ROCKY MOUNTAIN SPINE CLINIC, P.C.

Eric R. Jamrich, M.D. John R. Barker, M.D. Chad J. Prusmack, M.D. Michael W. Madsen, M.D.

Name_____ Birthdate _____
Last First Middle Initial

SSN_____

Address _____ Apt. # _____ City_____ State_____ Zip_____

Home Phone ( )_____ **Work Phone** ( )_____ **Cell Phone** ( )_____

E-mail Address_____ Preferred method of contact: ☐ Phone ☐ E-mail ☐ Text

Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer _____ Occupation_____

Employer's Address_____ City_____ State_____ Zip_____

Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired ☐ On Leave ☐ Other

In case of emergency contact _____ Relationship _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

REFERRING PHYSICIAN / COMPLETE NAME AND ADDRESS:

_____

PCP (if different from Referring Physician) COMPLETE NAME AND ADDRESS

_____

Pharmacy_____ Phone _____

INSURANCE INFORMATION ~ We will need a copy of your insurance card(s).

Primary Insurance Address (Street/City/State) Employer

_____ _____ _____

Group #_____ ID #_____ Policy Holder ☐ Self ☐ Spouse ☐ Parent/Guardian

Secondary Insurance Address (Street/City/State) Employer

_____ _____ _____

Group #_____ ID #_____ Policy Holder ☐ Self ☐ Spouse ☐ Parent/Guardian

INSURED RESPONSIBLE PARTY INFORMATION – If other than self

Name _____ Relationship_____ Birthdate_____ SSN_____

Address (if different from patient)_____

Home Phone ( )_____ Work Phone ( )_____ Employer_____

ACCIDENT INFORMATION

Is this a ☐ Work Comp or ☐ Motor Vehicle Accident? ☐ Yes ☐ No If YES, on what date did the injury occur? _____

Work Comp / Motor Vehicle Claim Number _____

Adjuster's Name _____

Phone Number ( ) _____ Fax Number ( ) _____

I authorize that payment of any insurance benefits for health care services be made directly to Rocky Mountain Spine Clinic, P.C. NOTE: If patient is a minor under the age of 18 years, these forms must be signed by parent or legal guardian. They cannot be signed by a minor.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

ROCKY MOUNTAIN SPINE CLINIC, P.C.

NAME:_____

What symptoms are you having? _____

_____

_____

How long ago did your symptoms begin?_____

How did your symptoms begin? (Circle one): Injury Accident Began slowly over time Began suddenly

Do your symptoms limit you?_____

Extent of symptoms: (Circle any that apply): Stabbing pain. Burning pain. Aching pain. Stiffness. Pins & needles. Numbness. Weakness. Headaches. Grinding or popping. Muscle spasms. Bowel/bladder function loss.

Is the pain constant, or does it come and go?_____

Does the pain radiate into your arms or legs?_____

Is the pain worse at night?_____

Do you have any weakness or numbness in your arms or legs?_____

Have you lost control of bowel or bladder function?_____

How long can you sit?_____stand?_____

How far can you walk?_____

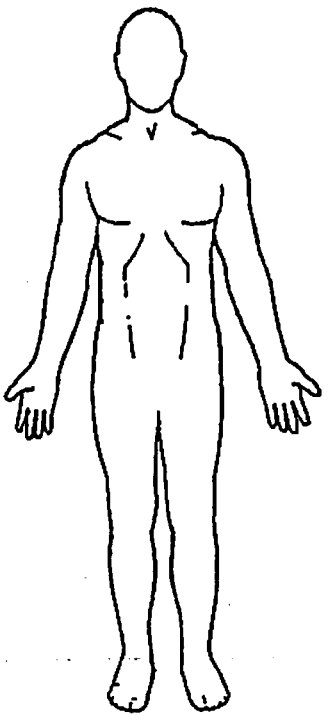
What, if anything, makes the pain better?_____

What makes your pain worse?_____

Using the symbols below, please draw your pain on the diagrams below:

FRONT

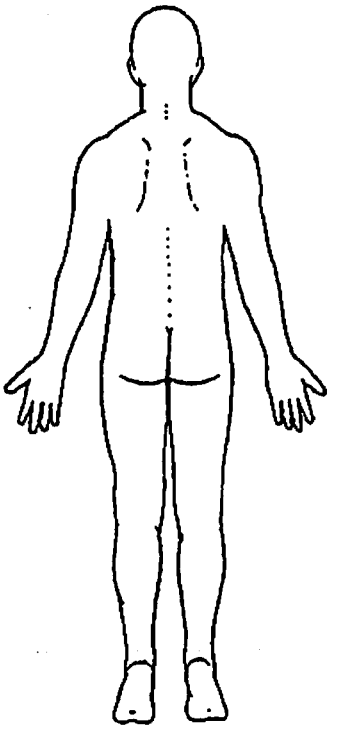
Right



Left

BACK

Left



Right

Stabbing Pain	Burning Pain	Aching Pain	Pins & Needles	Numbness
//////	ooooo	xxxxx	++++	-------

Circle your pain level on a scale of 1 to 10, with 10 being unbearable or the worst imaginable pain.

(no pain) 1 2 3 4 5 6 7 8 9 10 (extreme pain)

ROCKY MOUNTAIN SPINE CLINIC, P.C.

NAME _____

DOMINANT HAND: ☐ Right ☐ Left

Tell us about any previous treatments and/or tests you have had.

Who first treated you for this problem?_____

What treatments did you have?_____

_____

Did this include any surgery on your neck or back? If so, what and when:_____

_____

Have you had physical therapy?_____ If so, did it help?_____

Explain:_____

Do you do any special exercises for your neck or back?_____

Have you had any of the following tests regarding your back or neck within the last year?

☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG/nerve conduction studies

Have you had any injections for your problem?_____ If so, please describe:_____

_____

What do you hope to accomplish today?

_____

_____

_____

PAST MEDICAL HISTORY: (List all current medical problems)

_____

_____

_____

_____

_____

ROCKY MOUNTAIN SPINE CLINIC, PC.
HEALTH HISTORY FORM

NAME_____ **Date of Birth**_____ **Today's Date**_____

List all medications you are currently taking:

Medication	Dose	Times/Day	Medication	Dose	Times/Day

DRUG ALLERGIES: **REACTION:**

_____ _____
_____ _____
_____ _____

REACTION:

FOOD ALLERGIES: _____
ENVIRONMENTAL ALLERGIES: _____

Have you recently experienced fever/chills, weight gain, weight loss, chest pain or shortness of breath? (Circle)

PAST SURGICAL HISTORY ~ Please list all surgeries you have had, the year, and any complications.

_____
_____
_____
_____

Have you ever had any problems with anesthesia? ☐Yes ☐No If yes, explain:_____
_____

FAMILY HISTORY
Do your parents, grandparents, siblings or your children have any of the following? If yes, please explain:

Diabetes	☐Yes	☐ No	_____
High blood pressure	☐Yes	☐ No	_____
Heart conditions	☐Yes	☐ No	_____
Cancer	☐Yes	☐ No	_____
Arthritis	☐Yes	☐ No	_____

SOCIAL HISTORY

Do you live alone?	☐Yes	☐ No	
Do you have children?	☐Yes	☐ No	#_____
Do you exercise?	☐Yes	☐ No	How often? ☐ Daily ☐ Weekly ☐ Rarely ☐ Never
What types of exercises do you do?			_____
Do you currently smoke?	☐Yes	☐ No	How many packs per day _____ for how long_____
Have you quit smoking?	☐Yes	☐ No	When did you quit:_____
Do you chew tobacco?	☐Yes	☐ No	How much:_____
Do you drink alcohol?	☐Yes	☐ No	How much / how often:_____
History of substance abuse?	☐Yes	☐ No	Explain:_____
Marijuana use?	☐Yes	☐ No	

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NAME:_____

REVIEW OF SYSTEMS

Are you currently having or have you had problems with:

		Describe all YES responses
Eyes	☐Yes ☐ No	_____
Ears, Nose, Throat	☐Yes ☐ No	_____
Lungs/Breathing	☐Yes ☐ No	_____
Digestion/Ulcers	☐Yes ☐ No	_____
Bowel movements	☐Yes ☐ No	_____
Bladder problems	☐Yes ☐ No	_____
Diabetes	☐Yes ☐ No	_____
Heart problems / Chest pain (including rheumatic fever)	☐Yes ☐ No	_____
High blood pressure	☐Yes ☐ No	_____
High cholesterol	☐Yes ☐ No	_____
Bleeding problems / Blood clots	☐Yes ☐ No	_____
Balance problems	☐Yes ☐ No	_____
Numbness / Tingling	☐Yes ☐ No	_____
Blackouts / Fainting	☐Yes ☐ No	_____
Psychological problems / Depression	☐Yes ☐ No	_____
AIDS / Hepatitis	☐Yes ☐ No	_____
Cancer	☐Yes ☐ No	_____
Arthritis / Rheumatoid	☐Yes ☐ No	_____
Polio	☐Yes ☐ No	_____
Other	Explain	_____
		_____

Patient's Signature:_____ Date:_____

Physician's Initials:_____ Date:_____