

Name: _____

SSN: _____

Patient Medical Information

Name: First _____ Middle _____

Last _____

Sex: M / F Age: _____ Date of Birth: _____

Social Security # _____ Driver's License # _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Occupation: _____ Employer: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: _____ Spouse/Significant Other: _____

Cell: _____ Business/Other Phone: _____

Is this pain the result of an automobile accident? (Y / N)

Insurance Information

Our office policy requests copies of both your insurance card(s) and picture ID

Primary Insurance:
Company _____
Subscriber Name _____
DOB _____
Social Security # _____
Group # _____
Subscriber # _____

Secondary Insurance:
Company _____
Subscriber Name _____
DOB _____
Social Security # _____
Group # _____
Subscriber # _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with (name of insurance companies) _____ and assign directly to Dr. Mark Schlesinger all insurance benefits, if any, otherwise directly payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurances. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Name: _____

SSN: _____

Physicians

Who is your primary care physician? _____

Who referred you to this office? _____

Complete List of Physicians:

Cardiologist _____

Neurologist _____

Orthopedic Surgeon _____

Neurosurgeon _____

Other Physician _____

Other Physician _____

Other Physician _____

Reason for Visit:

When did the pain begin?

Where does it hurt?

Does the pain travel anywhere?

Describe your pain. Circle all that apply:

- | | | | |
|-----------|-----------|----------|---------------|
| Aching | Band-like | Burning | Cramping |
| Dull | Numbness | Piercing | Pinching |
| Prickly | Sharp | Shooting | Stabbing |
| Throbbing | Tingling | Twisting | Indescribable |

Other (describe): _____

Severity:

- | | | | |
|------|----------|--------|--------------|
| Mild | Moderate | Severe | Excruciating |
|------|----------|--------|--------------|

Episodic Severity:

- | | | | |
|----------|--------|--------------|------------|
| Moderate | Severe | Excruciating | Unbearable |
|----------|--------|--------------|------------|

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On a scale of 1 to 10 (0 being no pain and 10 being the worst pain imaginable), how would you rate your pain now? _____

Limitations

How does the pain interfere with your life?

Stand up straight Walk normally Sit comfortably Bend Over

Concentrate Groom yourself Bathe yourself Shopping

Housekeeping Days of work missed _____

Does the pain interfere with sleeping? Y / N, If so, how?

Falling asleep Staying asleep Getting back to sleep

Awakening too early Waking # time per night _____

When did the pain begin? _____

Was there an associated accident/injury/inciting event? Y / N, If so, when? _____

Failed Surgery Work Injury Heavy Lifting

Sports Injury Fall Threw Back Out

MVA Describe: _____

My pain is:

Continuous Intermittent Episodic

Episodic Frequency _____ Duration of Episode _____

RPMHx

Do you have a history of:

Spinal Fracture Spinal Curvature Arthritic Conditions Fibromyalgia

Disc Disease Spinal Stenosis Obesity

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What treatments have you tried that make your pain better? (circle all that apply)

Rest	Ice/Cold	Heat/Warm Compress
Immobilization	Massage	Specific Positions _____
Narcotics	Aspirin/Tylenol/Motrin	Physical Therapy
Chiropractic Care	Acupuncture	Muscle Relaxeres
Oral Steroids	Epidural Injections	By Whom? _____

What treatments have you tried that either do not make your pain better or in fact make it worse? (circle all that apply)

Rest	Ice/Cold	Heat/Warm Compress
Immobilization	Massage	Specific Positions _____
Narcotics	Aspirin/Tylenol/Motrin	Physical Therapy
Chiropractic Care	Acupuncture	Muscle Relaxeres
Oral Steroids	Epidural Injections	By Whom? _____

Do you have?

Bowel Incontinence Bladder Incontinence Weakness/Coordination Problems

Past Medical History (circle all that apply)

Cardiovascular

High Blood Pressure	Low Blood Pressure	Chest Pain	Heart Attack
Rhythm Problems	Embolism	Arterial Insufficiency	Venous Insufficiency

Respiratory

Asthma	Emphysema	Chronic Bronchitis	Frequent Pneumonia
Frequent Colds	Productive Cough	Positive TB test	Abnormal CXR

Gastrointestinal

Acid Reflux	Ulcers	Polyps	Hepatitis
Pancreatitis	Bowel Problems	Colitis	Hiatal Hernia
Gallbladder Problems	Irritable Bowel Synd.	Crohn's Disease	

Endocrine

Obesity	Hypothyroidism	Diabetes	Insulin
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Hematologic

Bleeding Disorders	Anemia	Easy Bruising	Blood Clots
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Neurologic

Memory Problems	Seizures	Stroke	Movement Disorders
Muscular Dystrophy	Polio	Neuropathy	Epilepsy
Migraines	Chronic Headaches		

Psychological

Nervous Breakdown	Depression	Anxiety	Panic Disorders
Claustrophobia	Psychosis	Alcohol Abuse	Drug Abuse

Genitourinary

Sexual Dysfunction	STD's	Prostate Problems	Kidney Problems
Bladder Problems	Chronic Infection	Incontinence	

Musculoskeletal

Fibromyalgia	Rheumatoid Arthritis	Osteoarthritis	Osteoporosis
Back Problems	Neck Problems	Scoliosis	

Cancer History

Site	Date of Diagnosis	Chemotherapy	Radiation
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Have you ever been tested for HIV? Y / N Results: _____

Have you ever been tested for Hepatitis? Y / N Results: _____

Have you ever had a blood transfusion? Y / N Dates: _____

Are you taking any blood thinners such as coumadin, plavix or ticlid? _____

Please list all of your medicines.

