: ___/___/20___

Reason for today's visit: _____

Hand Dominance: Right Left Date of Onset: _____ Date of Injury:_____

Injury occurred at: ____ Home _____ Work ____ MVA Other: _____

This condition is: _____ New _____ Chronic _____ Recurring _____ Reinjured

WHAT MAKES YOUR PAIN WORSE?		WHAT MAKES YOUR PAIN BETTER?	
____ Sitting	____ Stooping	____ Sitting	____ Stooping
____ Standing	____ Twisting	____ Standing	____ Twisting
____ Walking	____ Coughing	____ Walking	____ Coughing
____ Bending	____ Sneezing	____ Bending	____ Sneezing
____ Lying	____ Other	____ Lying	____ Other

Do you lose your balance, feel unsteadiness, frequent falls, clumsiness? ____ No ____ Yes

Do you have trouble with writing, zippers, buttons, dropping small objects? ____ No ____ Yes

___Difficulty with sleeping ___Increased headaches Are you on aspirin or another blood thinner? ____No ___Yes

Allergies: _____

Past medical history: _____

_____

Past surgical history: _____

Family history: _____

Social history: Do you **smoke**? ____ No ____ Yes ____ Quit ____ Packs/Day _____ How many years?

Illicit drug abuse/overuse: ____ Never ____ Currently ____ In the past **Alcohol**: ___No ___Yes ___Occasional

Working: ____ No ____ Yes Retired: ____ No ____ Yes Occupation: _____

(please circle) **NO PAIN** 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **SEVERE PAIN**

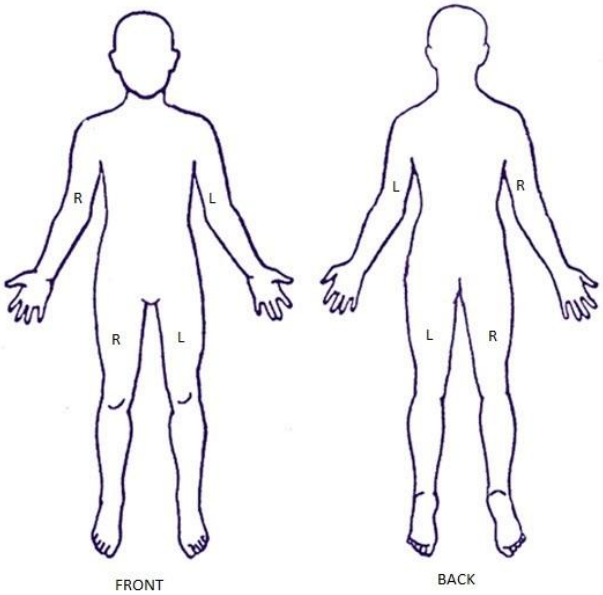
Types of pain:

Dull:
uuuuuuu

Pins and Needles:
+++++++++

Sharp:
!!!!!!!!!!

Numbness:
oooooooo



Pain is:
_____Constant
_____ Intermittent

Patient signature_____ Asst initials_____ Date ____/____/20____

Vital Signs: Temp____ BP____/____ Pulse____ Respirations____ Weight_____lbs Height_____in. BMI_____

Patient Name:_____ DOB: ___/_____/_____ Today's Date: _____/_____/_____

CURRENT MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY (How often the med is taken)

REVIEW OF SYSTEMS

Check all that apply

Patient Name:_____ **Date: ____/____/20____**

General:

____Fevers ____Chills ____Sweats ____Anorexia
____Fatigue ____Malaise ____Weight gain ____Weight loss

Eyes:

____Wears glasses ____Wears contacts ____Blurring vision ____Double vision
____Change in vision ____Wears bifocals ____Discharge ____Watering
____Vision loss ____Eye pain ____Photophobia ____Glaucoma

