



SOUTHERN COAST SPECIALISTS

NEUROSURGERY | SPINE | PAIN

NEW PATIENT INTAKE FORM

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care.

GENERAL PATIENT INFORMATION

LAST NAME

FIRST NAME

MIDDLE NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

MAILING ADDRESS

(IF DIFFERENT FROM ABOVE)

CITY

STATE

ZIP CODE

DATE OF BIRTH

(YY/YY/YYYY)

MARITAL STATUS

SOCIAL SECURITY NO.

EMPLOYMENT STATUS

EMPLOYED

UNEMPLOYED

DISABLED

RETIRED

CONTACT INFORMATION

CHECK BOX FOR PREFERRED METHOD OF CONTACT

HOME PHONE

CELL PHONE

WORK PHONE

May we leave messages
Regarding healthcare?

May we leave messages
Regarding healthcare?

May we leave messages
Regarding healthcare?

OTHER PHONE NUMBERS

May we leave messages regarding healthcare?

EMAIL ADDRESS

EMERGENCY CONTACT INFORMATION

NAME

TELEPHONE NUMBER

RELATIONSHIP

ADDRESS

(ADDRESS, CITY, STATE, ZIP CODE)

May we discuss personal health information
with this person? YES NO

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PRIMARY CARE

PRIMARY CARE PHYSICIAN

Please list your primary care physician and their contact information.

Physician's Name

Name of Office

Address

Phone number

Fax Number

CARDIOLOGIST

Are you being treated by a Cardiologist? If yes, please list your Cardiologist and their contact information. If you are not being treated by a Cardiologist, please skip this part and continue on to the Insurance portion.

Physician's Name

Name of Office

Address

Phone number

Fax Number

INSURANCE INFORMATION

INCLUDE NAME AND ID NUMBER

PRIMARY INSURANCE

Name of insurance

Insurance ID number

SECONDARY INSURANCE

Name of insurance

Insurance ID number

TERTIARY INSURANCE

Name of insurance

Insurance ID number

Are you currently under worker's compensation? YES NO

Is there an ongoing lawsuit related to your visit today? YES NO

Is your visit related to a recent motor vehicle accident? YES NO

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Patient's Name

Patient's Date of Birth

DIAGNOSTIC TESTING AND IMAGING

TYPE

AREA OF BODY

MRI of the: _____

Facility: _____ Date: _____

XRAY of the: _____

Facility: _____ Date: _____

CT Scan of the: _____

Facility: _____ Date: _____

EMG/NCV Study of the : _____

Facility: _____ Date: _____

Other Diagnostic Testing : _____

Facility: _____ Date: _____

Did you bring disk(s) or report(s) today? Yes No

I have not had ANY diagnostic tests for my current pain complaint.

CURRENT MEDICATIONS

ARE YOU CURRENTLY TAKING ANY BLOOD THINNERS OR ANTI-COAGULANTS? YES NO

IF YES, WHICH ONES? Aspirin Plavix Coumadin Lovenox Other: _____

ARE YOU CURRENTLY TAKING ANY NARCOTICS? YES NO

IF YES, WHICH ONES?

Medication Name _____ Last fill date _____

Medication Name _____ Last fill date _____

Medication Name _____ Last fill date _____

Medication Name _____ Last fill date _____

PLEASE LIST ALL OTHER MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING VITAMINS.

