Texas Spine Clinic™

SPINE CONSULTATION

NEW PATIENT INTAKE FORM

Date: _____

1 · PATIENT INFORMATION

Full Name _____ Date of Birth _____

Address _____ Age _____

City / State / ZIP _____ Sex ○ Male ○ Female

Home Phone _____ Cell Phone _____

Email Address _____ Marital Status S / M / D / W

Employer _____ Occupation _____

Insurance Company _____ Policy Holder Name _____

Policy Holder DOB _____ Policy Holder Employer _____

Emergency Contact Name _____ Emergency Contact Phone _____

Preferred Language _____ Family Physician _____

Preferred Pharmacy Name _____ Pharmacy Phone Number _____

Race / Ethnicity: ○ Hispanic / Latino ○ Non-Hispanic / Latino ○ Decline to State

2 · SPINE HISTORY

1. Have you been formally diagnosed with a spinal condition by a physician?
□ Yes □ No

2. If yes, what was the diagnosis? (Check all that apply)

□ Herniated disc (cervical)
□ Herniated disc (lumbar)
□ Bulging disc
□ Degenerative disc disease
□ Spinal stenosis (cervical)
□ Spinal stenosis (lumbar)
□ Spondylolisthesis
□ Spondylosis / osteoarthritis
□ Compression fracture
□ Scoliosis / kyphosis
□ Radiculopathy (nerve root)
□ Other (specify below)

Other / specify diagnosis: _____

3. Where is your primary area of pain or symptoms?
○ Neck (cervical) ○ Upper back (thoracic) ○ Lower back (lumbar) ○ Tailbone / sacral ○ Multiple regions

4. How long have you been experiencing spinal symptoms?
○ Less than 1 month ○ 1–6 months ○ 6–12 months ○ 1–3 years ○ More than 3 years

5. How did the problem start?
○ Sudden injury / trauma ○ Gradual onset ○ After lifting / bending ○ After surgery ○ Unknown

6. Have you seen a spine surgeon, neurosurgeon, or neurologist for this condition? □ Yes □ No
If yes, physician name:

7. Date of last spine imaging (X-ray / MRI / CT): _____

8. Ordering physician / facility: _____

3 · CHIEF COMPLAINT — SYMPTOMS

WHAT SYMPTOMS ARE YOU EXPERIENCING? CHECK ALL THAT APPLY:

- □ Neck pain
- □ Upper back pain
- □ Lower back pain
- □ Pain at rest
- □ Pain with movement / activity
- □ Pain radiating into arm / hand
- □ Pain radiating into buttock / leg
- □ Numbness or tingling in arm / hand
- □ Numbness or tingling in leg / foot
- □ Muscle weakness in arm or leg
- □ Headaches from neck
- □ Difficulty walking / balance problems

Additional symptoms:

PAIN DETAIL:

Character — Circle all that apply:

○ Dull ○ Aching ○ Sharp ○ Stabbing ○ Burning ○ Electric / shooting ○ Constant ○ Intermittent

Severity (0 = none, 10 = worst imaginable): 0 1 2 3 4 5 6 7 8 9 10

Frequency: ○ Occasional (0–25%) ○ Intermittent (25–50%) ○ Frequent (50–75%) ○ Constant (75–100%)

What makes pain worse?

What makes pain better?

When did symptoms start?

How did symptoms begin?

Does the pain affect your ability to perform daily activities (dressing, walking, work)? □ Yes □ No

Have you experienced any bowel or bladder changes related to your spine symptoms? □ Yes □ No

Does the pain affect your sleep? □ Yes □ No

4 · PREVIOUS TREATMENTS

CONSERVATIVE TREATMENTS TRIED — CHECK ALL THAT APPLY:

- □ Physical therapy
- □ Chiropractic care
- □ Home exercise program
- □ Traction therapy
- □ NSAIDs (ibuprofen / naproxen)
- □ Tylenol / acetaminophen
- □ Muscle relaxants
- □ Prescription pain medication
- □ Nerve pain medication (gabapentin, etc.)
- □ Ice / heat therapy
- □ TENS / electrical stimulation
- □ Other (specify below)

Notes / specify medications or other treatments:

INJECTIONS OR PROCEDURES TRIED — CHECK ALL THAT APPLY:

- □ Epidural steroid injection
- □ Facet joint injection
- □ Nerve root block (selective)
- □ Medial branch block
- □ Radiofrequency ablation (RFA)
- □ Trigger point injection
- □ Spinal cord stimulator
- □ Intrathecal pump
- □ Other (specify below)

SPINE SURGERIES — CHECK ALL THAT APPLY:

- □ Discectomy (cervical)
- □ Discectomy (lumbar)
- □ Microdiscectomy
- □ Laminectomy / laminotomy
- □ Spinal fusion (cervical)
- □ Spinal fusion (lumbar)
- □ ACDF (anterior cervical discectomy)
- □ Foraminotomy
- □ Kyphoplasty
- □ Vertebroplasty
- □ Artificial disc replacement
- □ Other (specify below)