Ears/Nose/Throat

____Ear ache ____Ear discharge ____Ringing in ear ____Hearing loss
____Sinus problems ____Nosebleeds ____Sore throat ____Hoarseness
____Difficulty swallowing ____Nasal polyps ____Mouth lesions ____Bleeding gums
____Change in your voice

Cardiovascular:

____Chest pain ____Palpitations ____ Dyspnea on exertion ____ Syncope
____Peripheral edema ____Heart murmur ____Hypertension ____Heart attack
____Stroke ____Heart disease

Respiratory:

____Cough ____Short of breath ____Excessive sputum ____Cough up blood
____Wheezing ____Tuberculosis ____Recent pneumonia ____Chest tightness
____Inspiration pain ____Snoring ____Asthma ____COPD

Genitourinary:

____Difficulty with urination ____Blood in urine ____Discharge ____Frequent urination
____Urinary hesitancy ____Urinary urgency ____**Urinary retention** ____Flank pain
____Urination at night ____Burning on urination ____**Bowel incontinence** ____Genital sores
____Decreased libido ____Pregnant ____**Bladder incontinence**

Gastrointestinal:

____Nausea ____Heartburn ____Loss of appetite ____Hemorrhoid
____Vomiting ____Gastric reflux ____Abdominal pain ____Hematocheza
____Difficulty swallowing ____Bloody stool ____Diarrhea ____Melena
____Change in bowel habits ____Hepatitis ____Black tarry stool ____Constipation
____Jaundice ____History of Ulcers

Musculoskeletal:

____Back pain ____Stiffness ____Joint pain ____Joint swelling
____Muscle cramps ____Muscle weakness ____Arthritis ____Instability
____Redness to joints ____Joint feels hot

Skin:

____Rash ____Itching ____Dryness ____Suspicious lesions
____Excessive bruising ____Skin changes ____Redness ____Poor healing

Circulatory:

____Swollen ankles ____Calf cramps with walking

Neurologic:

____Transient paralysis ____Vertigo ____Seizures ____Tremors
____Dizziness ____Blackouts ____Headaches ____Migraines
____Weakness ____Numbness ____Tingling

Psychiatric:

____Depression ____Anxiety ____ Mental disturbance ____ Memory loss
____Suicidal ideations ____hallucinations ____Paranoia ____Chronic pain

Endocrine:

____Cold intolerance ____Heat intolerance ____Frequently thirsty ____Frequently hungry
____Recent weight change ____History of diabetes ____Changes in skin texture ____Thyroid disease

Heme/Lymphatic:

____Abnormal bruising ____Enlarged lymph nodes ____ Takes blood thinners ____ Bleeding

Allergic/Immunologic:

_____Hives _____Hay fever ____Persistent infections ____HIV exposure

MEDICAL HISTORY QUESTIONNAIRE

Please check any of the following that apply to your medical history

Patient Name_____ DOB_____ Date_____

___ Headaches
___Migraines
___Seizures/Epilepsy
___Depression
___Anxiety
___Mental health issues
___Insomnia
___Sleep Apnea
___ Hearing Loss
___Ringing in the Ears
___Glaucoma/Cataracts
___Fatigue
___Stroke
___Thyroid Disease
___Dizziness/Fainting
___Weakness
___Chest Pain
___Heart Murmur
___Heart Palpitations
___Heart Disease
___High Blood Pressure
___Low Blood Pressure
___Circulation Problems
___Bleeding Tendency
___Anemia

___Shortness of Breath
___Wheezing
___Asthma
___ Pneumonia
___Tuberculosis (TB)
___Heartburn/Indigestion
___Ulcer
___Abdominal Pain
___Bowel Irregularity
___Rectal Bleeding
___Hemorrhoids
___Gallbladder Disease
___Bladder Infections
___Incontinence
___Prostate Problems
___Kidney Disease
___STD
___HIV +/ AIDS
___Hepatitis
___Sexual Dysfunction
___Infertility
___Arthritis
___Osteoporosis
___Gout
___Neck Pain