Medicine	Dose	Starting Date	Times per day	As Needed	Pills per day

Name: _____

SSN: _____

Please list all of your allergies. (None)

Medication	Reaction

Local Pharmacy (Where would you like your prescriptions to be filled?)

Name _____ Phone # _____
 Address _____ Fax # _____

Family History

Relative	Condition 1	Condition 2	Condition 3	Condition 4
Father				
Mother				
Brother				
Sister				
Other				

Surgical History

Please List All

Operations:

Procedure	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Marital Status

Single Married Widowed Divorced Other: _____

Smoking

Never Started: _____ Stopped: _____ Packs per day: _____

Alcohol

Never Rarely Socially Daily # of Drinks _____

Have you ever been treated for Alcoholism? Y / N

If so, how long have you been sober? _____

Height: _____ Weight: _____

Have there been any recent changes?

Name: _____

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Pain Diagram

TYPE OF PAIN YOU ARE CURRENTLY EXPERIENCING...

Place appropriate symbol or letter on the diagram.

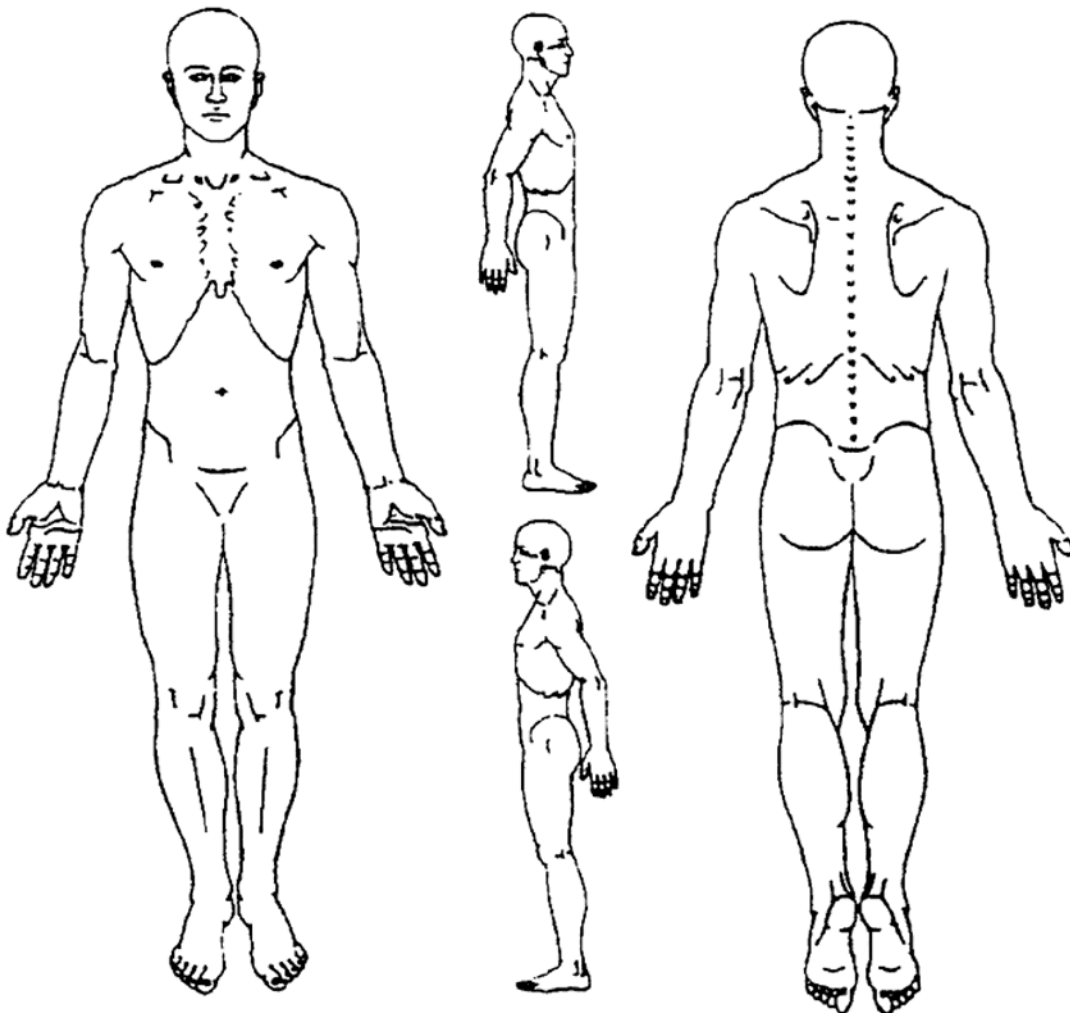
Ache = AAAAA

Numbness = NNNNN

Pins and Needles = OOOOO

Burning = XXXXX

Stabbing = /////



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Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem**.

Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Walking*

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 2 kilometres
- Pain prevents me from walking more than 1 kilometre
- Pain prevents me from walking more than 500 metres
- I can only walk using a stick or crutches
- I am in bed most of the time

Section 5: Sitting

- I can sit in any chair as long as I like
- I can only sit in my favourite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9: Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10: Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment