

**NEUROSURGERY ONE NEW PATIENT PAPERWORK**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sex**: (circle) M F  **Preferred pronouns**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Would you prefer to speak to your healthcare provider through a Translator?** Yes No

Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for your visit (chief complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My main goal(s) for my visit today (check all that apply)

* First opinion
* Second opinion
* Recommendation for Physical Therapy
* Injection/Conservative Therapy/Treatment
* Surgery
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Onset of current symptoms**: (circle)

Acute injury Gradual over time Worker’s-compensation Motor vehicle accident

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe your current symptoms:**

* Location (where on your body) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Quality (words to describe pain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Approximate date of symptom onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Duration (how long have you been experiencing the pain?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Timing (constant, intermittent, with position change, activity, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Does anything make the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Does anything make the pain worse? (lifting, coughing, standing, laying down, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Progression: (circle) Worsening Unchanging Improving Changing –\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Associated symptoms (circle) Numbness Tingling/Pins and Needles Weakness

Other, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you use any assistive devices to help with ambulating?

No Cane Walker Wheelchair Motorized Scooter Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

* Is there litigation surrounding the case? (circle) Yes No
	+ If yes, Attorney’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Indicate the current severity of your pain by circling a number below:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Please use the illustration below to shade affected areas**:



Indicate what **treatments** you have already tried for your current problem: (check any that apply)

* No treatment
* Physical Therapy
* Trigger Point Injections
* Epidurals/Nerve Blocks
* Chiropractor/Chiropractic Treatment
* Physiatrist
* Massage or Ultrasound
* Dry Needling
* Acupuncture
* Yoga/Pilates
* NSADS (medication management)
* TENS Unit
* Surgery
* Other treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What **diagnostic test** have you had performed for this problem? (check all that apply)

* X-RAYS
* MRI
* CT/CAT SCAN
* EMG/NERVE CONDUCTION STUDY
* OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide your care team, if applicable:

* Neurology \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Neurosurgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Endocrinology\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Physiatry\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* ENT/Otolaryngology\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If recommended, please rate how interested you are in having surgery to treat your problem:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

*Not at all* *Maybe* *Definitely*

**PATIENT HISTORY**

**Current Medications**: include prescriptions, over the counter medications, vitamins and supplements. Note: Please include as-needed medications as well.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies**:

* No known drug allergies
* Known allergies include (please include drug and reaction) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**: check any medical problems you have been treated for.

* Alcoholism
* Anemia
* Arrhythmia (irregular heart beat)
* Arthritis
* Asthma
* Atrial fibrillation
* Bronchitis
* Coronary Artery/Heart Disease
* Cancer (Type\_\_\_\_\_\_\_\_\_\_\_)
* Cardiovascular Disease
* Congestive Heart Failure
* Crohn’s Disease
* Cirrhosis
* Colitis
* Constipation
* COPD (lung disease)
* Chronic Renal Failure
* CVA (stroke/brain hemorrhage)
* Dementia/Alzheimer’s
* Degenerative Disc Disease
* Degenerative Joint Disease
* Diabetes, Type I
* Diabetes, Type II
* Emphysema
* Epilepsy
* Fracture
* GERD
* Glaucoma
* Hepatitis
* High Cholesterol
* Hyperlipidemia
* Implanted Medical Device
* Kidney Disease
* Ulcers
* Liver Disease
* Migraine
* Multiple Sclerosis
* Nephrolithiasis (Kidney Stones)
* Obesity
* Osteoarthritis
* Osteoporosis
* Prior MI (Heart Attack)
* Pulmonary Disease
* RA (Rheumatoid Arthritis)
* Seizures
* Sickle Cell Disease
* Sexually Transmitted Disease
* Thyroid Disease
* TIA (mini-stroke)
* Tuberculosis
* Tumor
* Valve Problem

If YES to osteoporosis or osteopenia, date of last DEXA/Bone Density Scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History**: include approximate date for listed surgeries

* No prior surgeries
* Appendectomy
* D&C
* Hysterectomy
* Knee arthroscopy
* Mastectomy
* Shoulder surgery
* Spinal surgery
* Tonsillectomy
* Total knee replacement
* Total hip replacement
* Tubal ligation
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If YES to previous spinal surgery, please explain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**: indicate if family members have pertinent medical problems (M=Mother, F=Father, S=Sibling)

\_\_\_Ankylosing Spondylitis

\_\_\_Arthritis

\_\_\_Alcoholism

\_\_\_Anxiety

\_\_\_Asthma

\_\_\_Bleeding Disorder

\_\_\_CAD (Heart Disease)

\_\_\_MI (Heart Attack)

\_\_\_Cancer

\_\_\_Colitis

\_\_\_COPD
\_\_\_Crohn’s Disease

\_\_\_CVA/TIA (stroke)

\_\_\_Depression

\_\_\_Diabetes

\_\_\_Epilepsy

\_\_\_GERD

\_\_\_Gout

\_\_\_Hypertension

\_\_\_Kidney Disease

\_\_\_Liver Disease

\_\_\_Osteoarthritis

\_\_\_Osteoporosis

\_\_\_Psoriasis

\_\_\_Pulmonary Disease

\_\_\_Renal Disease

\_\_\_RA (Rheumatoid Arthritis)

\_\_\_SLE (Lupus)

\_\_\_Substance Abuse

\_\_\_Thyroid Condition

\_\_\_Tumor

\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**
Tobacco (circle) Never smoker Current every day smoker Current some day smoker Former smoker – Year quit\_\_\_\_\_\_\_\_\_, Years smoked\_\_\_\_\_\_\_\_\_

E-Cigarette/Vaping (circle) Every day user Some day user Former user Never User

Alcohol (circle) Yes Not currently Never Defer

Illicit Drug Use: Yes Not currently Never Defer

Marijuana Use Yes Not currently Never Defer

Marital Status: (circle) Single Life Partner Married Divorced Separated Widowed Defer

Diet: (circle all that apply) Well balanced Diabetic Vegetarian Vitamins/Herbs

With whom do you live? Alone Children Spouse/partner Parents Assisted Living \_\_\_\_\_\_\_\_\_\_\_\_\_

Safety:

* CO Detector in Home
* Seat Belt Use
* Water Heater Temp Set
* Guns Unloaded/Locked
* Smoke Detector in Home
* Helmet Use
* Sunscreen Use

Race:

* American Indian or Alaskan Native
* Black or African American
* Native Hawaiian or other Pacific Islander
* Asian
* White
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Decline

Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: Do you consider yourself to be Hispanic or Latino? Yes No Decline

Preventative Care: Last complete physical exam with your primary care provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: (circle below) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work full-time Work part-time Unemployed On Disability

Retired Student

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_