NEW PATIENT QUESTIONAIRE

INSIGHT INSTITUTE OF
NEUROSCIENCE AND NEUROSURGERY
THE FUTURE IS INSIGHT

We ask that you fill this form out and return it 1 week prior to your visit otherwise your appointment may need to be rescheduled. This questionnaire is confidential and will be kept as part of your medical record.

Returning patients need only to fill out changed or updated information.

~ Please print clearly ~

☐ INSURANCE CLAIM ☐ WORKER'S COMP ☐ AUTO CLAIM

RETURNING PATIENTS NEED ONLY TO FULL OUT CHANGED OR UPDATED INFORMATION

PATIENT INFORMATION (Please Print) DATE:

PATIENT'S NAME FIRST MIDDLE LAST	SEX ☐ M ☐ F	RACE	DATE OF BIRTH	SOCIAL SECURITY NO.

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO. ( )

E-MAIL	CELL PHONE NO. ( )

PATIENT'S EMPLOYER (NAME & ADDRESS)	WORK PHONE NO. (INCLUDE EXT.) ( )

OCCUPATION (DESCRIBE YOUR JOB DUTIES)	ACTIVE RETIRED DISABLED DATE

ARE YOU ON DISABILITY? ☐YES ☐NO	ARE YOU IN THE PROCESS OF OBTAINING DISABILITY? ☐YES ☐NO

PERSON TO CONTACT (OTHER THAN YOUR HOME PHONE NO.)	RELATIONSHIP	PHONE NO. ( )

REFERRING DOCTOR (NAME AND PHONE NUMBER)	FAMILY DOCTOR (NAME AND PHONE NUMBER)

HOW DID YOU HEAR ABOUT US?	PHARMACY NAME	PHONE NO. ( )

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY/CARRIER		
POLICY HOLDER'S NAME	POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE
CONTRACT / ID NUMBER		GROUP

SECONDARY

INSURANCE COMPANY/CARRIER		
POLICY HOLDER'S NAME	POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE
CONTRACT / ID NUMBER		GROUP

I AUTHORIZE INSIGHT ORTHOPEDIC SPECIALISTS THE REQUEST TO RELEASE ANY OF MY MEDICAL RECORDS FROM ANY HOSPITAL OR OTHER FACILITY I HAVE BEEN TREATED AT AND TO RELEASE ANY OF MY MEDICAL RECORDS TO THE FOLLOWING PEOPLE (Physicians, Lawyers, etc.) AND TO BE SPOKEN TO IN REGARDS TO MY MEDICAL CARE:

NAME	PHONE	FAX
NAME	PHONE	FAX

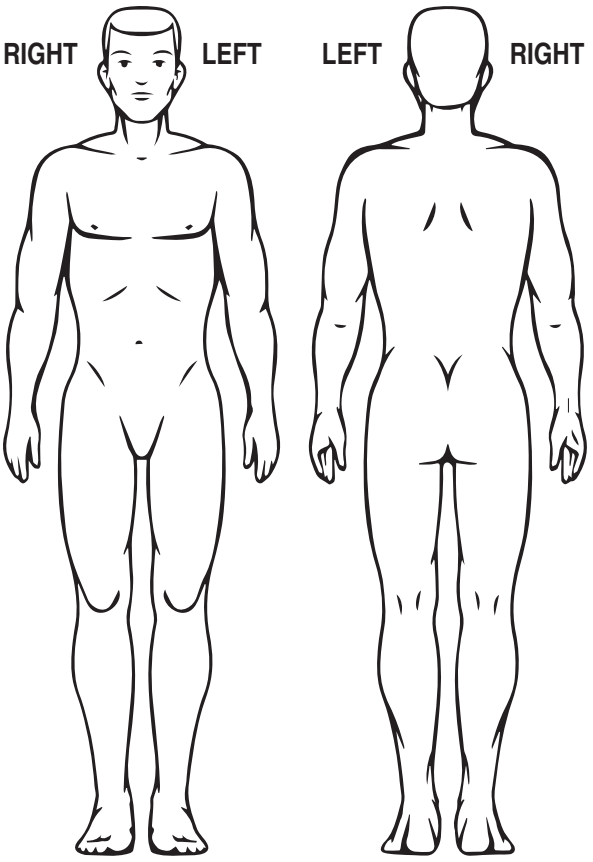
Patient's or authorized person's signature: I, the undersigned, authorize payment of medical benefits to the doctor for services rendered to me by the physician. I understand I am financially responsible for all co-pays, deductibles, or services not covered or considered not medically necessary. I authorize release of information concerning health care, advice, treatment, or supplies provided to me, to my insurance carrier. The information will be used only for the purpose of evaluation and administering claims for benefits.

