DEMOGRAPHICS

Name: Last, first, MI

Date of birth

Gender:

Address

Phone numbers

1-……………..

2……………,.,

3………………

SOCIAL STATUS:

Employment: FT, PT, Student, Retired, Unemployed

Occupation

Employer name and address

Marital Status

EMERGENCY CONTACTS

Name

Relation

Contacts numbers

Smoker? Heavy drinker?

INSURANCE

* Is it a work-related accident? Y/N
	+ If yes: date of accident
	+ State of the accident (NY; NJ; other)
	+ Lawyer’s information
* Is it a personal injury case?
	+ If yes: date of accident
	+ State of the accident (NY; NJ; other)
	+ Lawyer’s information
* Personal primary insurance:
	+ Name
	+ Policy #:
	+ Group #:
	+ Telephone#:
	+ Fax Number#:
* Secondary Insurance:
	+ Name
	+ Policy #:
	+ Group #:
	+ Telephone#:
	+ Fax Number#:

OTHER CARE TAKERS

* Who referred you to MOS?:…………………………………………..
* List all Health Care professionals involved in your care (Physicians, PT, Chiropractors etc…)

NAME ADDRESS CONTACT NUMBERS Send a Note?

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

* Which one is your Primary Care Physician?

SYMPTOMS

* Is it more your back or your neck?
* Does the pain radiate down your arms of legs?
* Do you have weakness
* Do you have numbness or tingling?
* Any problem controlling your bladder?
* Have you had spinal surgery before? If yes please detail:……………………………………………………………

MEDICAL HISTORY:

* List all your medications:…………………………………………………………………………………….
* Any allergy?
* Medical conditions
* Check all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| High blood pressure | Stroke | Depression | Kidney disease |
| Heart condition | Headache | Lyme disease | Diabetes |
| Respiratory disease | Liver disease | Cancer | HIV-Positive |

PREVIOUS SPINE TREATMENTS: Please check the treatments that you already tried:

|  |  |  |  |
| --- | --- | --- | --- |
| Physical Therapy | Acupuncture | Trigger point injections | Epidural injections |
| Chiropractor | Massages | Sacroiliac injections | radiofrequency |
| Spinal cord Stimulator | Implantable pain pump | Surgery | Narcotics |

Please provide us with details about these treatments in the box below:

Thank you for filling out this form. Please don’t forget to also fill out:

* The HIPPA form
* The general health questionnaires
	+ VAS + SF-12 + Oswestry before surgery on your lumbar spine
	+ VAS + sf-12 + Neck Disability Index (NDI) before surgery on your cervical spine