



PACIFIC HEIGHTS SPINE CENTER

Cervical, Complex and Minimally Invasive Spine Surgery

2100 Webster Street, Suite 314 • San Francisco, CA 94115

1580 Valencia Street, Suite 703 • San Francisco, CA 94110

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Cervical Spine

New Patient Forms



Your cooperation in answering all these questions is greatly appreciated.
It will help in your evaluation

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 Tel: (415) 737-0555 • Fax: (415) 737-0595

Confidential Intake Form – New Patient

TODAY'S DATE	TYPE OF APPOINTMENT <input type="checkbox"/> NEW-PATIENT CONSULTATION <input type="checkbox"/> SECOND OPINION	PREFERRED LANGUAGE
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Contact Information

LAST NAME		FIRST NAME (INITIALS, NICKNAMES)		MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
HOME ADDRESS			HOME TELEPHONE	CELL	
			WORK TELEPHONE	FAX	
EMPLOYED <input type="checkbox"/>	OCCUPATION	UNEMPLOYED <input type="checkbox"/>	RETIRED <input type="checkbox"/>	EMAIL	
IF EMPLOYED, EMPLOYER NAME AND ADDRESS			<input type="checkbox"/> EMPLOYED PART-TIME <input type="checkbox"/> EMPLOYED FULL-TIME	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> PARTNERED <input type="checkbox"/> DIVORCED	
			<input type="checkbox"/> STUDENT <input type="checkbox"/> PART-TIME <input type="checkbox"/> FULL-TIME	SPOUSE/PARTNER NAME	
		DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	
DIAGNOSIS/PROBLEM/SYMPTOMS					

Primary Insurance

INSURANCE CARRIER (COMPANY NAME)		TYPE <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> SELF-PAY		GROUP NUMBER	
ADDRESS OF INSURANCE CARRIER		SUBSCRIBER'S ID NUMBER		PLAN CODE	
		SUBSCRIBER'S NAME		DATE OF BIRTH	
BENEFITS/CUSTOMER SERVICE TELEPHONE		SUBSCRIBER'S ADDRESS			
AMOUNT OF DEDUCTIBLE \$	DEDUCTIBLE HAS BEEN MET <input type="checkbox"/> YES <input type="checkbox"/> NO				
AMOUNT OF COPAYMENT \$			SUBSCRIBER'S TELEPHONE	RELATIONSHIP TO SUBSCRIBER	

Secondary Insurance

INSURANCE CARRIER (COMPANY NAME)		TYPE <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> SELF-PAY		GROUP NUMBER	
ADDRESS OF INSURANCE CARRIER		SUBSCRIBER'S ID NUMBER		PLAN CODE	
		SUBSCRIBER'S NAME		DATE OF BIRTH	
BENEFITS/CUSTOMER SERVICE TELEPHONE		SUBSCRIBER'S ADDRESS			
AMOUNT OF DEDUCTIBLE \$	DEDUCTIBLE HAS BEEN MET <input type="checkbox"/> YES <input type="checkbox"/> NO				
AMOUNT OF COPAYMENT \$			SUBSCRIBER'S TELEPHONE	RELATIONSHIP TO SUBSCRIBER	

Referral Information

REFERRED BY	RELATIONSHIP TO PATIENT (E.G. PRIMARY DOCTOR)	TELEPHONE
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In Case of Emergency

CONTACT PERSON	RELATIONSHIP TO PATIENT	TELEPHONE
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Assignment of Benefits/Financial Responsibility/Authorization to Release Medical Information

I hereby assign medical and/or surgical payments – including major medical benefits to which I am entitled, private insurance, and proceeds from any other health plan – to Rayshad Oshtory, M.D., for services he provides. This assignment shall remain in effect until I submit a written revocation to him. I understand that I am financially responsible for all charges for the provided services, whether or not they are paid for by such insurance. I hereby authorize assignee to release any of the above information and/or any medical information necessary to secure payment. A copy of this assignment shall be as valid as the original.