___Hives
___Chronic Rash
___Diabetes
___Cancer
___Weight Loss
___Weight Gain
___Measles
___Mumps
___Chickenpox
___Whooping Cough
___Polio
___Tetanus
___Erectile Difficulties
___Blood Transfusion
___Leg Pain/Swelling
___Back Pain
___Bursitis/Tendonitis
___History of + Antibodies
___Other:_____

SPINE INSTITUTE OF OHIO

New Patient Registration Form

PATIENT INFORMATION

Name: _____
Nickname: _____
Address:_____
City: _____ State: _____ Zip: _____
Phone – Home:_____
Phone – Cell: _____
Pharmacy Name: _____
Phone: _____ Fax: _____

PATIENT EMPLOYMENT

( )Employed ( )Disabled ( )Retired
( )Not employed ( )Student ( )Other
Occupation: _____
Work phone:_____
Employer: _____
( )Work Comp ( )Liability Claim ( )Auto
Case/Injury #: _____

PRIMARY INSURANCE

( )Same as patient ( )Same as guarantor ( )Other
Insured's Name:_____
Subscriber's Name: _____
Subscriber's SSN:_____
Subscriber's Date of Birth: _____
Insurance ID #:_____
Insurance Carrier: _____
Policy Group #: _____

SECONDARY INSURANCE

( )Same as patient ( )Same as guarantor ( )Other
Insured's Name:_____
Subscriber's Name: _____
Subscriber's SSN:_____
Subscriber's Date of Birth_____
Insurance ID #:_____
Insurance Carrier: _____
Policy Group #: _____

Patient Confidentiality Release:

In the event that we/Spine Institute of Ohio cannot reach you, we would like your permission to leave a message on your voicemail or home answering machine regarding upcoming appointments, tests, surgical procedures, and test results.

( ) I agree to this authorization
( ) I deny this authorization

Patient/Guardian Signature: _____

Date: _____
Co-pay $_____ EMR ID#:_____
Email:
_____
Sex: ( )Male ( )Female
Date of Birth: _____
Social Security #: _____
Marital Status: ( )Married ( )Divorced ( )Single
( )Widowed ( )Separated
Emergency Contact: _____
Relationship: _____ Phone: _____

Race:_____ Ethnicity: _____ Language: _____

Smoking Status:( )Never ( )Current
( )Former ( ) Packs per Day ____

CONTACTS

Family Physician: Dr._____
Referring Physician: Dr._____
Other Physician: Dr._____

GUARANTOR

( )Same as patient ( )Same as guarantor ( )Other
Insured's Name:_____
Subscriber's Name: _____
SSN:_____
Date of Birth: _____
Insurance ID #:_____
Insurance Carrier: _____
Policy Group #: _____

Authorization to Provide Care:

( ) I authorize the providers of the Spine Institute of Ohio to provide any medical care deemed necessary according to their professional opinions.

I also authorize my Physician(s) and Spine Institute of Ohio to photograph me for medically related documentation purposes.

Notice to Patients: Receipt of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish.

( ) I acknowledge that I have received a copy of the Spine Institute of Ohio's notice of Privacy Practices.
( ) I was offered a copy of the Spine Institute of Ohio's notice of Privacy Practices, but declined it.

Spine Institute of Ohio
Josue P. Gabriel, MD
ORTHOPAEDIC SPINE SURGEON

340 E. Town St., Suite 8-900
Columbus, OH 43215
Phone: (614) 222-0743
Fax: (614) 222-0744

MEDICATION POLICY

Due to the increased scrutiny by State and Federal regulators, it has become necessary to further enhance our compliance program as it relates to controlled substance prescriptions and the management of your pre and post-operative pain. Therefore, **one or all of the following conditions of treatment may be in effect** in order to receive your prescriptions with our office:

1. A signed Medication Policy Agreement
2. Random/scheduled toxicology screenings
3. Random pill count
4. Any other practice imposed conditions of care.

