

EXPERTISE IN SPINE • EXCLUSIVELY SPINE**WHAT TO BRING**

- Sonoran Spine Center Information Sheet**
Complete this information sent to you.
- Medication List / Drug Allergies**
Make a list of any medications you are currently taking including dosages and frequency. Include a list of any drug allergies you may have.
- Insurance Company Information**
Please have your insurance card and insurance company information, including the group number and address where claims should be sent.
- Workers Compensation Information**
Bring the claim number, insurance carrier, address, contact person and phone number if you are covered by workers compensation.
- Co-pay**
If your insurance has a co-pay, you must pay this amount before being seen.
- Insurance Authorization / Doctor Referral**
We are on most insurance plans, but be sure your visit with us has been authorized by your insurance company, if this is required. We will not see you if we don't have a required referral and authorization. Any questions you may have should be directed to your primary care provider. This is your responsibility. Please have your authorization number when you make your appointment with us.
- X-rays, MRI Scan, CT Scan, Other Studies**
Please make certain you bring any x-rays, MRI scans, CT scans, etc., as well as any radiologist reports. Bring all studies that have been done.
- If You Require Disability Forms -**
We will fill out forms required by the government such as those from the State of Arizona or the Social Security Administration free of charge. However, If you require disability forms completed for privately-held policies such as those that protect your car, wages, home or credit cards, we charge \$5 per page up to a maximum of \$25/form. Your insurance plan will not reimburse you for the preparation of these forms nor will it reimburse Sonoran Spine Center, PC; therefore, we require payment before completing the form. Upon receipt of payment in full and your signature which acknowledges your understanding of our policy, we will complete your forms. Ask to sign our Disability Form Acknowledgement if you need disability forms filled out.

P A T I E N T I N F O R M A T I O N R E C O R D

P A T I E N T I N F O R M A T I O N

Patient Name _____ Age _____ Male Female
Date of Birth: _____/_____/_____ Social Security Number _____ - _____ - _____ Marital Status: S M W D Sep
Mailing Address _____ City _____ State _____ Zip Code _____
Daytime phone Number (____) _____ Cell phone (____) _____ Work phone (____) _____
Email address (PRINT) _____ How did you hear about us? _____
Employer _____ Occupation _____
Street Address _____ City _____ State _____ Zip Code _____ Phone (____) _____
Patient's Referring Doctor _____ Phone (____) _____
Patient's Primary Care Doctor _____ Phone (____) _____
Office Location: Street Address _____ City _____ State _____ Zip _____

A D D I T I O N A L I N F O R M A T I O N

Spouse (parent, if minor) _____
Date of Birth: _____/_____/_____ Social Security Number _____ - _____ - _____ Phone (____) _____
Street Address _____ City _____ State _____ Zip Code _____
Employer _____ Occupation _____
Street Address _____ City _____ State _____ Zip Code _____ Phone (____) _____
Name of Nearest Relative Not Living With You _____ Relationship _____
Street Address _____ City _____ State _____ Zip Code _____ Phone (____) _____

I N S U R A N C E I N F O R M A T I O N

Primary Insurance Company _____ Is this a work-related injury? (Circle one) Yes No
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 Code _____
Secondary Insurance Company _____
ID# _____ Policy # _____ Group # _____
Policy Holder's Name _____ Relationship to Patient _____ Date of Birth ____/____/____
Policy Holder's Address (if other than patient's) _____ City _____ State _____ Zip _____
Policy Holder's Employer Address _____ City _____ State _____ Zip Code _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for 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. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for \$50 or a fee of 45% of the balance due, whichever is higher. I have read and understand this form.

X _____ Date _____

NAME: _____ DATE: _____

BIRTHDATE: ____/____/____ HEIGHT: ____ FT. ____ IN. WEIGHT _____ LBS.

REFERRING PHYSICIAN NAME (First, Last Name): _____ Phone: _____

INTERNIST OR FAMILY PHYSICIAN NAME: _____ Phone: _____

A. 1. Chief complaint (check all that apply):

- Spinal Deformity (Scoliosis, Kyphosis, Flatback Syndrome, etc.)
 Neck pain Arm: Pain Numbness Weakness
 Back pain Leg: Pain Numbness Weakness Other: _____
2. Your age: ____ Years ____ Months Your gender: Male Female
3. How long has the pain (or your problem) been present? _____
4. Has your problem worsened recently? No Yes - How recently? _____
5. What started the pain (or problem)? _____
- _____

B. For NECK or ARM complaints (If you have no NECK or ARM complaints, go to NEXT page):

1. What % of your symptoms are in the neck and what % are in the arm? (check ONE of the following)
 All arm Neck 25%, Arm 75% Neck 50%, Arm 50% Neck 75%, Arm 25% All Neck
2. Which side are your symptoms on (check ONE of the following):
 Right 0%, Left 100% R 25%, L 75% R 50%, L 50% R 75%, L 25% R 100%, L 0%
3. There is: No pain of the arms and hands Pain of the (check the following):
Right: Upper back Shoulder Upper arm Forearm Hand/finger
Left: Upper back Shoulder Upper arm Forearm Hand/finger
- a. Raising the arm: Improves the pain Worsens the pain Does not affect the pain
b. Moving the neck: Improves the pain Worsens the pain Does not affect the pain
4. There is: No weakness of the arms and hands
 Weakness of the (check the following):
Right: Shoulder Upper arm Forearm Hand/finger
Left: Shoulder Upper arm Forearm Hand/finger
5. There is: No numbness of the arms and hands Numbness of the (check the following):
Rt: Upper arm Forearm Thumb Index finger Long finger Ring finger Small finger
Lt: Upper arm Forearm Thumb Index finger Long finger Ring finger Small finger
6. There (is is no) difficulty picking up small objects like coins or buttoning buttons.
7. There (is is no) problem with balance or tripping frequently.
8. There are: (Frequent Occasional No) headaches in the back of the head.

C. For BACK or LEG complaints:

1. What % of your complaint is in the back and what % is leg or buttock? (check appropriate box):
 All Leg Back 25%, Leg 75% Back 50%, Leg 50% Back 75%, Leg 25% All Back
2. Symptoms are (check ONE of the following):
 Right 0%, Left 100% R 25%, L 75% R 50%, L 50% R 75%, L 25% R 100%, L 0%
3. There is: No leg pain Leg pain as follows (check the following):
Right: Buttock Thigh-front Thigh-back Calf Foot
Left: Buttock Thigh-front Thigh-back Calf Foot
4. There is: No weakness of the legs Weakness of the (check the following):
Right: Thigh Calf Ankle Foot Big toe
Left: Thigh Calf Ankle Foot Big toe
5. There is: No numbness of the legs Numbness of the (check the following):
Right: Thigh Calf Foot
Left: Thigh Calf Foot
6. The worst position is: Sitting Standing Walking
7. How many minutes can you stand in one place without pain? 0-10 15-30 30-60 60+
8. How many minutes can you walk without pain? 0-10 15-30 30-60 60+
9. Lying down: Eases the pain Does not ease the pain Sometimes eases the pain
10. Bending forward: Increases the pain Decreases the pain Doesn't affect the pain

D. For patients with a SPINAL DEFORMITY/CURVATURE (If you have NONE, go to NEXT page)

How was your spinal deformity discovered?

-
1. Do you know your present curve measurement(s)? No Yes _____
 2. Reasons for seeking treatment now: Progressive deformity Pain Can't stand straight
 I don't like the appearance of my back/waistline Other: _____

E. ★★★ ALL PATIENTS SHOULD ANSWER THE FOLLOWING ★★★

1. Coughing or sneezing (Increases Sometimes increases Does not increase) my symptoms.
2. There is: No loss of bowel or bladder control Loss of bowel or bladder control since_____.
3. I have: Not missed any work because of this problem Missed (how much?) _____ work
4. Treatments have included: No medicines, therapy, manipulations, injections, or braces

Neck Back

- Physical therapy, exercise
- Massage & ultrasound
- Traction
- Manipulation
- Tens Unit
- Shoulder injections
- Braces

Neck Back

- Anti-inflammatory medications
- Narcotic medication
- Epidural steroid injections _____ times which relieved the pain for (how long)?_____
- Trigger point injections _____ times which relieved the pain for (how long)?_____
- Surgery (explain in section I)

5. Previous doctors seen about this problem: None

Doctor	Specialty	City	Treatments

F. MEDICATIONS YOU TAKE: None

G. ALLERGIES TO MEDICATIONS: No known drug allergies. If past adverse reaction, check boxes below:

MEDICATION	Rash	Swelling Wheezing or Shock	Upset Stomach	Unknown Reaction	Other
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

H. MEDICAL HISTORY: Check all that apply. None apply

- Heart attack Diabetes Lung disease Liver trouble
- Heart failure Stroke HIV Hepatitis
- High blood pressure Seizures AIDS Thyroid trouble
- Osteoarthritis Mental illness Tuberculosis Bleeding disorders
- Rheumatoid arthritis Kidney stones Asthma Anemia
- Ankylosing spondylitis Kidney failure Blood clot in leg Serious injuries (explain)
- Gout Cancer Blood clot in lung _____
- Osteoporosis Alcoholism Stomach ulcers Other: _____

I. SURGICAL HISTORY: Previous surgeries - List procedures, surgeon and date. None

OPERATION	SURGEON	DATE

J. FAMILY HISTORY: (Check all that apply)

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> None apply | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Gout | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney trouble or stones | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spine problems | <input type="checkbox"/> Cancer | _____ |
| | | <input type="checkbox"/> Bleeding disorders | _____ |

K. SOCIAL HISTORY:

- Work status: Homemaker Retired Disabled On leave Unemployed
 Working: Full time Part time Occupation: _____
- Marital status: Married Single Co-habiting Widowed Divorced
- Number of living children: 1 2 3 4 5 6 7 8 9 10
- I live: Alone With: _____
- I participate in sports (circle any): Golf Tennis Jog Bike Baseball Basketball
- Tobacco use: Never
 Cigar Chew Pipe Cigarettes _____ packs per day for _____ years.
 Quit - When? _____ after smoking _____ packs per day for _____ years (total)
- Alcohol: Never or rare Social Frequently intoxicated (more than 2x a week)
 Alcoholic Recovering alcoholic
- Drug overuse/abuse: Never Currently In the past
- Because of this spine problem, I have filed or plan to file:
 A lawsuit A Worker's Compensation claim Neither a lawsuit or Worker's Comp

L. REVIEW OF SYSTEMS: Check all that apply. None apply

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Reading glasses | <input type="checkbox"/> Abnormal heartbeat | <input type="checkbox"/> Frequent constipation | <input type="checkbox"/> Hot or cold spells |
| <input type="checkbox"/> Change of vision | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Recent weight change |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Calf cramps w/ walking | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Nervous exhaustion |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Burning on urination | Women only: |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Toothache | <input type="checkbox"/> Difficulty starting urination | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Gum trouble | <input type="checkbox"/> Get up more than once every night to urinate | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Frequent spotting |
| <input type="checkbox"/> Morning cough | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Frequent blackouts | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Frequent belching | <input type="checkbox"/> Frequent rash | _____ |
| <input type="checkbox"/> Heart or chest pain | <input type="checkbox"/> Frequent diarrhea | | _____ |

- Generally speaking, are your symptoms getting better or worse?
 Getting much better Getting somewhat better Staying about the same
 Getting somewhat worse Getting much worse
- If you had to spend the rest of your life with the symptoms you have right now, would you be:
 Very dissatisfied Somewhat dissatisfied Neutral
 Somewhat satisfied Very satisfied

