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**

☐ YES, e-mail info on PruTectRx supplements ☐ NO, I do not want info on PruTectRx supplements

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.
Two Year Update

NAME:_____ Date of Birth _____ Today's Date _____

What brings you in today? _____

_____

_____

How long ago did your symptoms begin?_____

Is this new pain? Yes No If Yes, circle: Injury Accident Began slowly over time Began suddenly

Circle symptoms: Stabbing pain. Burning pain. Aching pain. Pins & needles. Numbness. Weakness.

Stiffness. Grinding or popping. Muscle spasms. Headaches. Bowel/bladder function loss.

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

Have you had physical therapy? Did it help? _____

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

_____

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

List all current medical problems:

_____

_____

_____

List all medications you are currently taking with dosage and quantity:

_____

_____

_____

_____

RECENT SURGERIES SINCE LAST VISIT ~ Please list the surgery, the year, and any complications.

_____

_____

_____

SOCIAL HISTORY

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 use marijuana? ☐Yes ☐ No _____

DOMINANT HAND: ☐ Right ☐ Left

Patient's Signature _____ Date:_____

Physician's Initials_____ Date:_____

THE OSWESTRY PAIN QUESTIONNAIRE Name: _____

1. Pain Intensity
   - o I can tolerate the pain I have without having to use pain killers.
   - o The pain is bad but I can manage without pain killers.
   - o Pain killers give complete relief from pain.
   - o Pain killers give moderate relief from pain.
   - o Pain killers give very little relief from pain.
   - o Pain killers have no effect on the pain. I do not use them.

2. Personal Care
   - o I can look after myself normally without it causing extra pain.
   - o I can look after myself normally but it causes extra pain.
   - o It is painful to look after myself and I am slow and careful.
   - o I need some help but manage most of my personal care.
   - o I need help every day in most aspects of self-care.
   - o I do not get dressed, wash with difficulty and stay in bed.

3. Lifting
   - o I can lift heavy weights without extra pain.
   - o I can lift heavy weights but it gives extra pain.
   - o Pain prevents me from lifting heavy objects off the floor, but I manage if they are conveniently positioned e.g. on a table.
   - o Pain prevents me from lifting heavy objects off the floor, but I can manage light to medium weights if they are conveniently positioned.
   - o I can only lift very light weights.
   - o I cannot lift or carry anything at all.

4. Walking
   - o Pain does not prevent me from walking any distance.
   - o Pain prevents me from walking more than 1 mile.
   - o Pain prevents me from walking more than 1/2 mile.
   - o Pain prevents me from walking more than 1/4 mile.
   - o I can only walk using a stick or crutches.
   - o I am in bed most of the time and have to crawl to the toilet.

5. Sitting
   - o I can sit in any chair as long as I like.
   - o I can only sit in my favorite chair as long as I like.
   - o Pain prevents me from sitting more than one hour.
   - o Pain prevents me from sitting more than 30 minutes.
   - o Pain prevents me from sitting more than 10 minutes.
   - o Pain prevents me from sitting at all.

6. Standing
   - o I can stand as long as I want without extra pain.
   - o I can stand as long as I want but it gives extra pain.
   - o Pain prevents me from standing more than one hour.
   - o Pain prevents me from standing more than 30 minutes.
   - o Pain prevents me from standing more than 10 minutes.
   - o Pain prevents me from standing at all.

7. Sleeping
   - o Pain does not prevent me from sleeping well.
   - o I can sleep well only by using tablets.
   - o Even when I take tablets I have less than 6 hours sleep.
   - o Even when I take tablets I have less than 4 hours sleep.
   - o Even when I take tablets I have less than 2 hours sleep.
   - o Pain prevents me from sleeping at all.

8. Employment/Homemaking
   - o My normal homemaking/job activities do not cause pain.
   - o My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
   - o I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities. (e.g. lifting, vacuuming).
   - o Pain prevents me from doing anything but light duties.
   - o Pain prevents me from doing even light duties.
   - o Pain prevents me from performing any job or homemaking chores.

9. Social Life
   - o My social life is normal and gives me no extra pain.
   - o My social life is normal but increases the degree of pain.
   - o Pain has no significant effect on my social life apart from limiting my more energetic interests, (e.g. dancing).
   - o Pain has restricted my social life and I do not go out as often.
   - o Pain has restricted my social life to my home.
   - o I have no social life because of pain.

10. Traveling
   - o I can travel anywhere without pain.
   - o I can travel anywhere but it gives me extra pain.
   - o Pain is bad but I manage journeys over 2 hours.
   - o Pain restricts me to journeys less than 1 hour.
   - o Pain restricts me to short necessary journeys under 30 minutes.
   - o Pain prevents me from traveling except to the doctor or the hospital.