PACIFIC HEIGHTS SPINE CENTER
Premier Comprehensive Spine Care

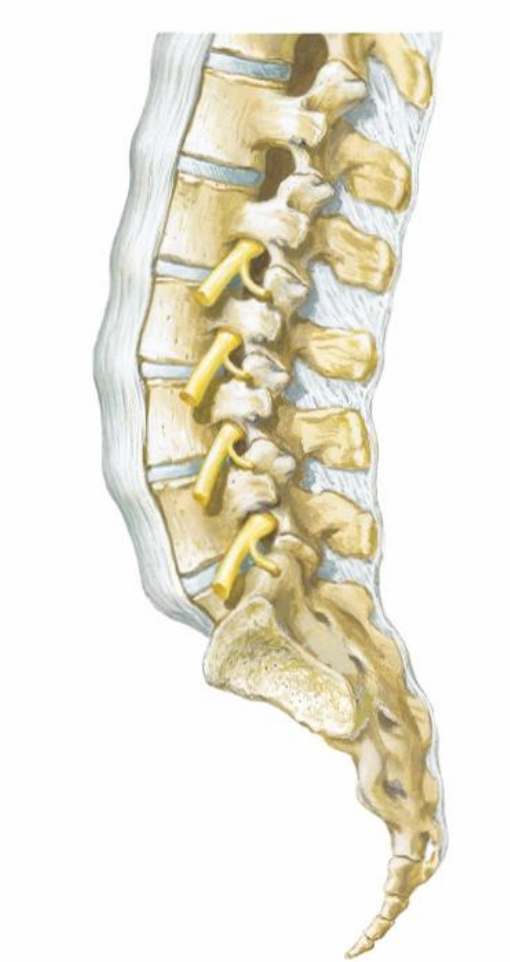
www.phspine.com

RAY OSHTORY, MD, MBA
Cervical, Complex and
Minimally Invasive Spine Surgery

KONRAD H. NG, MD
Multidisciplinary and
Interventional Pain Management

Lumbar Spine

New Patient Forms



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Confidential Intake Form – New Patient

TODAY'S DATE	TYPE OF APPOINTMENT ☐ NEW-PATIENT CONSULTATION ☐ SECOND OPINION	PREFERRED LANGUAGE

Contact Information

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

Primary Insurance

INSURANCE CARRIER (COMPANY NAME)		TYPE ☐ HMO ☐ PPO ☐ 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 ☐ YES ☐ NO		
AMOUNT OF COPAYMENT $		SUBSCRIBER'S TELEPHONE	RELATIONSHIP TO SUBSCRIBER

Secondary Insurance

INSURANCE CARRIER (COMPANY NAME)		TYPE ☐ HMO ☐ PPO ☐ 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 ☐ YES ☐ NO		
AMOUNT OF COPAYMENT $		SUBSCRIBER'S TELEPHONE	RELATIONSHIP TO SUBSCRIBER

Referral Information

REFERRED BY	RELATIONSHIP TO PATIENT (E.G. PRIMARY DOCTOR)	TELEPHONE

In Case of Emergency

CONTACT PERSON	RELATIONSHIP TO PATIENT	TELEPHONE

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. and/or Konrad H. Ng, M.D., for services he provides. This assignment shall remain in effect until I submit a written revocation to them. 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.

