# 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**

☐ May we leave messages Regarding healthcare?

☐ **CELL PHONE**

☐ May we leave messages Regarding healthcare?

☐ **WORK PHONE**

☐ 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

# SOUTHERN COAST SPECIALISTS
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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 | SECONDARY INSURANCE | TERTIARY INSURANCE |
|---|---|---|
| Name of insurance | Name of insurance | Name of insurance |
| Insurance ID number | Insurance ID number | 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

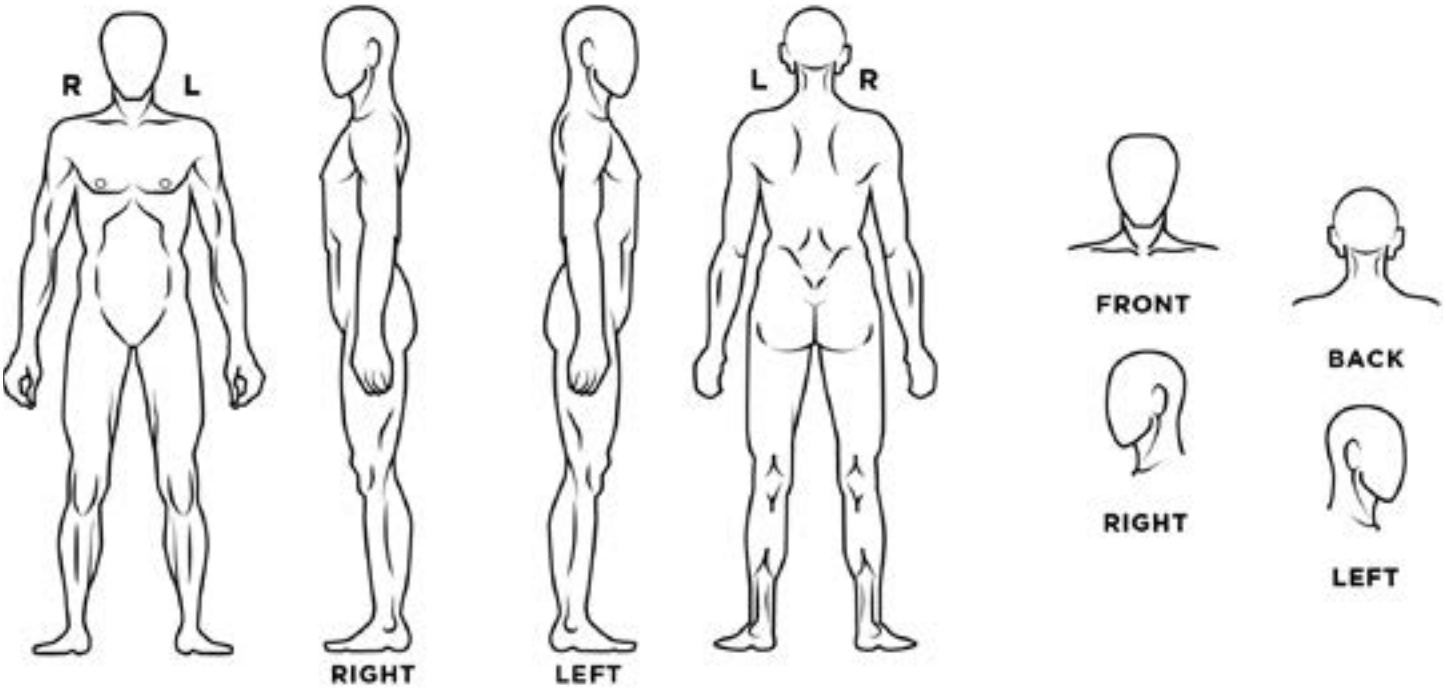
# SOUTHERN COAST SPECIALISTS
NEW PATIENT INTAKE FORM

Patient's Name _____ Patient's Date of Birth _____

## PAIN HISTORY

What area(s) of your body are you experiencing pain?

Use the diagram below to indicate the area of your pain. Mark the area with an "X"
(If filling out the form on the computer, please print and mark the areas with a pen)




What date did the pain start?

Have you been given a diagnosis for the cause of your pain? Or do you know what caused your pain?