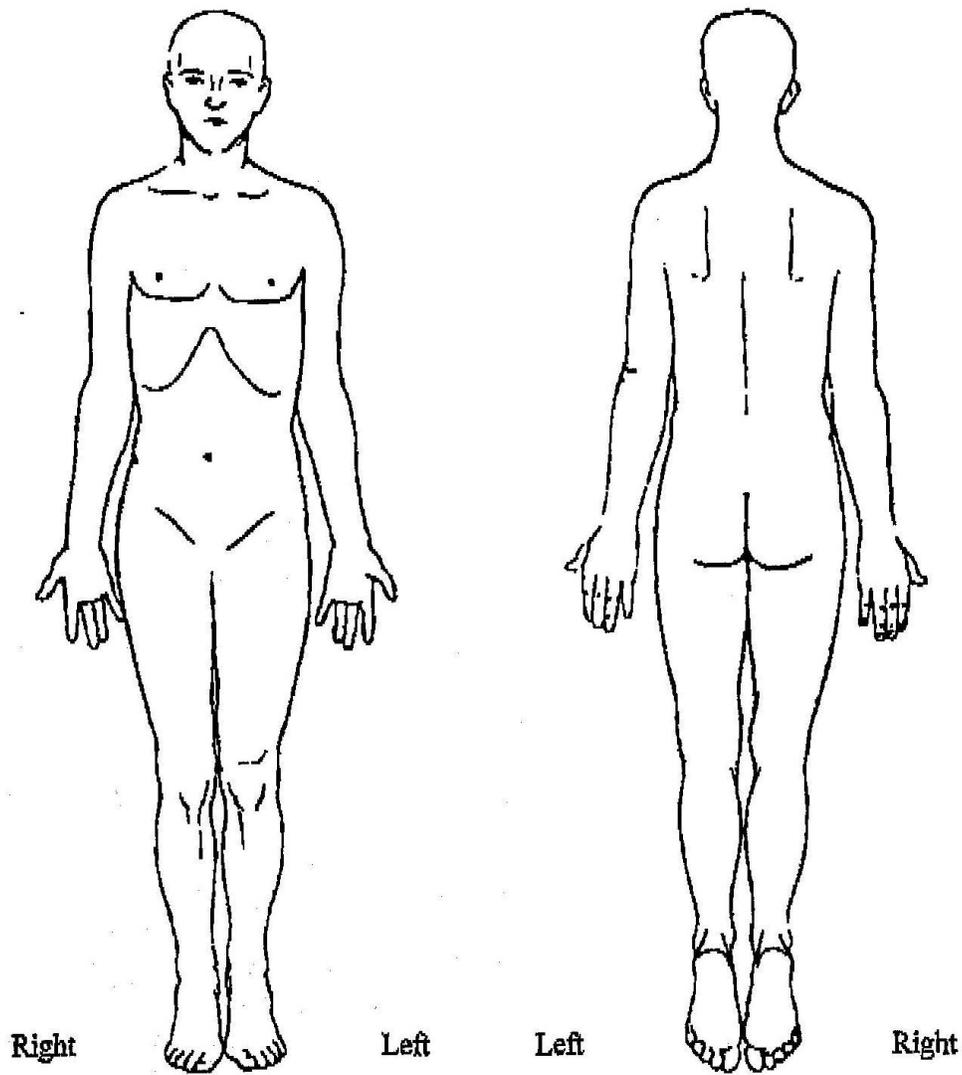
Date: _____ Patient Acknowledgement (Signature): _____

Name: _____ Date: _____

Pain Drawing

This pain drawing will help us understand the pain you have been experiencing. Using the diagrams below, use the symbols listed below to indicate what type of pain you are having and where it is located:

---	Numbness
□□□	Pins and needles
○○○	Burning pain
△△△	Stabbing pain
×××	Aching pain



Name: _____ Date: _____

Date of Birth: _____ Sex: M F

What is your Height: _____ What is your Weight: _____

Who referred you here: _____

MAJOR Complaint: (if both neck and arm please give a PERCENTAGE in each)

Pain in: Neck _____ Arm _____ Left _____ Right _____

Please indicate the severity of the pain as it is *most* of the time by marking the line with a **SINGLE vertical line “|”** (0=no pain, 10=worst pain)

Neck



Arm



Duration of current symptoms: _____ Weeks _____ Months _____ Years

Date of initial onset (if known): _____

Is there numbness and/or tingling associated with the pain: Yes No

Is there weakness in the affected arm or hand: Yes No

Have you noticed bowel or bladder problems (e.g. incontinence): Yes No

What have you tried for your symptoms thus far:

- Physical Therapy Traction Exercise
- Acupuncture Chiropractic TENS unit
- Injections Medications Other: _____

Indicate which activities WORSEN your symptoms:

- Sitting Standing Walking
- Lying down Bending forward Bending backward

Indicate which activities IMPROVE your symptoms:

- Sitting Standing Walking
- Lying down Bending forward Bending backward

Name: _____ Date: _____

Is your pain worse:

- In the morning
- Mid-day
- In the evening
- Other: _____

Is your pain better:

- In the morning
- Mid-day
- In the evening
- Other: _____

Which studies of your back or neck, if any, have you had in the last 2 years:

- Regular X-rays
- Bending X-rays
- MRI
- CT Scan
- Myelogram
- EMG
- Discogram
- CT Myelogram

Indicate any Medical History you have:

- High blood pressure
- Heart
- Lung
- Diabetes
- Thyroid
- Kidneys
- Liver
- Stomach
- Hepatitis C
- HIV
- Other (Please list): _____

Have you ever had neck or back surgery before: Yes No

Please list ALL prior surgeries (Spine AND Non-Spine) with dates (Month/Year):

List (or include a list) of all current Medications:

Are you Allergic to any medications: Yes No

If yes, please list Medication(s) and Reaction(s): _____

Name: _____ Date: _____

Do you smoke or use Tobacco products: Yes No

If yes, for how long: _____

Packs smoked per day: <1/2 1/2 1 2 3 4

Do you drink Alcohol: Yes No

If yes, drinks per day: <1 1 2 3 4 5 >5

Do you use any other Drugs: Yes No If yes, which drugs: _____

Are you on Disability: Yes No If yes, Date started: _____

Is there a lawsuit associate with this injury: Yes No

Is this a worker's compensation claim: Yes No

If yes, When was the date of injury: _____

BRIEFLY describe the mechanism of injury: _____

Are you currently: Employed Unemployed Student Retired

If employed, what is your occupation: _____

Are you presently working: Yes No

If no, what is the last date worked: _____

Are you: Married/Partnered Single Divorced/Separated Widowed

Number of Children, if any: _____

List any family member, with history of heart, lung, liver or kidney disease; arthritis, gout, glaucoma, or cancer; neck or back problems:

Relationship: _____ Disease: _____

Name: _____ Date: _____

EXTENDED REVIEW OF SYSTEMS: Do you presently have any problems or symptoms in the following areas? If “Yes”, please explain briefly:

	Yes	No	Explanation:	Provider Comments:
1. General				
Good health	<input type="checkbox"/>	<input type="checkbox"/>		
Fever, chills, sweats	<input type="checkbox"/>	<input type="checkbox"/>		
2. Eyes				
Wear glasses or contact lenses	<input type="checkbox"/>	<input type="checkbox"/>		
Vision problems (blurred, double, or loss of vision)	<input type="checkbox"/>	<input type="checkbox"/>		
3. Ears/Nose/Mouth/Throat				
Change in hearing or ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		
4. Cardiovascular				
Heart trouble or heart attack	<input type="checkbox"/>	<input type="checkbox"/>		
Chest pain/angina (sharp, crushing, or heaviness)	<input type="checkbox"/>	<input type="checkbox"/>		
Heart racing/palpitations/arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>		
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>		
5. Respiratory				
Asthma, wheezing, shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		
Cough	<input type="checkbox"/>	<input type="checkbox"/>		
6. Gastrointestinal				
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>		
Bleeding ulcers	<input type="checkbox"/>	<input type="checkbox"/>		
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>		
7. Endocrine				
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>		
8. Hematologic/Lymphatic				
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent bleeding	<input type="checkbox"/>	<input type="checkbox"/>		
9. Skin and breasts				
Rashes or sores	<input type="checkbox"/>	<input type="checkbox"/>		
Skin cancer or melanoma	<input type="checkbox"/>	<input type="checkbox"/>		
Non-healing wounds	<input type="checkbox"/>	<input type="checkbox"/>		
10. Allergic/Immunologic				
Allergic reaction to drugs	<input type="checkbox"/>	<input type="checkbox"/>		
Recent cold or flu	<input type="checkbox"/>	<input type="checkbox"/>		
11. Genitourinary				
Painful or burning urination	<input type="checkbox"/>	<input type="checkbox"/>		
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>		
Bladder infection/other infections	<input type="checkbox"/>	<input type="checkbox"/>		
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>		
12. Musculoskeletal				
Joint stiffness or pain	<input type="checkbox"/>	<input type="checkbox"/>		
Back pain	<input type="checkbox"/>	<input type="checkbox"/>		
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>		
13. Neurological				
Numbness or tingling in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>		
Weakness in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		
14. Psychiatric				
Depression	<input type="checkbox"/>	<input type="checkbox"/>		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>		
15. Other (Please write in):				