Patient Signature

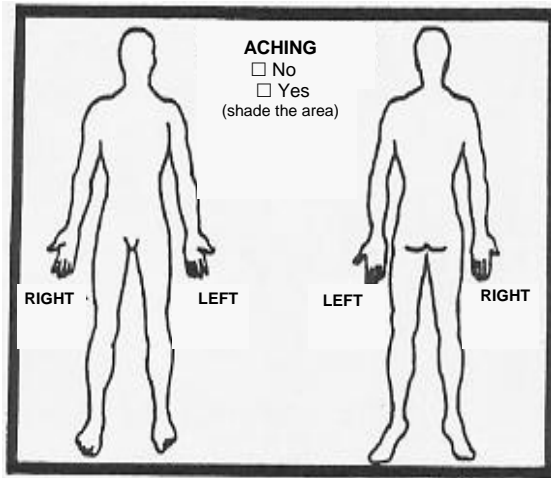
Date

Physician Signature

Date

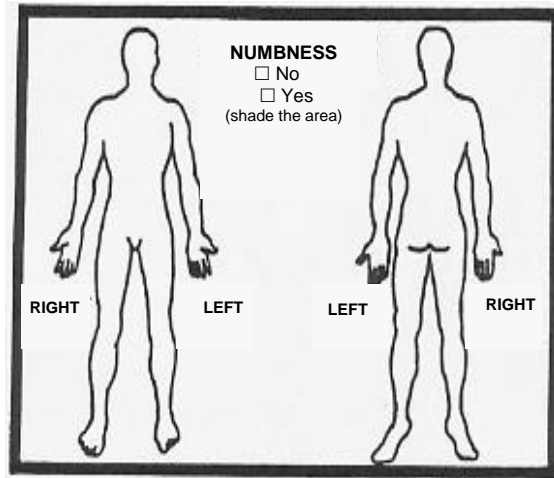
Please fill in drawings:

ACHING
 No
 Yes
(shade the area)



RIGHT LEFT LEFT RIGHT

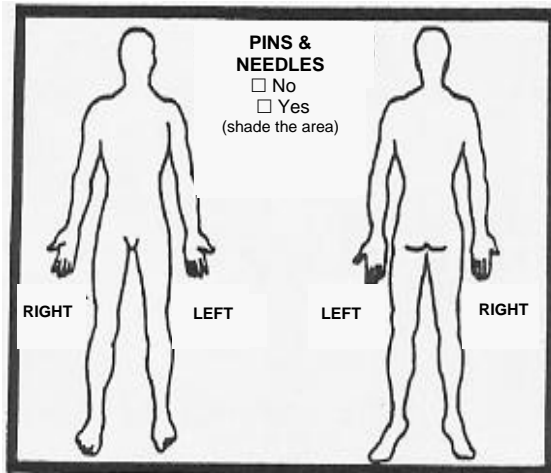
NUMBNESS
 No
 Yes
(shade the area)



RIGHT LEFT LEFT RIGHT

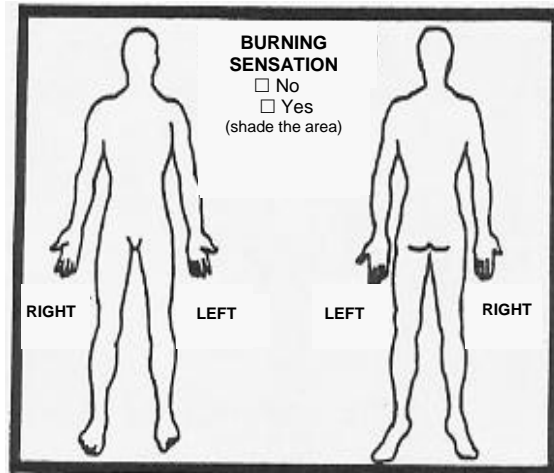
Yes
(shade the area)

PINS & NEEDLES
 No
 Yes
(shade the area)



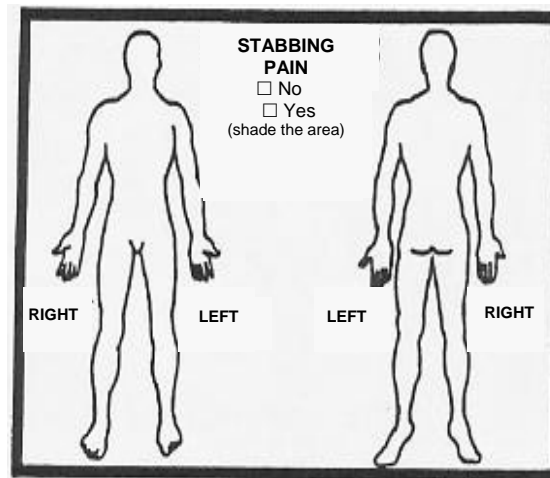
RIGHT LEFT LEFT RIGHT

BURNING SENSATION
 No
 Yes
(shade the area)



RIGHT LEFT LEFT RIGHT

STABBING PAIN
 No
 Yes
(shade the area)



RIGHT LEFT LEFT RIGHT

OSWESTRY FUNCTION TEST

Please mark ONE answer in each section that most clearly describes your BACK problem.

