NEUROSPINE
SURGICAL CONSULTANTS

Today's Date: _____

PATIENT INFORMATION

DOB: _____

Patient Name: _____

Address: _____

_____

Phone #: _____

Sex (circle one) Female Male

In case of emergency, please contact:

Name: _____

Relationship: _____

Phone #: _____

MEDICAL SUMMARY

Medical Allergies: _____

_____

Major Illnesses: _____

_____

PHARMACY INFORMATION

Address: _____

_____

Phone #: _____

CONSENT TO TREAT

I understand that I have presented myself to NeuroSpine Surgical Consultants for evaluation and/or treatment of my Neurological or Spinal condition. I am aware that I may require necessary treatment during my episode of care. I further understand that all options will be discussed prior to the administration of such treatments.

Patient's signature: _____

Were you injured while working?
_____Yes _____No Date of Injury: _____

Is your visit related to an automobile accident?
_____Yes _____No Date of accident: _____

HIPAA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I can request a copy of this notice at any time. I have the right to review the notice prior to signing this consent. I have had the opportunity to receive and review the Notice of Privacy Practices of NeuroSpine Surgical Consultants.

Initials_____

I authorize the release of any and all medical information necessary for my medical care and to process medical claims. I understand that all fees incurred in the course of my treatment by NeuroSpine Surgical Consultants and/or its authorized agents are my responsibility. I hereby authorize the insurance companies to make payment directly to NeuroSpine Surgical Consultants for those fees I have not previously paid. Additionally, I agree to all charges not paid by my medical insurance companies are ultimately my responsibility. I authorize the use of my signature on insurance submissions.

☐ YES ☐ NO

Signature: _____

I give authorization for NeuroSpine Surgical Consultants' staff to contact the following person(s) and leave messages regarding appointments or test/surgery scheduling in the event I am unable to be reached at the number(s) I have provided.

Name: _____

Relationship: _____

Phone #: _____

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Patient History of Present Problem

Patient name:_____ **Date:**_____

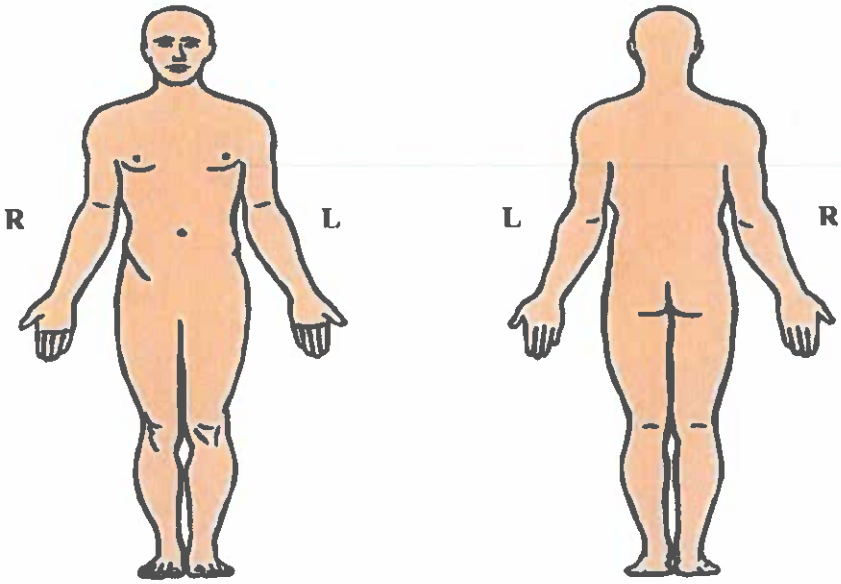
Age: _____ **Race:**_____ **R or L handed** **Sex: Male Female**

In one sentence or less, please state the reason you are seeking a surgical evaluation:

_____

Mark the areas on your body where you feel the described sensations by using the appropriate symbol.

Ache: ^^^^ **Numbness:** OOOO **Pins & Needles:** = = = = **Burning:** XXXX **Stabbing:** ////



Are you experiencing any of the following symptoms:

- ☐ Radiating pain
- ☐ Numbness (loss of sensation)
- ☐ Tingling
- ☐ Loss of control of bowels or bladder
- ☐ Weakness in arms or legs
- ☐ Gait changes
- ☐ Headaches
- ☐ Problems controlling your fingers

Please mark the level of your pain on the following scale:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Possible**

Since their onset, have the symptoms: ☐ Improved ☐ Remained the same/leveled off ☐ Progressively worsened

List two physical activities which aggravate your pain: _____

List two physical activities/positions which make the pain better: _____

Is the pain the result of an injury? ☐ Yes ☐ No ☐ Unsure – please explain:_____

If this is an injury, is it: ☐ Work related ☐ Motor vehicle related ☐ Other: _____

What is the date of injury? _____ If not an injury, date symptoms began:_____ Have you missed work because of your pain? ☐Yes ☐ No If yes, how long? _____