Results of prior treatment(s) / any complications:

5 · PAST MEDICAL HISTORY

CURRENT CONDITIONS — CHECK ALL THAT APPLY:

- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart disease
- ☐ DVT / blood clots
- ☐ Osteoporosis / osteopenia
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Depression / anxiety
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Cancer (specify below)
- ☐ Coagulation disorder

Other conditions / cancer details:

Previous injuries or trauma to spine / neck / back:

Allergies (medications, contrast dye, iodine, latex, etc.):

CURRENT MEDICATIONS:

Medication Name	Dose / Frequency	Medication Name	Dose / Frequency

PREVIOUS SURGERIES:

Procedure / Surgery	Year	Procedure / Surgery	Year

6 · FAMILY & SOCIAL HISTORY

Associated health problems in family members (spinal disease, arthritis, osteoporosis, cancer, heart disease, diabetes, etc.):

SOCIAL HISTORY:

Cigarettes / tobacco: ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No
If yes, how much per week:

Exercise regularly: ☐ Yes ☐ No
If yes, type / frequency:

Is your spine condition related to your occupation or work activities? ☐ Yes ☐ No

Is this a Workers' Compensation or personal injury claim? □ Yes □ No

7 · REVIEW OF SYSTEMS

Please check any symptoms you are currently experiencing. Check "None of the above" if no symptoms in that category.

Allergic / Immunologic
- □ Cancer
- □ Seasonal allergies
- □ Immune deficiency
- □ None of the above

Cardiovascular
- □ Chest pain
- □ Palpitations
- □ Fainting
- □ SOB on exertion
- □ Edema / swelling
- □ Heart murmurs
- □ None of the above

Endocrine
- □ Excess thirst
- □ Cold intolerance
- □ Heat intolerance
- □ Frequent urination
- □ Excessive hunger
- □ Goiter
- □ None of the above

Ear / Nose / Throat
- □ Nosebleed
- □ Hoarseness
- □ Sinusitis
- □ Hearing difficulty
- □ Thyroid mass
- □ Neck stiffness
- □ None of the above

Gastrointestinal
- □ Loss of appetite
- □ Difficulty swallowing
- □ Heartburn
- □ Nausea / vomiting
- □ Constipation
- □ Diarrhea
- □ Hemorrhoids
- □ None of the above

Constitutional
- □ Weight loss / gain
- □ Fever
- □ Loss of appetite
- □ Fatigue
- □ None of the above

Genitourinary
- □ Urgency / frequency
- □ Burning urination
- □ Blood in urine
- □ Bladder incontinence
- □ Recurring infection
- □ None of the above

Head / Eyes
- □ Headache
- □ Dizziness
- □ Lightheadedness
- □ Vision changes
- □ Double vision
- □ Eye pain
- □ Head injury
- □ None of the above

Hematologic / Lymphatic
- □ Easy bruising
- □ Blood clots
- □ Lymphedema
- □ Easy bleeding
- □ Swollen glands
- □ Blood transfusion
- □ None of the above

Musculoskeletal
- □ Joint pain
- □ Joint swelling
- □ Joint stiffness
- □ Muscle weakness
- □ Muscle cramps
- □ None of the above

Neurological
- □ Seizures
- □ Paralysis
- □ Tremors
- □ Numbness / tingling
- □ Memory loss
- □ Balance difficulty
- □ None of the above

Psychiatric / Respiratory
- □ Depression
- □ Anxiety
- □ Suicidal thoughts
- □ SOB / wheezing
- □ Cough
- □ Night sweats
- □ None of the above

8 · AUTHORIZATION & SIGNATURE

I have read the above information and certify it to be true and correct to the best of my knowledge. I hereby authorize Texas Spine Clinic to perform any necessary examinations and/or treatment in accordance with Texas statutes and laws.

Patient Signature _____ Date _____

Guardian Signature (if applicable) _____ Date _____

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may 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 every day 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 causes 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.
F. I cannot lift or carry anything at all.

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

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 engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a 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 all all.

SIGNATURE:_____ **DATE:**_____

DISABILITY INDEX SCORE: **%**_____

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
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

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from walking more than 1/2 mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 -- Standing

A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from sleeping at all.