01. Pain Intensity

- 0. I can tolerate the pain I have without having to use pain killers
- 1. The pain is bad but I manage without taking pain killers
- 2. Pain killers give complete relief from pain.
- 3. Pain killers give moderate relief from pain.
- 4. Pain killers give little very little relief from pain.
- 5. Pain killers have no effect on the pain, I do not use them.

02. Personal Care (Washing, Dressing, etc)

- 0. I can look after myself normally without it causing extra pain.
- 1. I can look after myself normally but it causes extra pain.
- 2. It is painful to look after myself and I am slow and careful.
- 3. I need some help but manage most of my personal care.
- 4. I need help everyday in most aspects of self care.
- 5. I do not get dressed, wash with difficulty and stay in bed.

03. Lifting

- 0. I can lift heavy weights without extra pain.
- 1. I can lift heavy weights but it gives extra pain.
- 2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g. on a table)
- 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4. I can lift only very light weights.
- 5. I cannot lift or carry anything at all.

04. Walking

- 0. Pain does not prevent me from walking any distance.
- 1. Pain prevents me walking more than 1 mile.
- 2. Pain prevents me walking more than ½ mile.
- 3. Pain prevents me walking more than ¼ mile.
- 4. I can only walk using a cane, crutches or walker.
- 5. I am in bed most of the time and have to crawl to the toilet.

05. Sitting

- 0. I can sit in any chair as long as I like.
- 1. I can only sit in my favorite chair as long as I like.
- 2. Pain prevents me from sitting more than one hour.
- 3. Pain prevents me from sitting more than 30 minutes
- 4. Pain prevents me from sitting more than 10 minutes.
- 5. Pain prevents me from sitting at all.

06. Standing

- 0. I can stand as long as I want without extra pain.
- 1. I can stand as long as I want but it gives extra pain.
- 2. Pain prevents me from standing more than one hour.
- 3. Pain prevents me from standing more than 30 minutes.
- 4. Pain prevents me from standing more than 10 minutes.
- 5. Pain prevents me from standing at all.

07. Sleeping

- 0. Pain does not prevent me from sleeping well.
- 1. I can sleep well only by using tablets.
- 2. Even when I take tablets I have less than 6 hours sleep.
- 3. Even when I take tablets I have less than 4 hours sleep.
- 4. Even when I have tablets I have less than 2 hours sleep.
- 5. Pain prevents me from sleeping at all.

08. Employment/Homemaking

- 0. My normal homemaking/job activities do not cause pain.
- 1. My normal homemaking/job activities increase my pain but I can still perform all that is required of me.
- 2. I can perform most of my homemaking /job duties, but pain prevents me from performing more physically stressful activities (lifting, vacuuming).
- 3. Pain prevents me from doing anything but light duties.
- 4. Pain prevents me from doing even light duties.
- 5. Pain prevents me from performing any job or homemaking chores.

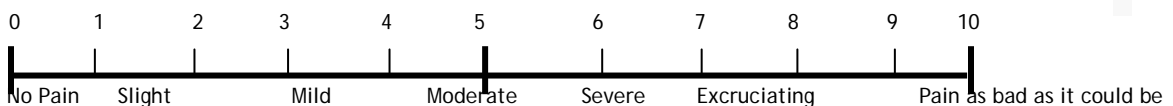
09. Social Life

- 0. My social life is normal and gives me no extra pain.
- 1. My social life is normal but increases my degree of pain.
- 2. Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc).
- 3. Pain has restricted my social life and I do not go out as often.
- 4. Pain has restricted my social life to home.
- 5. I have no social life because of the pain.