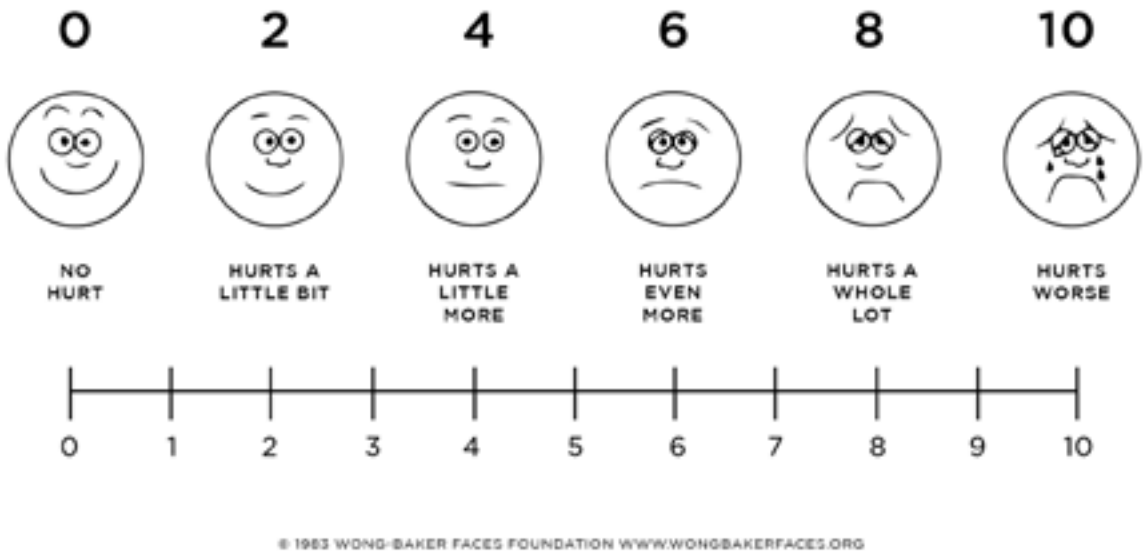
Has the pain gotten better, worse, or stayed the same since it first started?

How would you describe your pain? ( Check all that apply)

| | | | |
|---|---|---|---|
| ☐ Aching | ☐ Dull | ☐ Shock | ☐ Shooting |
| ☐ Burning | ☐ Hot | ☐ Numb | ☐ Stabbing |
| ☐ Cold | ☐ Pressure | ☐ Pinching | ☐ Stinging |
| ☐ Cramping | ☐ Sharp | ☐ Spasm | ☐ Tingling |

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain? (Use the WONG-BAKER FACES™ chart below for reference.)

On Average: _____ The worst it gets: _____






Is the pain constant throughout the day, worse at night, worse in the morning, or does the pain suddenly get worse at points throughout the day

Does anything help your pain?

Does anything make your pain worse?

# SOUTHERN COAST SPECIALISTS
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What daily tasks do you have difficulty with, due to your pain??
(EX. DRESSING YOURSELF, STANDING FOR LONG PERIODS OF TIME, ETC.)

Do you currently use a walking cane, wheelchair, walker, scooter or crutches or are you currently able to walk without assistance?

## TREATMENTS FOR PAIN RELIEF
PLEASE MARK ALL OF THE FOLLOWING TREATMENTS YOU'VE RECEIVED

| | NO CHANGE | WORSENED PAIN | HELPED PAIN |
|---|---|---|---|
| SPINE SURGERY | ☐ | ☐ | ☐ |
| PSYCHOLOGICAL TREATMENT | ☐ | ☐ | ☐ |
| BRACE SUPPORT | ☐ | ☐ | ☐ |
| ACUPUNCTURE | ☐ | ☐ | ☐ |
| HOT/COLD PACKS | ☐ | ☐ | ☐ |
| MASSAGE THERAPY | ☐ | ☐ | ☐ |
| TENS UNIT | ☐ | ☐ | ☐ |

Have you had physical therapy in the past? ☐ YES ☐ NO

If yes, What facility did you go to?_____ Date started _____

How many sessions did you complete? _____ Percentage of relief it provided _____

Have you had Chiropractic treatments in the past? ☐ YES ☐ NO

If yes, What facility did you go to?_____ Date started _____

How many sessions did you complete? _____ Percentage of relief it provided _____

## INTERVENTIONAL PAIN TREATMENT HISTORY

**PLEASE LIST ANY OTHER PAIN PHYSICIANS YOU HAVE SEEN IN THE PAST**

Name of Doctor _____ Name of office _____

Have you had any pain injections? Please list them below

| Injection | Date | Percentage of relief | Length of relief |
|---|---|---|---|
| Injection | Date | Percentage of relief | Length of relief |
| Injection | Date | Percentage of relief | Length of relief |

What medications have you tried for your pain in the past and did they help?

# SOUTHERN COAST SPECIALISTS
NEW PATIENT INTAKE FORM

## 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# SOUTHERN COAST SPECIALISTS
NEW PATIENT INTAKE FORM

## 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
_____
_____
_____

# SOUTHERN COAST SPECIALISTS
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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:

| Procedure | Date (month and year) | Were you hospitalized? |
|---|---|---|
| | | ☐ 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) |
|---|---|
| | |
| | |
| | |

# SOUTHERN COAST SPECIALISTS
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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

# SOUTHERN COAST SPECIALISTS
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)

☐ *Excesive 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*

# SOUTHERN COAST SPECIALISTS
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? | 0 ☐ 1 or 2 | +1 ☐ 3 or 4 | +2 ☐ 5 or 6 | +3 ☐ 7 to 9 | +4 ☐ 10 or more |
| How often do you have six or more drinks on one occasion? | 0 ☐ Never | +1 ☐ less than monthly | +2 ☐ monthly | +3 ☐ weekly | +4 ☐ Daily or almost daily |

**TOTAL:** _____

# SOUTHERN COAST SPECIALISTS
## 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 |
| 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 a 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**

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

Total Point Score _____

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



PainEDU
Improving Pain Treatment Through Education