Capital Neurological Surgeons

NAME OF ***PRIMARY CARE*** DR. _____ PHONE _____

NAME OF ***REFERRING*** DR. _____ PHONE _____

PATIENT NAME _____ADDRESS_____
Last *First* *M*
CITY/ST_____ ZIP_____

HM PHONE _____ WK PHONE_____ CELL PHONE _____

EMAIL ADDRESS: _____

BIRTHDATE _____ AGE ____ EMPLOYER _____ OCCUPATION_____

SS#_____ SEX: M F SPOUSE / SO NAME_____ Phone _____

RACE: _____ ETHNICITY: _____PRIMARY LANGUAGE: _____ (Government requirement)

PERSON TO NOTIFY IN EMERGENCY_____PHONE_____

Have you or has anyone in your family been seen in our office before? _____

PRIVATE INSURANCE INFORMATION

PRIMARY CARRIER_____

SUBSCRIBER NAME _____ SEX: M F SUBSCRIBER BIRTHDATE _____

ID #_____ GROUP #_____ CO-PAY $_____ AUTH PHONE_____

SECONDARY CARRIER _____

SUBSCRIBER NAME _____ SEX: M F SUBSCRIBER BIRTHDATE _____

ID #_____ GROUP #_____ AUTHORIZATION PHONE _____

WORKERS COMPENSATION INFORMATION

Work Comp CARRIER_____

ADDRESS_____PHONE_____ ADJUSTER_____

EMPLOYER AT TIME OF INJURY_____ ADDRESS _____

EMP PHONE _____ DATE OF INJURY_____ CLAIM # _____

I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I assign medical and/or major medical insurance benefits to Capital Neurological Surgeons. I authorize Capital Neurological Surgeons to release all information necessary to secure payment and to file in my behalf any complaints to the California Insurance Commissioner.

_____ _____
Signature Date

NAME _____ Age ___ Height _____ Weight _____

Reason for neurosurgical consultation: What is the main problem for which you are here?

(back pain, neck pain, headache, etc) _____

Medications: Please list all current medications and dosages: _____

_____ _____ _____ _____

_____ _____ _____ _____

***Allergies* to Medications or Latex?** _____

Chronic Problems: Check any of the conditions that apply to you:

○High Blood Pressure	○Arthritis	○Alcoholism	○Skin Disease
○Diabetes	○Depression	○Hepatitis	○Sleep Apnea
○Fibromyalgia	○Cancer	○Emphysema	○Seizures
○Heart Disease	○Kidney problems	○Heartburn	○Asthma
○Stroke	○Anemia	○History of drug use	

Operations: Please list any surgeries that you have had and the dates: _____

_____ _____ _____ _____

Hospitalizations: Please list any recent hospitalizations (other than above) and the dates: _____
_____

Family History: Please mark if any of your immediate family had any of the following conditions – please note the relationship of the individual (e.g. father, mother, sister, brother)

○High blood pressure	○Seizures	○Diabetes
○Anesthesia problems	○Stroke	○Birth Defects
○Heart disease	○Cancer	○Neurological Diseases
○Kidney Disease		

Social History:

Education (number of years, degrees): _____ Hand you write with: R L

Occupation _____ Employer _____ Years employed _____

Are you working now? ____ if not, when is the last day you worked? _____ Marital Status: S M D W

Spouse/significant other: _____ Ages of children living at home with you:_____

Habits:

Tobacco: Yes No *If yes,* ○chew ○cigars ○pipe ○cigarettes ____packs/day for ___yrs
If no, have you ever used tobacco in the past? Yes No

Alcohol: ○Never ○Occasional (2-6/month) ○Frequent (2-6/week) ○Daily

NAME _____ Age _____

Pain Report

My pain began about ____days ____weeks ____months ____years ago.

On a scale from 0-10, with 0 being no pain and 10 being the worst pain imaginable, what is your pain level? _____

Do you have any:

Sharp pain? ___ If so, where? _____ Is it constant or intermittent (circle one)

Burning pain? ___ Where? _____ _ constant or intermittent

Aching pain? ___ Where? _____ constant or intermittent

Numbness? ___ Where? _____ _ constant or intermittent

Tingling? ___ Where? _____ constant or intermittent

Weakness? ___ Where? _____ constant or intermittent

What makes the pain better? _____

What makes the pain worse? _____

The pain makes it difficult for me to do these daily activities: (circle all that apply)

Bathing Eating Dressing Toileting Walking Climbing stairs Driving

Sleeping Performing normal housework/yardwork

Conservative Management

I have tried the following conservative treatment:

Medications (please list) _____ helped ___% _____ helped ___%

_____ helped ___% _____ helped ___%

Physical Therapy at _____ (Facility) _____ times a week for _____ weeks helped ___%

Epidural Steriod Injections Yes No How many? _____ Date of Injection #1 _____ helped ___%

Injection #2 _____ helped _____% Injection #3 _____ helped ____%

Used a (circle all that apply) cane walker brace TENS unit Did it help? Yes No ___%

Bed rest for _____weeks

Other _____

Have you had an EMG? Yes No If yes, provider _____

Oswestry Disability Index

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | *Unbearable pain*

Name_____ Today's Date_____ DOB_____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 - Pain Intensity
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Section 2 - Personal Care (Washing, Dressing, etc.)
0. I can look after myself normally 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 manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - 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 lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed. e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently placed.
5. I can lift very light weights.
6. I cannot lift or carry anything at all

Section 4 - Walking
0. Pain does not prevent me walking any distance.
1. Pain prevents me from walking more than 1 mile.
2. Pain prevents me from walking more than ½ mile.
3. Pain prevents me from walking more than 100 yards.
4. I can only walk using a stick or crutches.
5. I am in bed most of the time.

Section 5 - Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 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.

Section 6 - 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 me extra pain.
2. Pain prevents me from standing for more than 1 hour.
3. Pain prevents me from standing for more than 30 minutes.
4. Pain prevents me from standing for more than 10 minutes.
5. Pain prevents me from standing at all.

Section 7 - Sleeping
0. My sleep is never disturbed by pain.
1. My sleep is occasionally disturbed by pain.
2. Because of pain I have less than 6 hours sleep.
3. Because of pain I have less than 4 hours sleep.
4. Because of pain I have less than 2 hours sleep.
5. Pain prevents me from sleeping at all.

Section 8 - Sex life (if applicable)
0. My sex life is normal and causes no extra pain.
1. My sex life is normal but causes some extra pain.
2. My sex life is nearly normal but is very painful.
3. My sex life is severely restricted by pain.
4. My sex life is nearly absent because of pain.
5. Pain prevents any sex life at all.

Section 9 - Social life
0. My social life is normal and gives me no extra pain.
1. My social life is normal but increases the degree of pain.
2 Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport.
3. Pain has restricted my social life and I do not go out as often.
4. Pain has restricted my social life to my home.
5. I have no social life because of pain.

Section 10 - Travelling
0. I can travel anywhere without pain.
1. I can travel anywhere but it gives me extra pain.
2. Pain is bad but I manage journeys over two hours.
3 Pain restricts me to journeys of less than one hour.
4. Pain restricts me to short necessary journeys under 30 minutes.
5. Pain prevents me from travelling except to receive treatment