Briefly describe how your injury occurred or how the symptoms began:_____

_____

_____

When (date) did you begin to seek medical care for your symptoms? _____

Who did you seek treatment from (physician name/specialty):_____

Please list all other physicians you have sought treatment or opinions from:

_____

_____

Patient name:_____

Please mark all diagnostics done with dates: ❑ MRI _____ ❑ CT/Myelogram _____ ❑ X-Ray _____

❑ EMG/NVC _____ ❑ Other_____

What treatments have you tried to help alleviate your symptoms (Dates- only within the last year)

❑ Physical therapy* When:_____ ❑ Epidural Steroid Injections (ESI's)*When_____

❑ Over the Counter medication* When_____ ❑ Oral Steroids*When:_____ ❑ Heat /Ice* When_____

❑ Facet injections* When_____ ❑Chiropractic *When_____ ❑ Other_____* When:_____

Medication Information

List all medications to which you are allergic:

_____

Please list any medications & dosages you are currently taking (include over the counter and herbals).

_____ _____

_____ _____

Past Surgical History

Starting with the most recent, please list in date order any **SPINE** surgeries you may have had:

_____ _____

Date Operation Date Operation

Starting with the most recent, please list any other types of surgery you may have had:

_____ _____

Date Operation Date Operation

_____ _____

Date Operation Date Operation

Family History

Family Member	Living	Deceased	Age	Health Status or Cause of Death
Mother	❑	❑	____	_____
Father	❑	❑	____	_____
Brother/Sister	❑	❑	____	_____
Brother/Sister	❑	❑	____	_____
Grandmother (mom's)	❑	❑	____	_____
Grandfather (mom's)	❑	❑	____	_____
Grandmother (dad's)	❑	❑	____	_____
Grandfather (dad's)	❑	❑	____	_____

Social History

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Occupation:_____ Do you have children? ❑ Yes ❑ No If yes, how many?_____

Do you live alone? ❑ Yes ❑ No If no, who lives with you?_____

Do you **smoke or Vape**? ❑ Yes ❑ No If Yes, how many packs per day? _____ For how long? _____

If you're a former smoker or vaper , how long ago did you quit? _____ How many packs per day were you smoking?_____

Do you drink **alcohol**? ❑No ❑Rarely ❑No, but I used to ❑Yes, daily ❑Yes, 1 or more times a week ❑Yes, socially

Are you at risk for AIDS (e.g. sexual orientation, history of drug use, previous blood transfusion)? ❑ Yes ❑ No

Health History/Review of Systems

Have you had or been told you have any of the following conditions or symptoms? Please check all that apply.

General
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Loss of appetite
- ☐ **Recent Fever**
- ☐ Recent fatigue
- ☐ Recent night sweats
- ☐ **HIV**

Eyes, Ears, Nose, Throat
- ☐ Frequent headaches
- ☐ **Migraine**
- ☐ Head Injury
- ☐ Vertigo
- ☐ Light headedness
- ☐ Visual loss
- ☐ **Double vision**
- ☐ Wear glasses/contact lenses
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ **Ear Drainage**
- ☐ Frequent nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Toothaches
- ☐ Frequent sore Throat
- ☐ Hoarseness
- ☐ Voice changes
- ☐ Neck swelling
- ☐ Neck stiffness\Any other disorder of the eyes, ears, nose or throat

Respiratory
- ☐ Shortness of breath with activity
- ☐ **Shortness of breath while lying flat**
- ☐ Shortness of breath awaking you at night
- ☐ **Wheezing**
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Pleurisy
- ☐ **Asthma**
- ☐ **Chronic bronchitis**
- ☐ **Emphysema**
- ☐ **TB**
- ☐ Any other chronic respiratory disorder
- ☐ Date of last chest x-ray _____

Cardiovascular
- ☐ **Chest pain or tightness**
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ **Heart attack**
- ☐ Swelling in ankles
- ☐ **High blood pressure**
- ☐ Pain in calves when walking
- ☐ Phlebitis
- ☐ Blood clots
- ☐ Any other disease or disorder of the heart or blood vessels
- ☐ Date of last EKG_____

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Frequent nausea/vomiting
- ☐ Vomiting of blood
- ☐ Abdominal pain
- ☐ Colic
- ☐ **Jaundice**
- ☐ Frequent Diarrhea
- ☐ Chronic constipation
- ☐ **Black, tarry stools**
- ☐ **Bloody stools**
- ☐ Change in bowel habits
- ☐ Hemorrhoids
- ☐ Rectal pain
- ☐ Hernia
- ☐ Recurrent indigestion
- ☐ **Ulcer**
- ☐ Pancreatitis
- ☐ **Hepatitis**
- ☐ Gallstones
- ☐ Any other disease or disorder of the stomach, intestines or liver