MEDICATION NAME	DOSE	FREQUENCY
-----------------	------	-----------

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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PAST MEDICAL HISTORY

MARK THE FOLLOWING CONDITIONS/DISEASES THAT YOU HAVE BEEN TREATED FOR IN THE PAST

CANCER/ONCOLOGY

Cancer - Type _____
Cancer - Type _____
Cancer - Type _____

CARDIOVASCULAR/ HEMATOLOGIC

Anemia
Heart Attack
Coronary Artery Disease
High Blood Pressure
Peripheral Vascular Disease
Stroke/ TIA
Heart Valve Disorder
Presence of stent/ pacemaker/
Defibrillator

GASTROINTESTINAL

GERD (Acid Reflux)
Gastrointestinal Bleeding
Stomach Ulcers
IBS? /Crohns Disease

UROLOGICAL

Chronic Kidney Disease
Kidney Stones
Urinary Incontinence
Dialysis

NEUROLOGICAL

Multiple Sclerosis
Peripheral Neuropathy
Seizures
Balance Disorder
Head Injury
Headaches
Migraines

ENT

Glaucoma
Vertigo
Hearing Problems
Nosebleeds

RESPIRATORY

Asthma
Bronchitis/Pneumonia
Emphysema/ COPD

MUSCULOSKELETAL/RHEUMATOLOGIC

Bursitis
Carpal Tunnel Syndrome
Fibromyalgia
Osteoarthritis
Osteoporosis
Rheumatoid Arthritis
Chronic Joint Pains

PSYCHOLOGICAL

Depression
Anxiety
Schizophrenia
Bipolar Disorder
ADD/ ADHD
PTSD

ENDOCRINOLOGY

Diabetes- Type _____
Hypothyroidism
Hyperthyroidism

OTHER DIAGNOSED CONDITIONS

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ALLERGIES

DO YOU HAVE ANY DRUG/MEDICATION ALLERGIES? YES NO

IF SO, PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

MEDICATION NAME	ALLERGIC REACTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

TOPICAL ALLERGIES

Latex Iodine Tape IV Contrast

PAST SURGICAL HISTORY

PLEASE LIST ANY SURGICAL PROCEDURES YOU HAVE HAD DONE IN THE PAST INCLUDING DATE:

		Were you hospitalized?	
Procedure	Date (month and year)	YES	NO
_____	_____	YES	NO
_____	_____	YES	NO
_____	_____	YES	NO
_____	_____	YES	NO
_____	_____	YES	NO
_____	_____	YES	NO

Were you hospitalized for another reason(s) other than surgery?

_____	_____
Reason	Date (month and year)
_____	_____
Reason	Date (month and year)
_____	_____
Reason	Date (month and year)

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FAMILY HISTORY

PLEASE FILL OUT TO THE BEST OF YOUR ABILITY

Has anyone in your family (including maternal and paternal grandparents, parents, siblings, or children) had any of the following conditions? Please check all that apply and fill in the relationship to the person who has the condition and whether they are living or deceased.

	FAMILY RELATIONSHIP	LIVING OR DECEASED?
Diabetes	_____	_____
Hypertension	_____	_____
Heart Disease	_____	_____
Mental Illness	_____	_____
Stroke	_____	_____
Cancer	_____	_____
Alcohol Abuse	_____	_____
Psychoactive substance abuse	_____	_____
Gambling Addiction	_____	_____

SOCIAL HISTORY

TOBACCO USE:

Current user Former User Never Used
Packs per day? _____ How many years? _____ Quit Date _____

ILLEGAL DRUG USE:

Denies any illegal drug use Currently uses illegal drugs Formerly used illegal drugs (not currently)
Have you ever abused narcotic or prescription medications? YES NO

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NEW PATIENT INTAKE FORM

REVIEW OF SYSTEMS

MARK THE FOLLOWING SYMPTOMS THAT YOU CURRENTLY SUFFER FROM:

GENERAL / CONSTITUTIONAL

NO YES (Check the following symptoms you are experiencing)

Fever Chills Sweats Weakness Fatigue Decreased Activity Malaise
Unexplained weight gain Unexplained weight loss Low sex drive Difficulty sleeping

ALLERGY / IMMUNOLOGY

NO *Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV.*

Other _____

OPHTHALMOLOGIC

NO YES (Check the following symptoms you are experiencing)

Blurriness Double Vision Visual Disturbance Pain

ENT

NO YES (Check the following symptoms you are experiencing)