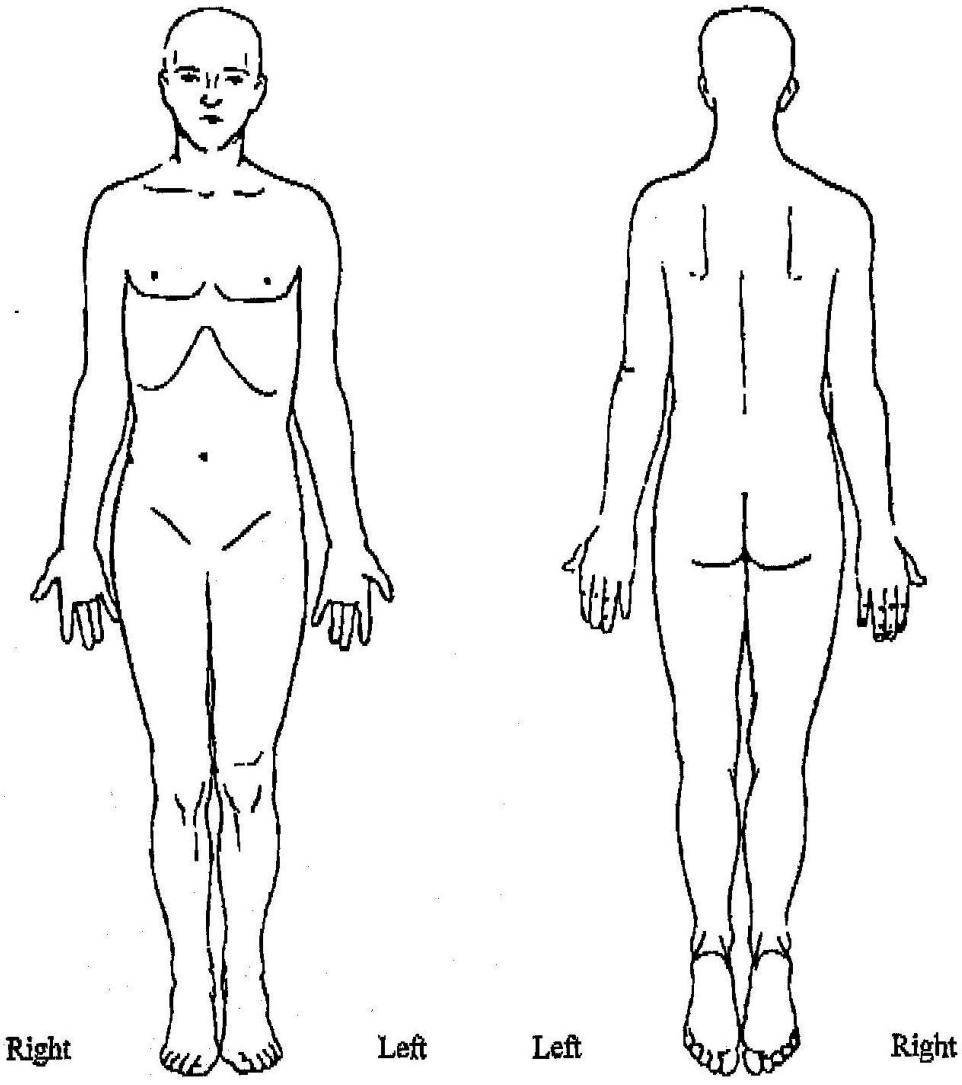
Date: _____ Patient Acknowledgement (Signature): _____

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
ΔΔΔ	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 back and leg please give a PERCENTAGE in each)

Pain in: Back_____ Leg _____ 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)

Back

[----------]
0 10

Leg

[----------]
0 10

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 leg or foot: ☐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 neck or back, 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: ☐<½ ☐½ ☐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:_____

