

ATTENTION!

IN ORDER TO KEEP A TIMELY SCHEDULE, WE ASK YOU TO PLEASE COMPLETE THIS QUESTIONNAIRE PRIOR TO YOUR APPOINTMENT AND BRING IT WITH YOU ALONG WITH YOUR FILMS, INSURANCE INFORMATION AND REFERRAL, IF YOUR INSURANCE REQUIRES ONE.

Main Line Spine

Please be aware that there are two entrances to our building. One entrance is for the Doctor's Office and the other is for Main Line Spine Surgery Center. Once inside you cannot access the other side.

**Entrance to Main Line Spine
Doctors Office
Suite 308 C**

**Entrance to Main Line Spine
Surgery Center
Suite 335**



Dear:

**Your initial office visit with Dr._____ is scheduled for
_____ at _____ in _____.**

Enclosed please find all the necessary paperwork that we need you to fill out for us. In order to see the doctor, please fill out all the paperwork and bring it with you to the appointment. DO NOT MAIL BACK. Please make certain that all pertinent insurance information is completed. PHOTO I.D. AND INSURANCE CARD ARE REQUIRED UPON REGISTRATION. If you have an insurance that requires a referral, we ask that you obtain the referral or referral number. (THIS IS AN INSURANCE REFERRAL FROM YOUR PRIMARY PHYSICIAN.)

PLEASE MAKE SURE TO BRING THE FOLLOWING:

- 1. If you had any X-Rays, MRIs, Bone Scans or CT-Scans done we ask that you obtain the films and bring them along with the report.**
- 2. Please have the referring physician fax us a copy of your last office visit report to: 610-337-3506**

Thank you.

Sincerely,

Main Line Spine

PATIENT REGISTRATION

DATE: _____

NAME: _____ AGE: _____ D.O.B. _____ SEX: _____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

S.S. #: _____ PHONE # TO LEAVE PERSONAL MESSAGE: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT & NUMBER _____

EMPLOYER NAME & ADDRESS: _____

DATE OF INJURY: _____ REASON FOR VISIT: _____

REFERRED BY DOCTOR: _____ PRIMARY DOCTOR: _____

ADDRESS: _____ ADDRESS: _____

PHONE: _____ FAX: _____ PHONE: _____ FAX: _____

BILLING INFO (CIRCLE ONE): WORKER'S COMP. AUTO PRIVATE HEALTH INS

#1 INS. CO. NAME: _____ #2 INS. CO. NAME: _____

ADDRESS: _____ ADDRESS: _____

PHONE: _____ FAX: _____ PHONE: _____ FAX: _____

CL/ID#: _____ GRP#: _____ CL/ID#: _____ GROUP#: _____

SUBSCRIBERS NAME: _____ RELATION: _____ D.O.B: _____

*** PLEASE LET US COPY YOUR HEALTH INS. CARD EVEN IF WORKER'S COMP. OR AUTO***

IF APPLICABLE, NAME OF ATTORNEY: _____

ADDRESS: _____ PHONE: _____

_____ FAX: _____

WE DO NOT BILL ATTORNEY'S OFFICES FOR SERVICES RENDERED. NOR DO WE ACCEPT LETTERS OF PROTECTION.

I AUTHORIZE INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN AND UNDERSTAND I AM RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIANS TO RELASE ANY INFORMATION REQUIRED IN THE PROCESSING OF THE CLAIMS

PATIENT'S SIGNATURE: _____ DATE: _____

NAME: _____

DATE: _____

PAIN QUESTIONNAIRE

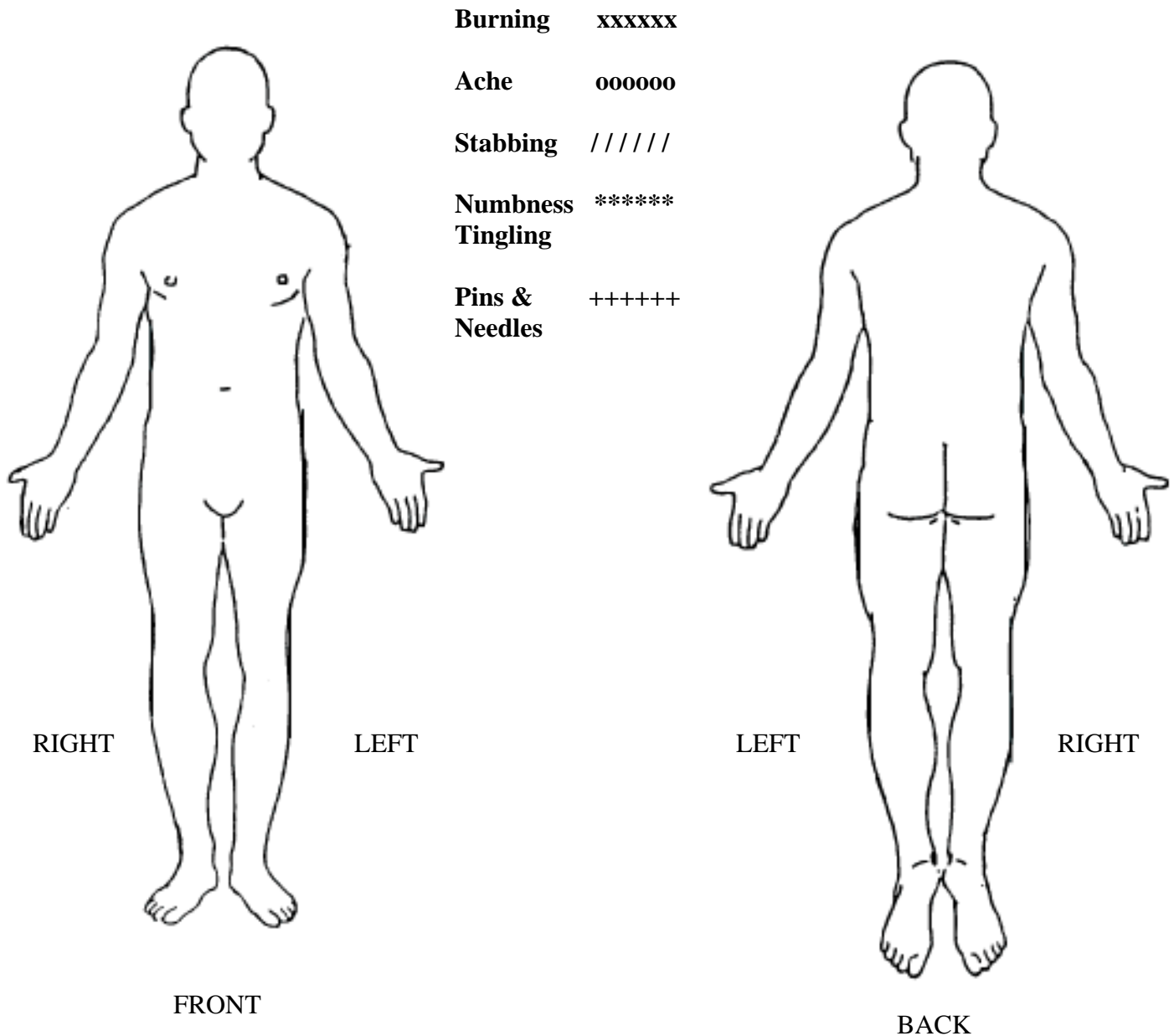
WELCOME TO MAIN LINE SPINE

THIS QUESTIONNAIRE IS DESIGNED TO HELP YOUR DOCTOR GATHER INFORMATION IN ORDER TO DIAGNOSE AND TREAT YOUR PROBLEM.

PLEASE ANSWER ALL THE QUESTIONS TO THE BEST OF YOUR ABILITY, CIRCLE ANSWERS UNLESS OTHERWISE INDICATED

PAIN DIAGRAM

Please mark the diagram according to the symptoms you are currently experiencing. Indicate the location of your symptoms and the nature of your symptoms by using the markers shown here.



1. Date of injury: _____
2. Date pain began: _____
3. Did your injury occur at work? Yes_____ No_____
4. Describe your injury or symptoms: _____

5.	Back Pain	Leg Pain	Neck Pain	Arm Pain
Are you				
Improved	_____	_____	_____	_____
Worsened	_____	_____	_____	_____
Same	_____	_____	_____	_____

(Please check one)

6. DESCRIBE YOUR PAIN RATIO:

(Circle one line that best describes your symptoms)

Back Pain/Leg Pain %	Neck Pain /Arm Pain %
100%/0%	100%/0%
90%/10%	90%/10%
80%/20%	80%/20%
70%/30%	70%/30%
60%/40%	60%/40%
50%/50%	50%/50%
40%/60%	40%/60%
30%/70%	30%/70%
20%/80%	20%/80%
10%/90%	10%/90%
0%/100%	0%/100%