SECTION 9--Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms off travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

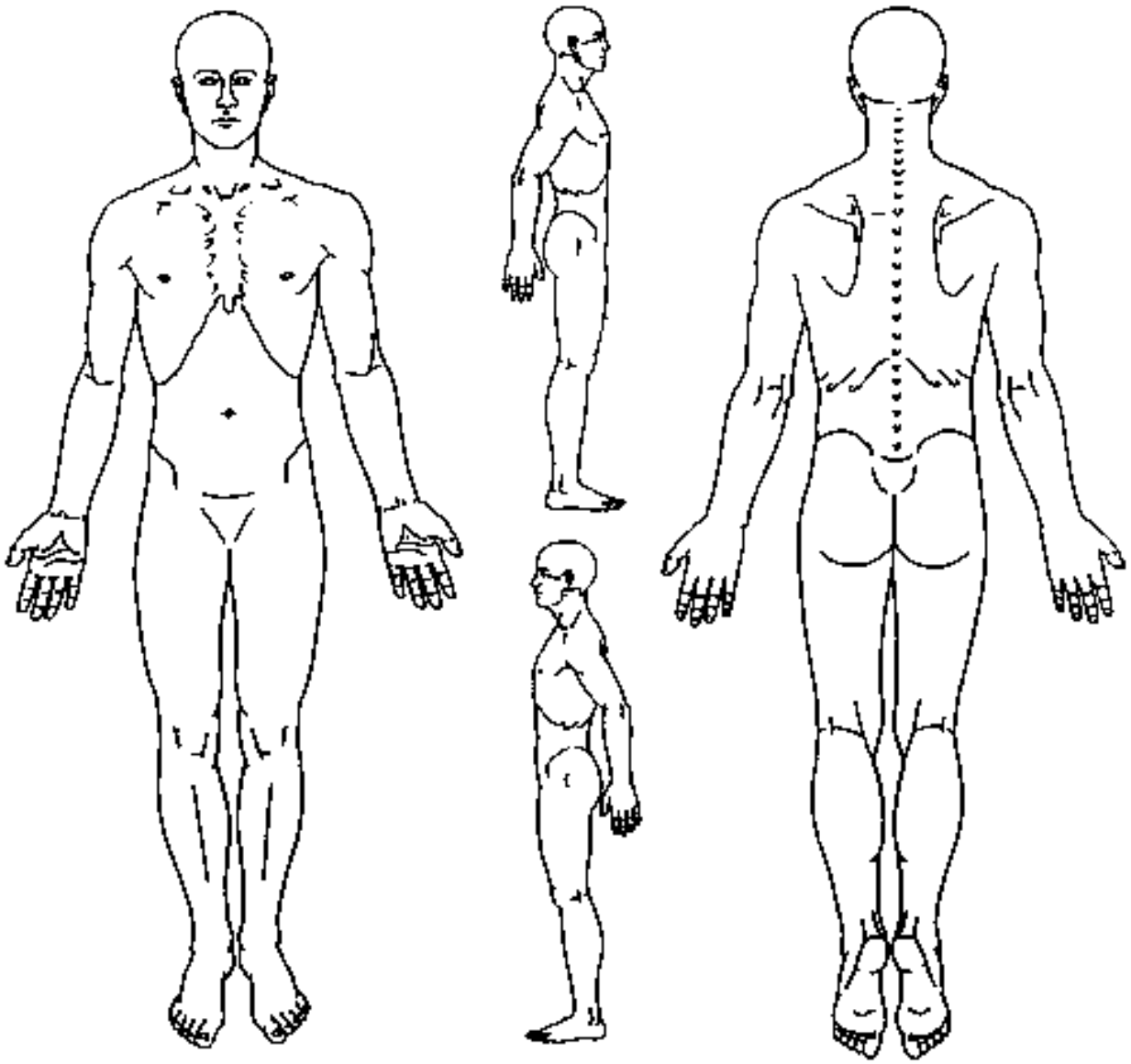
DISABILITY INDEX SCORE: %_____

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME _____ DATE _____

How long have you had back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER

Patient Information:

Full Name: _____

Address: _____

Date of Birth: _____ Soc. Sec. # _____

Medical Records Release

Facility Information is Requested From

_____
_____
_____

Requesting Organization

Texas Spine Clinic
3212 NAPIER PARK
SAN ANTONIO, TX 78231

Date and Type of Information Requested

_____/_____/_____ _____

_____/_____/_____ _____

_____/_____/_____ _____

I, _____, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1.) I do hereby authorize Texas Spine Clinic to obtain and release the following types of medical information: MRI/CT/Radiograph reports, History/Physical examination reports, Progress reports, Surgical reports and/or any information that could be relevant to my medical condition.
2.) I have the right to revoke this authorization at any time by writing to the health care provider listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3.) I understand that signing this authorization in voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be condition upon my authorization of this disclosure.
4.) Information disclosed under this authorization may be subject to redisclosure by the recipient.
5.) Date of authorization and expiration _____/_____/_____ thru _____/_____/_____

_____ _____

Patient Signature *Date*

New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, the Texas Spine Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that the Texas Spine Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Texas Spine Clinic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Texas Spine Clinic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Who may we share your information regarding ☐Medical information ☐ Billing/Payment information?

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including but not limited to disclosures via fax, email, telephone, and by mail.

I fully understand and accept / decline the terms of this consent.

_____ _____

Patient's Signature Date