SIGNATURE DATE

Medicare patients: Medicare lifetime signature on file: I request that payment of authorized Medicare benefits be made on my behalf to the physician for any services rendered to me by the physician. I authorize any holder of medical information about me to be released to health care financing administration and its agents. I also authorize any information needed to determine these benefits payable for related services released to the health care financing administration or its agents.

SIGNATURE DATE

PLEASE place an "X" over AREA (S) OF PAIN including the areas where the pain radiates to



If you have pain in more than one area, which one are you seeing the doctor for today? _____

Date of onset of pain: _____

Under what circumstances did this pain start?

❑ Spontaneous ❑ Motor Vehicle Accident ❑ Accident at work
❑ Following surgery ❑ Don't recall ❑ Other:_____

Briefly describe how your pain started: _____

_____

_____

_____

ON A SCALE OF 0-10, RATE YOUR PAIN WITH 10 BEING THE MOST SEVERE:

At Best_____ At Worst_____ Average_____ Now_____

Your pain is: ❑Constant ❑Intermittent ❑Constant with intermittent flare ups

Your pain is: ❑Heavy ❑Shooting ❑Sharp ❑Burning ❑Throbbing ❑Tight ❑Dull ❑Numb ❑Tingling ❑Squeezing ❑Cutting ❑Cramping ❑Other-specify: _____

What makes pain worse? ❑Sitting ❑Bending forward ❑Bending backward ❑Physical activity ❑Others-specify**:** _____

What makes pain better? ❑Lying down ❑Physical activity ❑Nothing helps ❑Others-specify: _____

Check All symptoms that apply to you: ❑ None

❑ Weakness - where? _____Since when?_____
❑ Numbness - where? _____Since when?_____
❑ Tingling - where? _____
❑ Sensitivity to clothes - where? _____
❑ Loss of urinary control. Since when? _____
❑ Loss of fecal (bowel) control. Since when? _____
❑ Erectile dysfunction. Since when?_____
❑ Changes in limb color, temp or sweating patterns
❑ Limb tremors, jerks
❑ Decrease in limb muscle mass
❑ Limb hair loss

Medical History: Check ALL conditions that apply

❑ A-fib	❑ Blood Clots in Lungs	❑ Glaucoma	❑ Kidney Disease	❑ Siezures
❑ Anemia	❑ COPD	❑ Heart Attach	❑ Kidney Failure	❑ Sleep Apnea
❑ Anxiety	❑ Coronary Disease	❑ Heartburn/Reflux	❑ Liver	❑ Stents in Heart
❑ Asthma	❑ CPAP	❑ Hepatitis B	❑ Liver Failure	❑ Stents in Legs
❑ Attention Deficit	❑ Depression	❑ Hepatitis C	❑ Narcolepsy	❑ Stomach Ulcer
❑ Bipolar	❑ Diabetes	❑ High Blood Pressure	❑ Obsessive Compulsive	❑ Stroke
❑ Bleeding Disorder	❑ Fibromyalgia	❑ HIV	❑ Pancreas Disease	❑ Thyroid Disease
❑ Blood Clots in Leg	❑ Gastritis	❑ Irritable Bowel	❑ Schizophrenia	❑ Vascular Disease

Other medical conditions or diseases: Specify _____

Your Daily Activity/Self Care is: ❑ Good ❑ Fair ❑ Poor Due to Pain ❑ Poor Due to Other Reasons

Your Sleep is: ❑ Good ❑ Fair ❑ Poor Due to Pain ❑ Poor Due to Other Reasons

Family History:

Father	❑ Illegal Drug Use	❑ Rx Drug Abuse	❑ Alcoholism	❑ Alive ❑ Deceased
Mother	❑ Illegal Drug Use	❑ Rx Drug Abuse	❑ Alcoholism	❑ Alive ❑ Deceased
Siblings	❑ Illegal Drug Use	❑ Rx Drug Abuse	❑ Alcoholism	❑ Alive ❑ Deceased