Genitourinary
- ☐ **Pus or blood in the urine**
- ☐ Trouble starting to urinate
- ☐ Frequency
- ☐ Frequent walking to urinate
- ☐ **Burning with urination**
- ☐ Incontinence
- ☐ Venereal disease
- ☐ Kidney stones
- ☐ **Kidney or bladder infections**
- ☐ **Kidney failure**

Men only:
- ☐ Impotence
- ☐ Prostate problems
- ☐ Abnormal discharge from penis
- ☐ Vasectomy

Women only:
- ☐ Abnormal Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Abnormal nipple discharge
- ☐ Painful intercourse
- ☐ Hysterectomy

If not hysterectomy, are currently having regular menstrual cycles?_____

If in menopause, or have had a hysterectomy, are you on hormone replacement therapy?_____

Could you be pregnant? _____

Date of last menstrual cycle _____

Skin
- ☐ Easy bruising
- ☐ Bleeding tendency
- ☐ Rash
- ☐ Itching
- ☐ Enlarged or painful lymph node
- ☐ Cyst
- ☐ Tumor
- ☐ Skin cancer
- ☐ Abnormal scarring
- ☐ Other disease or disorder of the skin

Endocrine
- ☐ **Sugar in the urine**
- ☐ Excessive urination
- ☐ Excessive hunger
- ☐ Excessive Thirst
- ☐ Temperature sensitivity
- ☐ **Diabetes**
- ☐ Hyper-thyroidism
- ☐ Hypo-thyroidism
- ☐ Abnormal hormone levels
- ☐ Other endocrine disorders

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Weakness in arms
- ☐ Weakness in legs
- ☐ Fractures
- ☐ Deformity
- ☐ Amputation
- ☐ Rheumatism
- ☐ Gout

Neurological
- ☐ Weakness
- ☐ Paralysis
- ☐ Atrophy
- ☐ Tremors
- ☐ Seizures
- ☐ Imbalance
- ☐ Numbness
- ☐ Tingling
- ☐ Transient ischemic attacks
- ☐ Stroke
- ☐ Multiple sclerosis
- ☐ Fibromyalgia

Mental status
- ☐ Problem with relationships
- ☐ Sudden mood changes
- ☐ Hallucinations
- ☐ Delusions
- ☐ Depression
- ☐ Insomnia
- ☐ Drug addiction
- ☐ Claustrophobic
- ☐ Other mental disorder

The information provided is accurate to the best of my knowledge.

_____

Patient Signature & Date

_____

Please print your name

_____

I have reviewed the information provided by the patient. Physician Signature & Date

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X-RAY CONSENT FORM

Patient: _____ Minor Yes No

Do you have a Spinal Cord Stimulator? Yes No

**If yes, please turn off your stimulator 5 minutes prior to x-ray

I consent to any diagnostic x-ray procedure(s) my medical provider may consider necessary or advisable in the course of my health care. I understand that diagnostic x-ray procedures may be ordered to be performed in accordance with my appointment today and they will be performed at Neurospine Surgical Consultants under the supervision of a registered Non-Certified Radiologic Technician. I understand the nature and purposes of these procedure(s) and the risks involved.

_____ Date: _____

Patient/Guardian Signature

FEMALE PATIENTS ONLY

I understand the physician has ordered an x-ray and I am giving permission to have the procedure(s) performed. I am aware radiation to the abdomen or pelvis can cause injury to a fetus.

Onset of last menstrual period: Date: _____ Today's Date: _____

I am verifying I:

- ☐ I am pregnant, _____ weeks
- ☐ May be pregnant

I believe I am NOT pregnant due to:

- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Use of birth control measures: _____
- ☐ Abstinence

By signing below, I attest the above statements are true. I hereby release Neurospine Surgical Consultants from liability for any adverse effects that may arise from undergoing diagnostic imaging at this time if I am subsequently found to have been pregnant and I assume responsibility for my decision to undergo this procedure.

_____ Date: _____

Patient/Guardian Signature

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Medication Prescription and Refill Policy

As a reminder to our patients, this is a surgical practice.

Pain medications will be prescribed in the immediate post-operative period only. Use of pain medications beyond the immediate post-operative period will need to be managed by a pain management specialist.

Refill requests for medications prescribed by our office will be accepted **only from your pharmacy** during our regular business hours, which are Monday thru Friday from 9am-4:30pm. If you need a refill on your medication, you must call the refill request into the pharmacy at which it was originally filled. **Do not call the office** directly as this will only delay the process. If your request is received after 2:00 pm Monday-Thursday, or after 12:00 pm on Friday, it will be processed the next business day.

Absolutely no refills will be authorized on Saturday or Sunday.

We understand that pharmacies may have a shortage of medications. Please allow at least **5 business days** for our office to send requests to the new pharmacy.

I have read and understand the above policy.

Patient Name (Printed) _____

_____ _____

Patient Signature Date

Revised 03/04/2023