THE SPINE & PAIN CENTER

PATIENT DEMOGRAPHICS

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

Social Security Number:_____ Email Address:_____

Cell Number:_____ Home Number:_____ Work Number:_____

Address:_____ Employer Name and Number:_____

Referring Physician:_____ Primary Care Physician:_____

Primary Insurance:_____ Ins. ID:_____ Secondary Insurance:_____ Ins. ID:_____

Workers Compensation Related: Yes ◯ No ◯ Motor Vehicle Accident Related: Yes ◯ No ◯

MEDICAL HISTORY

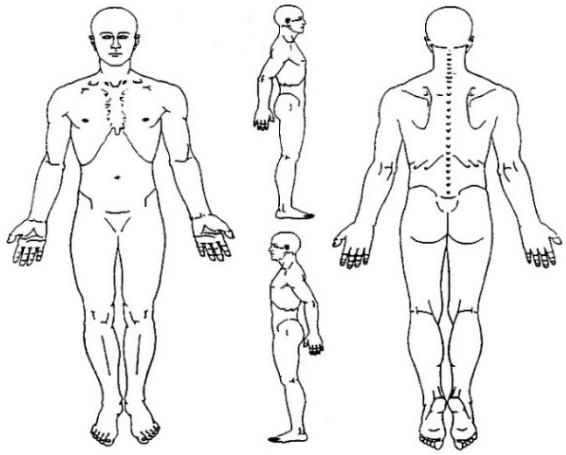
☐ Male ☐ Female Height:_____ Weight:_____ Age:_____

Briefly describe your main problem:_____

When/How did your pain start? (Approximate date)_____

Is your pain constant or does it come and go?_____

Indicate on the diagram below the area(s) of your pain. Use "X" for pain and "O" for numbness.



Present level of pain intensity (select one)

0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

No pain Mild Moderate Severe Excruciating

What words best describe your pain? (check many that apply) Sharp Burning Throbbing Shooting Aching Cramping Stabbing Crushing Dull Tingling Coldness Hotness Electricity

What brings on the pain or makes it worse? (check many that apply) Sitting Standing Walking Twisting Lifting Sneezing Coughing Using arms Bending Forward Bending Backward Other:_____

What helps/eases the pain? (check as many that apply) Lying down Standing Exercise Arthritis Medication Pain medication Muscle Relaxants Nothing Other:_____

Have you received/tried any of the following to treat your pain? (please check any that apply) Tens Unit Chiropractic Therapy Physical Therapy Biofeedback njection Therapy(Please note injections):_____

Please check all the following medical problems that you have been **diagnosed** with:

☐ Diabetic Neuropathy	☐ Diabetes	☐ Liver Disease	☐ Heart Problems-Specify:_____
☐ Postherpetic Neuralgia	☐ Stroke	☐ Osteoporosis	☐ Lung Problems-Specify:_____
☐ High Blood Pressure	☐ Depression	☐ Kidney Disease	☐ Thyroid Problems-Specify:_____
☐ Restless Leg Syndrome	☐ Hepatitis	☐ HIV/AIDS	☐ Cancer-Specify:_____
☐ Stomach Ulcers	☐ Seizures	☐ Fibromyalgia	☐ Other:_____

CURRENT MEDICATIONS

(Include over the counter medications/supplements)

Medication	Dose/Frequency	Medication	Dose/Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Medical Marijuana? ☐ Yes ☐ No

ALLERGIES

☐ No Known Drug Allergies

☐ Allergy to IODINE/INJECTABLE DYE- Reaction/Severity: _____

Name	Reaction/Severity	Name	Reaction/Severity
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

If applicable, please provide your **Cardiologist's name and number**: _____

Please list all past surgeries you have had (include year of surgery):

_____ _____ _____

_____ _____ _____

Do you have any implantable devices? If yes, please explain: _____

REVIEW OF SYSTEMS (Please circle any that apply)

General	Fever Weight loss/gain Poor Appetite Sexual Problems Insomnia
Neurological	Headache Seizures Paralysis Confusion Disorientation
Eye, Ear, Nose, Throat	Blurry Vision Trouble Swallowing Loss of Hearing Voice Changes
Respiratory	Emphysema Bronchitis Asthma Tuberculosis Shortness of Breath
Cardiovascular	Chest Pain Abnormal Heart Beats Heart Failure Heart Murmurs
Gastrointestional	Nausea Vomiting Hepatitis Pancreatitis Blood in Stool Constipation
Genitourinary	Blood in Urine Recurrent Urinary Infections Kidney Stones Trouble Urinating
Musculoskeletal	Rheumatoid Arthritis Lupus Erythematosus Gout
Skin	Rash Open Sores Recurrent Infections Tumors Skin Cancer
Endocrine	Diabetes Thyroid Problems Adrenal Dysfunction Pituitary Problems
Hematologic	Leukemia Lymphoma Anemia Bleeding Gums
Other:	

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

What is/was your occupation? _____

☐ Work full time ☐ Work part time ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Disability

If not currently working, when was the last time you worked? _____

Current Tobacco Use: ☐ Non-smoker ☐ 1-9 cigs/day ☐ 10-19 cigs/day ☐ 20-39 cigs/day ☐ 40+ cigs/day

☐ Ex-smoker Date: _____ ☐ Cigar smoker ☐ Chews tobacco

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have 6 or more drinks on 1 occasion?