10. Traveling

- 0. I can travel anywhere without extra pain.
- 1. I can travel anywhere but it gives extra pain.
- 2. Pain is bad but I manage journeys over two hours.
- 3. Pain restricts me to journeys less than 1 hour.
- 4. Pain restricts me to journeys under 30 minutes.
- 5. Pain prevents me from traveling except to the doctor or hospital.

MY PAIN / DISCOMFORT IS (circle number)



- 1. PAIN MEDICATIONS CURRENTLY TAKING: _____
- 2. A. DID YOU WORK BEFORE SURGERY? YES / NO _____ B. DATE YOU RETURNED TO WORK _____

**Please fill out the following
questionnaire if you are being seen for
a neck (cervical spine) problem.**

NECK DISABILITY INDEX

Please mark ONE answer in each section that most clearly describes your NECK problem.

01. Pain Intensity

- 0. I have no pain at the moment.
- 1. The pain is mild at the moment.
- 2. The pain comes and goes and is moderate.
- 3. The pain is moderate and does not vary much.
- 4. The pain is severe but comes and goes.
- 5. The pain is severe and does not vary much.

02. Personal Care

- 0. I can look after myself without causing extra pain.
- 1. I can look after myself normally but it causes extra pain.
- 2. It is painful to look after myself and I am slow and careful.
- 3. I need some help but I manage most of my personal care.
- 4. I need help every day in most aspects of self care.
- 5. I do not get dressed, washing with difficulty and stay in bed.

03. Lifting

- 0. I can lift heavy weights without extra pain.
- 1. I can lift heavy weights but it causes extra pain.
- 2. Pain prevents me from lifting heavy objects off the floor, but I can if they are conveniently positioned, for example, on a table.
- 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4. I can lift only very light weights.
- 5. I cannot lift or carry anything at all.

04. Reading

- 0. I can read as much as I want to with no pain in my neck.
- 1. I can read as much as I want with slight pain in my neck.
- 2. I can read as much as I want with moderate neck pain.
- 3. I cannot read as much as I want because of moderate neck pain.
- 4. I cannot read as much as I want because of severe neck pain.
- 5. I cannot read at all.

05. Headaches

- 0. I have no headaches at all.
- 1. I have slight headaches which come infrequently.
- 2. I have moderate headaches which come infrequently.
- 3. I have moderate headaches which come frequently.
- 4. I have severe headaches which come frequently.
- 5. I have headaches almost all of the time.

06. Concentration

- 0. I can concentrate fully when I want to with no difficulty.
- 1. I can concentrate with slight difficulty.
- 2. I have a fair degree of difficulty in concentrating.
- 3. I have a lot of difficulty in concentrating.
- 4. I have a great deal of difficulty in concentrating.
- 5. I cannot concentrate at all.

07. Work

- 0. I can do as much work as I want to.
- 1. I can only do my usual work, but no more.
- 2. I can do most of my usual work, but no more.
- 3. I cannot do my usual work.
- 4. I can hardly do my usual work.
- 5. I cannot do any work at all.

08. Driving

- 0. I can drive my car without neck pain.
- 1. I can drive my car as long as I want with slight pain in my neck.
- 2. I can drive my car as long as I want with moderate pain in my neck.
- 3. I cannot drive my car as long as I want because of moderate pain in my neck.
- 4. I can hardly drive my car at all because of severe pain in my neck.
- 5. I cannot drive my car at all.

09. Sleep

- 0. I have no trouble sleeping.
- 1. My sleep is slightly disturbed (less than 1 hour sleepless).
- 2. My sleep is mildly disturbed (1-2 hours sleepless).
- 3. My sleep is moderately disturbed (2-3 hours sleepless).
- 4. My sleep is greatly disturbed (3-5 hours sleepless).
- 5. My sleep is completely disturbed (5-7 hours sleepless).

10. Recreation

- 0. I am able to engage in all recreational activities with no pain in my neck at all.
- 1. I am able to engage in all recreational activities with some pain in my neck.
- 2. I am able to engage in most, but not all, recreational activities because of pain in my neck.
- 3. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- 4. I can hardly do recreational activities because of pain in my neck.
- 5. I cannot do any recreational activities at all.

PAIN MEDICATIONS CURRENTLY TAKING: _____

MY PAIN / DISCOMFORT IS (circle number)