List Previous and Current PAIN Treatments

Previous and Current Pain Medications	Helped	Some Help	No Help	Side Effects: Specify	Previous and Current Pain Medications	Helped	Some Help	No Help	Side Effects: Specify	Previous and Current Pain Medications	Helped	Some Help	No Help	Side Effects: Specify
Acetaminophen (Tylenol)	☐	☐	☐		Fentanyl Patch	☐	☐	☐		Nortriptyline (Pamelor)	☐	☐	☐	
Amitriptyline (Elavil)	☐	☐	☐		Flector patch	☐	☐	☐		Nucynta	☐	☐	☐	
Aqua Therapy	☐	☐	☐		Gabapentin (Neurontin)	☐	☐	☐		Nucynta ER	☐	☐	☐	
Aspirin (Bayer, Excedrin)	☐	☐	☐		H. Wave	☐	☐	☐		Opana ER	☐	☐	☐	
Avinza	☐	☐	☐		Hydrocodone (Lortab)	☐	☐	☐		Other: Specify	☐	☐	☐	
Biofeedback/Relaxation	☐	☐	☐		Hydrocodone (Norco)	☐	☐	☐		Oxycodone	☐	☐	☐	
Braces	☐	☐	☐		Hydrocodone (Vicodin)	☐	☐	☐		OxyContin	☐	☐	☐	
Butrans patch	☐	☐	☐		Hydromorphone (Dilaudid)	☐	☐	☐		Oxymorphone (Opana)	☐	☐	☐	
Celecoxib (Celebrex)	☐	☐	☐		Ibuprofen (Advil, Motrin)	☐	☐	☐		Percocet (Endocet)	☐	☐	☐	
Chiropractic	☐	☐	☐		Indomethacin (Indocin)	☐	☐	☐		Physical Therapy	☐	☐	☐	
Codeine ☐#2 ☐#3 ☐#4	☐	☐	☐		Lidoderm patch	☐	☐	☐		Pregabalin (Lyrica)	☐	☐	☐	
Compound cream	☐	☐	☐		Meloxicam (Mobic)	☐	☐	☐		Sacroiliac Joint Injection	☐	☐	☐	
Counseling	☐	☐	☐		Metaxalone (Skelaxin)	☐	☐	☐		TENS "Electrical pads"	☐	☐	☐	
Cyclobenzaprine (Flexeril)	☐	☐	☐		Methadone	☐	☐	☐		Tizanidine (Zanaflex)	☐	☐	☐	
Desipramine (Norpramin)	☐	☐	☐		Methocarbamol (Robaxin)	☐	☐	☐		Traction	☐	☐	☐	
Duloxetine (Cymbalta)	☐	☐	☐		Milnacipran (Savella)	☐	☐	☐		Tramadol (Ultram)	☐	☐	☐	
Epidural Injection	☐	☐	☐		Morphine ER (Kadian)	☐	☐	☐		Tramadol ER (Ryzolt)	☐	☐	☐	
Exalgo	☐	☐	☐		Morphine IR	☐	☐	☐		Trigger point Injection	☐	☐	☐	
Exercise	☐	☐	☐		MS Contin	☐	☐	☐		Ultracet	☐	☐	☐	
Facet Injection	☐	☐	☐		Naprosyn, Aleve	☐	☐	☐		Voltaren Gel	☐	☐	☐	

Unlisted Medication(s):

Allergies: *Including Seafood, IV dye, Local Anesethetic, Betadine, Chloraprep, Alcohol or Latex* ❑ NONE

Drug/Food	Type of Reaction

Surgical History: *Procedure/Hospital/Surgeon Name/Year* ❑ NONE

Hospitalization History: *Hospital/Location/Reason/Year* ❑ NONE

Social History:

Do you have any metal implants in your body? ❑ No ❑ Yes: explain _____

Marital Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced **With whom do you live with?** _____

Caffeine Use: ❑ Never ❑ Use Now: Type & Amount: _____ ❑ Quit - When: _____

Tobacco Use: ❑ Never ❑ Use Now: Type & Amount: _____ ❑ Quit - When: _____

Alcohol Use: ❑ Never ❑ Use Now: Type & Amount: _____ ❑ Quit - When: _____

Illegal Drug Use: ❑ Never ❑ Use Now: Type & Amount: _____ ❑ Quit - When: _____

Have you ever had a problem with alcohol or any drugs? ❑ No ❑ Yes: explain _____

Have you ever been convicted of a crime? ❑ No ❑ Yes: explain _____

Is there a change that you are pregnant? ❑ No ❑ Yes, Date of LMP: _____ ❑ Unsure ❑ N/A

Exposure to X-ray , ultrasound as well as taking or stopping medications during pregnant and breast feeding can harm the baby.
Please notify the doctor if you plan to or become pregnant.

Your pain or nerve medication may affect balance and ability to ambulate, drive or operate machinery. Upon initiating the medication and after every increase in dose you will have a responsible adult in attendance, ambulate with caution and will not drive or operate machinery for a few to several days, until you know the medicine is not causing you to be sleepy, dizzy or clumsy. Also, your judgment, reflexes and reaction time may be slowed even in the absence of drowsiness, dizziness or impaired mental ability.