By signing this Medication Policy you are agreeing to the following;

- I do not have current problems with substance abuse or dependence (addiction).
- I am not currently involved in the sale, diversion, illegal possession or transport of controlled substances.
- I agree to take my medications exactly as prescribed by my doctor.
- I agree to submit a urine specimen at my doctor's request to test for compliance.
- I agree to allow my doctor to contact family members or friends to help monitor my progress if necessary.
- I will allow other relevant healthcare providers to communicate with my physician regarding my medication use.
- I understand that NO ALLOWANCE will be made for lost or stolen prescriptions of drugs.
- If I am a female, I certify that I am not pregnant and will use appropriate measures to prevent pregnancy during the course of this treatment.
- I agree to follow the advice of healthcare providers in regard to stopping controlled substances if it is felt necessary.
- No refills of medications will be made after hours, during weekends, or during holiday periods.
- I am responsible for making an appointment or calling the office for a refill at least **72 hours** before running out of my medication.
- I will obtain my prescriptions from the following pharmacy:_____ located at _____ and give Spine Institute of Ohio permission to contact any other pharmacy to enquire about additional medications.

I have read this document, understand it, and have had all questions answered satisfactorily. I consent to the use of medications to help control my pain and I understand that this treatment will be conducted in accordance with the conditions stated above.

Patient Signature:_____ Date:_____/_____/_____

Sharing of Medical Information

SPINE INSTITUTE OF OHIO

I give the physician(s)/office staff of Spine Institute of Ohio permission to discuss my medical condition with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Authorization for Pharmacy Benefits Manager

I authorize the physician and/or staff of Spine Institute of Ohio to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager, and/or any third party pharmacy payors for treatment purposes.

Patient Authorization for Medicare Patients

I authorize the physician and/or staff of Spine Institute of Ohio to release to Social Security Administration, Health Care Financing Administration, or its Intermediaries or Carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient Authorization for PPO and HMO Patients

I authorize the physician and/or staff of Spine Institute of Ohio to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named Insurance Company to pay directly to Spine Institute of Ohio the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my Insurance company.

Financial Policy for All Patients

We will file your insurance claim to the insurance company as a courtesy to you. After hearing from your insurance company we will sent you a bill that reflects your balance due. Payment in full is expected at this time. Copayments are due at the time of the visits. Patients without insurance will be required to pay for services at the time of the visit. If necessary, payment arrangement for the remainder of the balance will be made. For personal injury involving legal action, we will not hold your account for settlement of a legal suit. We accept cash, check, Visa, and MasterCard. There will be a $30.00 fee for all returned checks. Refunds from services charged on a credit card will be returned to the same credit card. I understand that I am financially responsible for services rendered in the office and surgical procedures. Failure to pay for services or any residual account balance that is not pain will be placed to a collection agency and possibly negatively affect my credit report. I authorize my insurance benefits to be paid directly to Spine Institute of Ohio. I authorize the release of any information by the Spine Institute of Ohio and/or Billing Contractor Agency to my insurance carrier, pertinent to my health insurance claim. I understand that I am financially responsible for this account unless other arrangements have been made. Also, to release any medical information that may be necessary to request claim reimbursement from the insurance carriers or other payers to whom claims have been or are being submitted.

If you are a no show for your appointment, you must pay a $25.00 rescheduling fee prior to rescheduling your next appointment. Payment can be made via cash or credit card only.

I, the undersigned, agree that if payment on this patient's account is not made, I will pay reasonable attorney's fees and collection fees incurred for the collection process. I authorize the release of credit information to the appropriate information gathering services.

There will be a fee for filling out forms of $25.00 per form (disability, etc.), the fee to be paid in advance. It may take up to a week to fill out the form, and we will notify you when it is done.

I certify that I have read the forgoing and I am the patient or am duly authorized to execute the above agreement for the patient and accept its terms.