Hearing Problems Ear Pain Sinus Problems Sore Throat Nosebleeds

ENDOCRINE

NO YES (Check the following symptoms you are experiencing)

Excessive Thirst Excessive Urination Heat Intolerance Cold Intolerance Hair Loss
Dry Skin

GASTROINTESTINAL

NO YES (Check the following symptoms you are experiencing)

Nausea Vomiting Diarrhea Constipation Heartburn Abdominal Pain

MUSCULOSKELETAL

NO YES (Check the following symptoms you are experiencing)

Back Pain Neck Pain Joint Pain Muscle Pain Muscle Cramp Muscle Spasm
Gain Disturbances Joint Stiffness Joint Swelling Trauma

SKIN

NO YES (Check the following symptoms you are experiencing)

Rash Itching Lesions Bruising

Other _____

NEUROLOGIC

NO YES (Check the following symptoms you are experiencing)

Abnormal Balance Confusion Numbness Tingling Dizziness Headaches
Loss of Coordination Memory Loss Seizures Tinnitus Tremors Vertigo

PSYCHIATRIC

NO YES (Check the following symptoms you are experiencing)

Feeling Anxious Depressed mood Suicidal Thoughts Hallucinations Stress Problems
Suicidal Planning Thoughts of harming others

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AUDIT-C ASSESSMENT TOOL

QUESTIONS	0	+1	+2	+3	+4
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 drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have six or more drinks on one occasion?	Never	less than monthly	monthly	weekly	Daily or almost daily

TOTAL: _____

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PATIENT HEALTH QUESTIONNAIRE-2

OVER THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?

	0	+1	+2	+3
Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly half the days

	0	+1	+2	+3
Feeling down, depressed, or hopeless.	Not at all	Several days	More than half the days	Nearly half the days

Total Point Score _____

Information from Kroenke K, Spitzer, William JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Med Care. 2003;41:1284-1292

Source:
Thibault JM, Steiner RW. Efficient Identification of adults with depression and dementia. Am Fam Physician. 2004;70:1101-1110

SOUTHERN COAST SPECIALISTS

SOAPP® VERSION 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at Southern Coast Specialists who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions using the following scale:

0 = NEVER, 1= SELDOM, 2= SOMETIMES, 3= OFTEN, 4= VERY OFTEN

- | | | | | | |
|--|---|---|---|---|---|
| 1. How often do you have mood swings? | 0 | 1 | 2 | 3 | 4 |
| 2. How often do you smoke a cigarette within an hour after you wake up? | 0 | 1 | 2 | 3 | 4 |
| 3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 4. How often have any of your close friends had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 5. How often have others suggested that you have a drug or alcohol problem? | 0 | 1 | 2 | 3 | 4 |
| 6. How often have you attended an AA or NA meeting? | 0 | 1 | 2 | 3 | 4 |
| 7. How often have you taken medication other than the way that is was prescribed? | 0 | 1 | 2 | 3 | 4 |
| 8. How often have you been treated for an alcohol or drug problem? | 0 | 1 | 2 | 3 | 4 |
| 9. How often have your medications been lost or stolen? | 0 | 1 | 2 | 3 | 4 |
| 10. How often have others expressed concern over your use of medication? | 0 | 1 | 2 | 3 | 4 |
| 11. How often have you felt a craving for medication? | 0 | 1 | 2 | 3 | 4 |
| 12. How often have you been asked to give a urine screen for substance abuse? | 0 | 1 | 2 | 3 | 4 |
| 13. How often have you used illegal drugs (marijuana, cocaine, etc.) in the past 5 years? | 0 | 1 | 2 | 3 | 4 |
| 14. Have often, in your lifetime, have you had legal problems or been arrested? | 0 | 1 | 2 | 3 | 4 |

Total Point Score _____

Please include any additional information you wish about the above answers. Thank you.

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