Relationship:_____ Disease:_____

Relationship:_____ Disease:_____

Relationship:_____ Disease:_____

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	☐	☐		
Fever, chills, sweats	☐	☐		
2. Eyes				
Wear glasses or contact lenses	☐	☐		
Vision problems (blurred, double, or loss of vision)	☐	☐		
3. Ears/Nose/Mouth/Throat				
Change in hearing or ringing in ears	☐	☐		
Chronic sinus problems	☐	☐		
4. Cardiovascular				
Heart trouble or heart attack	☐	☐		
Chest pain/angina (sharp, crushing, or heaviness)	☐	☐		
Heart racing/palpitations/arrhythmia	☐	☐		
Blood clots	☐	☐		
5. Respiratory				
Asthma, wheezing, shortness of breath	☐	☐		
Cough	☐	☐		
6. Gastrointestinal				
Heartburn	☐	☐		
Bleeding ulcers	☐	☐		
Nausea/Vomiting	☐	☐		
7. Endocrine				
Thyroid problems	☐	☐		
8. Hematologic/Lymphatic				
Easy bruising	☐	☐		
Frequent bleeding	☐	☐		
9. Skin and breasts				
Rashes or sores	☐	☐		
Skin cancer or melanoma	☐	☐		
Non-healing wounds	☐	☐		
10. Allergic/Immunologic				
Allergic reaction to drugs	☐	☐		
Recent cold or flu	☐	☐		
11. Genitourinary				
Painful or burning urination	☐	☐		
Blood in urine	☐	☐		
Bladder infection/other infections	☐	☐		
Sexually transmitted disease	☐	☐		
12. Musculoskeletal				
Joint stiffness or pain	☐	☐		
Back pain	☐	☐		
Neck pain	☐	☐		
13. Neurological				
Numbness or tingling in arms or legs	☐	☐		
Weakness in arms or legs	☐	☐		
Stroke	☐	☐		
14. Psychiatric				
Depression	☐	☐		
Anxiety	☐	☐		
15. Other (Please write in):				
_____				

Name:_____ **Date:**_____

MODIFIED OSWESTRY DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: 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 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.*

SECTION 1 - Pain Intensity ☐I can tolerate the pain I have without having to use pain medication. ☐The pain is bad, but I can manage without having to take pain medication. ☐Pain medication provides me with complete relief from pain. ☐Pain medication provides me with moderate relief from pain. ☐Pain medication provides me with little relief from pain. ☐Pain medication has no effect on my pain.	***SECTION 6 - Standing*** ☐I can stand as long as I want without extra pain ☐I can stand as long as I want, but it increases my 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 2 - Personal Care (Washing, Dressing, etc.) ☐I can take care of myself normally without causing increased pain. ☐I can take care of myself normally, but it increases my pain. ☐It is painful to take care of myself, and I am slow and careful. ☐I need help, but I am able to manage most of my personal care. ☐I need help every day in most aspects of my care. ☐I do not get dressed, I wash with difficulty, and I stay in bed.	***SECTION 7 - Sleeping*** ☐Pain does not prevent me from sleeping well. ☐I can sleep well only by using pain medication. ☐Even when I take medication, I sleep less than 6 hours. ☐Even when I take medication, I sleep less than 4 hours. ☐Even when I take medication, I sleep less than 2 hours. ☐Pain prevents me from sleeping at all
SECTION 3 - Lifting ☐I can lift heavy weights without extra pain ☐I can lift heavy weights, but it gives extra pain ☐Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table ☐Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned ☐I can lift very light weights ☐I cannot lift or carry anything at all	***SECTION 8 - Social Life*** ☐My social life is normal and does not increase my pain. ☐My social life is normal, but it increases my level of pain. ☐Pain prevents me from participating in more energetic activities (e.g., sports, dancing). ☐Pain prevents me from going out very often. ☐Pain has restricted my social life to my home. ☐I have hardly any social life because of my pain.
SECTION 4 - Walking ☐Pain does not prevent me walking any distance ☐Pain prevents me from walking more than 1 mile ☐Pain prevents me from walking more than ½ mile ☐Pain prevents me from walking more than 100 yards ☐I can only walk using a stick or crutches ☐I am in bed most of the time and have to crawl to the toilet	***SECTION 9 - Travelling*** ☐I can travel anywhere without increased pain. ☐I can travel anywhere, but it increases my pain. ☐My pain restricts my travel over 2 hours. ☐My pain restricts my travel over 1 hour. ☐My pain restricts my travel to short necessary journeys under 1/2 hour. ☐My pain prevents all travel except for visits to the physician, therapist or hospital.
SECTION 5 - Sitting ☐I can sit in any chair as long as I like ☐I can only sit in my favorite 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 10 - Employment / Homemaking*** ☐My normal homemaking / job activities do not cause pain. ☐My normal homemaking / job activities increase my pain, but I can still perform all that is required of me. ☐I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming). ☐Pain prevents me from doing anything but light duties. ☐Pain prevents me from doing even light duties. ☐Pain prevents me from performing any job or homemaking chores.