Responsible Party: _____ Relationship to patient: Self Parent Guardian

Patient Signature: _____ Printed Name: _____ Date: _____

Special Accommodation Authorization

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify Spine Institute of Ohio of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by Spine Institute of Ohio is the patient's responsibility.

Signature

Patient Signature: _____ Date: _____

Parent/Guarantor/Guardian Signature: _____

SF-12© **Patient Questionnaire**

Patient Initials: _____ Date of Birth: _____ Patkey: _____

Surgeon Name: Josue P. Gabriel, M.D. Date: _____

Examination Period: ____ Preop (1) ____ 1 Year (3) ____ 5 Year (5)
____ Immediate postop (2) ____ 3 Year (4) ____ Other (specify)(6):_____

SF-12©

This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by placing a checkmark on the line in front of the appropriate answer. It is <u>not</u> specific for arthritis. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:
____ Excellent (1) ____ Fair (4)
____ Very Good (2) ____ Poor (5)
____ Good (3)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling or playing golf:
____ Yes, limited a lot (1)
____ Yes, limited a little (2)
____ No, not limited at all (3)

3. Climbing SEVERAL flights of stairs:
____ Yes, limited a lot (1)
____ Yes, limited a little (2)
____ No, not limited at all (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:
____ Yes (1) ____ No (2)

5. Were limited in the KIND of work or other activities:
____ Yes (1) ____ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:
____ Yes (1) ____ No (2)

7. Didn't do work or other activities as CAREFULLY as usual:
____ Yes (1) ____ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?
____ Not at all (1) ____ Quite a bit (4)
____ A little bit (2) ____ Extremely (5)
____ Moderately (3)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?
____ All of the time (1) ____ Some of the time (4)
____ Most of the time (2) ____ A little of the time (5)
____ A good bit of the time (3) ____ None of the time (6)

10. Did you have a lot of energy?
____ All of the time (1) ____ Some of the time (4)
____ Most of the time (2) ____ A little of the time (5)
____ A good bit of the time (3) ____ None of the time (6)

11. Have you felt downhearted and blue?
____ All of the time (1) ____ Some of the time (4)
____ Most of the time (2) ____ A little of the time (5)
____ A good bit of the time (3) ____ None of the time (6)

12. During the PAST 4 WEEKS, how much of the time have your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?
____ All of the time (1) ____ Some of the time (4)
____ Most of the time (2) ____ A little of the time (5)
____ A good bit of the time (3) ____ None of the time (6)

Surgeon Signature
_____

Date _____

Neck Disability Index

Patient Name _____ DOB _____ Date _____

Please read: This questionnaire is designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section and circle the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement relate to you, but please just circle the one choice which 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 everyday 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 gives 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 light weights.

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 infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

Score % _____

Signature: _____

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 car 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 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

NECK PAIN & ARM PAIN
Visual Analog Scale

Patient Name _____ DOB _____ Date _____

Interval:

☐ Baseline	☐ 42-day	☐ 90-day	☐ 180-day
☐ 365-day	☐ 730-day	☐ 3 years	☐ 4 years
☐ 5 years	☐ 6 years	☐ 7 years	☐ Other, specify _____

Arm pain visual analog scale (to be completed by patient)

Directions: Indicate the severity of your arm pain by marking a single **|** on the line that describes your current level of arm pain TODAY, ranging from "no pain" to "worst possible pain."

Right arm **|----------|----------|**

No pain 5 Worst possible pain

0 10

Left arm **|----------|----------|**

No pain 5 Worst possible pain

0 10

Neck pain visual analog scale (to be completed by patient)

Directions: Indicate the severity of your neck pain by marking a single **|** on the line that describes your current level of neck pain TODAY, ranging from "no pain" to "worst possible pain."

|----------|----------|

No pain 5 Worst possible pain

0 10

Patient initials _____ Date _____

Confirmation of investigator review

Signature of investigator _____ Date _____