Name: _____ Date: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire has been designed to give us information as to how your neck or arm pain is affecting your ability to manage in everyday life. Please answer each section by checking 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 CHECK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

<p>SECTION 1 - Pain Intensity</p> <p><input type="checkbox"/> I have no pain at the moment. <input type="checkbox"/> The pain is very mild at the moment. <input type="checkbox"/> The pain is moderate at the moment. <input type="checkbox"/> The pain is fairly severe at the moment. <input type="checkbox"/> The pain is very severe at the moment. <input type="checkbox"/> The pain is the worst imaginable at the moment.</p>	<p>SECTION 6 - Concentration</p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty. <input type="checkbox"/> I can concentrate fully when I want to with slight difficulty. <input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to. <input type="checkbox"/> I have a lot of difficulty in concentrating when I want to. <input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to. <input type="checkbox"/> I cannot concentrate at all.</p>
<p>SECTION 2 -Personal Care (Washing, Dressing, etc.)</p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain. <input type="checkbox"/> I can look after myself normally, but it causes extra pain. <input type="checkbox"/> It is painful to look after myself and I am slow and careful. <input type="checkbox"/> I need some help, but manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of self care. <input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.</p>	<p>SECTION 7 - Work</p> <p><input type="checkbox"/> I can do as much work as I want to. <input type="checkbox"/> I can only do my usual work, but no more. <input type="checkbox"/> I can do most of my usual work, but no more. <input type="checkbox"/> I cannot do my usual work. <input type="checkbox"/> I can hardly do any work at all. <input type="checkbox"/> I cannot do any work at all.</p>
<p>SECTION 3 - Lifting</p> <p><input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights, but it gives extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift very light weights. <input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p>SECTION 8 - Driving</p> <p><input type="checkbox"/> I can drive my car without any neck pain. <input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck. <input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck. <input type="checkbox"/> I cannot drive my car as long as I want because of moderate pain in my neck. <input type="checkbox"/> I can hardly drive at all because of severe pain in my neck. <input type="checkbox"/> I cannot drive my car at all.</p>
<p>SECTION 4 - Reading</p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck. <input type="checkbox"/> I can read as much as I want to with slight pain in my neck. <input type="checkbox"/> I can read as much as I want to with moderate pain in my neck. <input type="checkbox"/> I cannot read as much as I want because of moderate pain in my neck. <input type="checkbox"/> I cannot read as much as I want because of severe pain in my neck. <input type="checkbox"/> I cannot read at all.</p>	<p>SECTION 9 - Sleeping</p> <p><input type="checkbox"/> I have no trouble sleeping. <input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour sleepless). <input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless). <input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless). <input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless). <input type="checkbox"/> My sleep is completely disturbed (5-7 hours).</p>
<p>SECTION 5 - Headaches</p> <p><input type="checkbox"/> I have no headaches at all. <input type="checkbox"/> I have slight headaches which come infrequently. <input type="checkbox"/> I have moderate headaches which come infrequently. <input type="checkbox"/> I have moderate headaches which come frequently. <input type="checkbox"/> I have severe headaches which come frequently. <input type="checkbox"/> I have headaches almost all the time.</p>	<p>SECTION 10 - Recreation</p> <p><input type="checkbox"/> I am able to engage in all of my recreational activities with no neck pain at all. <input type="checkbox"/> I am able to engage in all of my recreational activities with some pain in my neck. <input type="checkbox"/> I am able to engage in most, but not all of my recreational activities because of pain in my neck. <input type="checkbox"/> I am able to engage in a few of my recreational activities because of pain in my neck. <input type="checkbox"/> I can hardly do any recreational activities because of pain in my neck. <input type="checkbox"/> I cannot do any recreational activities at all.</p>