7. Do you experience numbness or tingling in your: (circle)

Leg and/or foot left right
Arm and/or hand left right

8. Do you experience weakness in your: (circle)

Leg and/or foot left right
Arm and/or hand left right

9. Using the following guidelines please circle the number that best describes your pain:

- 1 No pain
- 2-3 Mild pain
- 4-5 Moderate pain
- 6-7 Pain limits ability to perform daily activities
- 8-9 Severe pain limits all activities
- 10 The worst pain you can imagine -must go to the hospital-

Please Circle

Pain most of the time	1 2 3 4 5 6 7 8 9 10
Pain at its best	1 2 3 4 5 6 7 8 9 10
Pain at its worst	1 2 3 4 5 6 7 8 9 10
Pain in the morning	1 2 3 4 5 6 7 8 9 10

10. Are you currently in a physical therapy program?

Yes _____ No _____

If yes please describe your program _____

11. Do you have a home program yes _____ no _____

If yes, please describe _____

12. Do you use assistive devices yes _____ no _____

If yes what do you use? _____

13. Which of these activities increase (+) or decrease (-) the pain?

Sitting	_____	Standing	_____
Leaning forwards	_____	Walking	_____
Bending forwards	_____	Lying on your side	_____
Driving	_____	Lying on your back	_____
Coughing/sneezing	_____	Lying on your stomach	_____

14. Answer the following in lengths of time, i.e., 5 mins., 30 mins., etc., maximum time tolerated:

How long can you sit? _____

How long can you stand? _____

How long can you walk? _____

15. List all the medications you are using including prescription, over the counter, herbal and any others _____

16. Which of these treatments has been helpful or unhelpful?

	Helpful	Unhelpful	Never tried
Hot packs	_____	_____	_____
Ice	_____	_____	_____
Electrical stimulation	_____	_____	_____
Massage	_____	_____	_____
Chiropractor	_____	_____	_____
Acupuncture	_____	_____	_____
Press ups	_____	_____	_____
Sit ups	_____	_____	_____
Traction	_____	_____	_____
Brace/corset	_____	_____	_____
Epidural injections	_____	_____	_____
Facet joint injections	_____	_____	_____

17. Past medical history (answer from a-h for past history ONLY)

a. Have you had problems with your neck or back in the past?

Yes _____ No _____ When? _____

b. Did you miss work? Yes _____ No _____ How long? _____

c. Have you had spine surgery in the past? Yes _____ No _____

d. Did you improve? _____ Worsen? _____ Stayed the same? _____

e. Did you return to work after last surgery? Yes _____ No _____

f. To the same job? Yes _____ No _____

g. Circle any of the following medical problems you have had:

High blood pressure	Heart disease	Diabetes	Thyroid
Seizures	Hepatitis	Cancer	Asthma
Tuberculosis	Stomach ulcers	Kidney stones	Kidney infections
HIV/AIDS			

h. List any non-spine surgeries: _____

18. Do you have a family history of:

Back problems _____ Rheumatoid Arthritis _____

Degenerative arthritis _____

19. Do you smoke cigarettes? Yes _____ No _____ How many? _____

Do you drink alcohol? Yes _____ No _____ How much? _____

20. Do you have any allergies? _____

Do you have any allergies to X-Ray contrast, iodine or sea food?

Yes _____ No _____

21. Do you regularly experience: (Circle all that apply)

Unintentional Weight Loss/Gain	Blurry Vision	Headaches
Shortness of Breath	Chest Pain	Constipation
Abdominal Pain	Nausea/Vomiting	Dizziness
Loss of Bladder/Bowel Function	Unsteady Gait	Joint Pain
Loss of Consciousness	Depression	Anxiety

22. Are you working? Yes _____ No _____
If not when did you last work? _____

23. What is your occupation? _____

How much time at work is spent:

Sitting _____ Driving _____
Standing _____ Lifting _____
Walking _____ How many lbs. do you lift? _____

24. Are you Married _____ Divorced _____ Single _____
Widowed _____ Children _____

25. List three activities you are unable to do because of your pain:

1. _____
2. _____
3. _____

26. What are your favorite activities/hobbies? _____

27. Have you been pleased with the medical treatment you have received up to this point in time? Yes _____ No _____

28. Height: _____ Weight: _____

Patient Signature: _____ Date/Time: _____

Physician Signature: _____ Date/Time: _____