☐ Never ☐ Less than monthly ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

FAMILY/PERSONAL HISTORY QUESTIONAIRE

Do you have a family history of any of these problems? (check as many that apply) ☐ Depression ☐ Mental Illness ☐ Stroke
☐ Heart Problems ☐ Cancer-Type:_____ Other: _____

Please check any of the following that you have been diagnosed with:

☐ Attention Deficit Disorder ☐ Obsessive Compulsive Disorder ☐ Bipolar ☐ Schizophrenia ☐ Depression ☐ None

Is your age between 16-45? ☐ Yes ☐ No

Do you have a history of Preadolescent Sexual Abuse? ☐ Yes ☐ No

Do you have a family history of? ☐ Alcohol Abuse ☐ Illegal Drug Use ☐ Prescription Drug Abuse ☐ None

Do you have a personal history of? ☐ Alcohol Abuse ☐ Illegal Drug Use ☐ Prescription Drug Abuse ☐ None

PAPERLESS STATEMENT AUTHORIZATION

☐ opt in

I understand that by electing to receive my billing statements electronically, I will not receive these documents in paper form by mail or otherwise. I understand that I must inform The Spine and Pain Center/Stem Cell Therapies of Oklahoma of changes to my email address.

☐ opt out

I understand that by electing to receive my billing statements in paper form, I will not receive these documents in electronic form or otherwise. I understand that I must inform The Spine and Pain Center/Stem Cell Therapies of Oklahoma of changes to my physical address.

By signing this document, I acknowledge receipt and understanding of the Paperless Statement Authorization.

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

By signing this document, I do willfully and voluntarily authorize the release of information to the following family member(s) or person(s) listed below on my behalf. The Spine and Pain Center/Stem Cell Therapies of Oklahoma will not release any information to individuals that call the office on your behalf unless they are listed below. I understand that this release will remain in effect until a change is requested in paper.

By signing this document, I acknowledge receipt and understanding of the Authorization and Consent for Release of Information.

Emergency Contact #1: _____ Relationship: _____ Phone Number: _____

Emergency Contact #2: _____ Relationship: _____ Phone Number: _____

FINANCIAL POLICY

By signing this document, I acknowledge receipt and understanding of The Spine and Pain Center/Stem Cell Therapies of Oklahoma's Financial Policy. I understand that if I would like a copy of this notice, they are available at the front desk or I may view it on www.thespineandpaincenter.com.

By signing this document, I acknowledge receipt and understanding of the Financial Policy.

DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

By signing this document, I acknowledge receipt and understanding of The Spine and Pain Center/Stem Cell Therapies of Okahoma's Disclosure of Physician Ownership Notice. I understand that if I would like a copy of this notice, they are available at the front desk or I may view it on www.thespineandpaincenter.com.

By signing this document, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Tulsa Spine and Specialty Hospital.

PATIENT COMMUNICATION AGREEMENT

By signing this document, I agree to allow The Spine and Pain Center/Stem Cell Therapies of Oklahoma to contact me via e-mail, phone and/or text messaging. I understand that these methods of communication can be utilized for appointment reminders, online portal access, appointment intake forms and necessary notifications from the practice to patients.

By signing this document, I acknowledge receipt and understanding of the Patient Communication Agreement.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing this document, I acknowledge receipt and understanding of The Spine and Pain Center/Stem Cell therapies of Oklahoma's Privacy Practices. I understand that if I would like a copy of this notice, they are available at the front desk or I may view it on www.thespineandpaincenter.com.

By signing this document, I acknowledge receipt and understanding of the Acknowledgement of Privacy Practices.

SIGNATURE & DATE

By signing this document, I certify that the above information is complete and was answered to the best of my knowledge. Furthermore, I acknowledge receipt and understanding of the Paperless Statement Authorization, Authorization and Consent for Release of Information, Financial Policy, Disclosure of Physician Ownership Notice to Patients, Patient Communication Agreement, and Acknowledgement of Privacy Practices. I acknowledge that copies of these notices/policies have been offered to me and are readily available at the front desk.

Patient Name/Responsible Party (Printed)	Patient/Responsible Party Signature	Today's Date

THE SPINE & PAIN CENTER

Authorization and Consent for Release of Medical Records

In order for The Spine and Pain Center/Stem Cell therapies of Oklahoma to provide you with the best possible care, we may require copies of your medical records. For us to obtain this information, we will need your written permission. Please review the Authorization and Consent for Release of Medical Records below. Your signature on this form will allow us to obtain the necessary information.

Being competent, eighteen (18) years of age or older and duly authorized; do willfully and voluntarily authorize the release of all medical records and information to The Spine and Pain Center/Stem Cell Therapies of Oklahoma.

I further understand and acknowledge the information authorized for release may include information which may be considered a communicable or venereal disease which may or may not include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome or AIDS.

_____

Full Name of Patient (Please print)

XXX-XX-_____/___/_____

Last 4 Social Security Number Date of Birth

_____/___/_____

Authorized Signature Today's Date

For medical records use only, please DO NOT complete this section.

Record Holder: _____ Fax Number: _____

The Spine and Pain Center/Stem Cell Therapies of Oklahoma requests the following information at this time:

_____ All dictated reports _____ All radiology reports

_____ All anesthesia reports _____ All therapy records

Other: _____

Please fax this information to The Spine and Pain Center/Stem Cell Therapies of Oklahoma at 918-727-7200. If you are unable to fax the chart due to its size, please contact our office so that other arrangements can be made.