BSV neuroscience

Brain, Spine & Vascular Neuroscience Institute

Patient Information
Please complete and sign form at bottom

Patient Name	Social Security # Sex M F		Date of Birth
Street Address (If student, permanent address)	City and State Zip Code	Home Phone	
	Email	Cell Phone	
Marital Status S M D W	Spouse's Name	Spouse's Phone	Permission to release your info? Y N
Employer (Indicate if retired)	Occupation (Indicate if student)	Business Phone & EXT	Currently working? Y N
Employer Street Address	City and State	Zip Code	
Emergency Contact	Phone		Permission to release your info? Y N
Referring Physician (First Name, Last Name)	Address	Phone	
Primary Care Physician (First Name, Last Name)	Address	Phone	
Race/Ethnicity		Spoken Language	

PHARMACY INFORMATION

Pharmacy Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

PLEASE PROVIDE ALL INSURANCE INFORMATION REQUESTED BELOW.

IF YOU ARE HERE FOR A WORK-RELATED INJURY OR MOTOR VEHICLE ACCIDENT, SEE REVERSE SIDE

Primary Insurance Company & Address	Name of Policyholder	Identification #	Group #
Secondary Insurance Company & Address	Name of Policyholder	Identification #	Group #

Signature: _____ Date: _____

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WORKER'S COMPENSATION: Were you injured at work? YES NO (If you circled YES, complete information below).
Are you still working? YES NO

Compensation Carrier Name:	Address:	Phone: Fax:
WCB Number:	Carrier Case Number:	Date of Injury:
Name of Employer (at the time of injury):	Employer Address:	Employer Phone:
Name of Adjuster:	Adjuster Phone:	Adjuster Fax:
Body part(s) injured:	Job duties at time of injury:	

NO FAULT: Were you injured by a motor vehicle? YES NO (If you circled YES, complete information below).

Agent Name:	Insurance Company Address:	Date of Accident:
Insurance Company:		Claim Number:
Name of Adjuster:	Adjuster Phone:	Adjuster Fax:
Body part(s) injured:		

You will need a referral for your insurance if Workers' Compensation/No Fault denies your claim.

Explain in detail how the injury occurred: _____

_____

_____

Explain in detail the nature of your injury, including all body parts injured: _____ _____ _____

_____

_____

_____

Have you given your employer or supervisor notice of this injury? YES NO

Are you disabled from performing your regular job duties? YES NO

A. Does any other doctor have you off of work? YES NO

If yes, who? _____

B. Does your employer have light duties or other jobs you can perform? YES NO UNSURE

Have you had any previous Workers' Compensation or No Fault injuries? YES NO

If yes, body part(s)? _____ Date of injury: _____

Doctor or hospital where treated: _____

Patient name (please print): _____

Signature: _____ Date: _____

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Patient Medical History

Patient Name: _____

Age: _____ Height: _____ Weight: _____ Right-handed ____ Left-handed ____ Are you Claustrophobic? YES NO

REASON FOR VISIT:

Chief complaint: _____

_____

_____

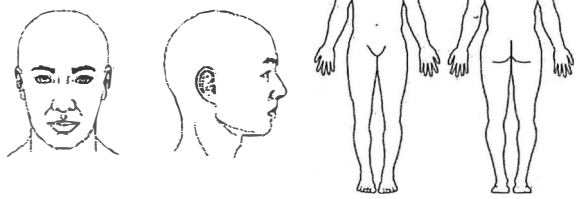
_____

_____

_____

PAIN DIAGRAM: Mark the picture where your symptoms are

Numbness	+++
Burning	XXX
Aching	
Stabbing	/////
Pins/needles	000



Have you seen another physician for this condition/injury? YES NO If yes, where, when and whom? _____

_____

How bad is your pain? (circle) 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 (worst pain)

Duration? Less than 1 week Less than 1 month Less than 1 year _____ More than 1 year _____

Food Allergies? YES NO (List all, and reactions you might have) _____

Dye Allergies? YES NO (List all, and reactions you might have) _____

Latex Allergies? YES NO (List all, and reactions you might have) _____

Drug Allergies? YES NO (List all, and reactions you might have) _____

Other? _____

****LIST CURRENT MEDICATIONS (names, dosage, frequency) *Attach list if needed*:** _____

_____

Smoker or use tobacco? YES NO How frequent? Every day _____ Some days _____ Pack/day _____ # Years _____

Former smoker/tobacco user: Quit when? _____ Never smoked or used tobacco _____

Do you believe you can quit? YES NO

Alcohol use? YES NO If yes, how frequent? ☐ Daily ☐ Weekly ☐ Socially

Drug use? YES NO If yes, how frequent? ☐ Daily ☐ Weekly ☐ Socially

Drug/alcohol therapy? YES NO If yes, describe: _____

****LIST PREVIOUS SURGERIES**: _____

_____

Hysterectomy? YES NO

Spinal cord stimulator? YES NO

Intrathecal pump? YES NO If yes, ☐ Morphine? ☐ Baclofen?

Metal implants? YES NO Location _____

Pacemaker/AICD? YES NO

PERSONAL HISTORY:

Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Hypertension	☐	☐	Ulcer/GI Bleed
☐	☐	High Cholesterol	☐	☐	Lung Disease/Asthma
☐	☐	Heart Disease	☐	☐	Cancer
☐	☐	Heart Attack	☐	☐	Hepatitis
☐	☐	Heart Surgery	☐	☐	Kidney Disease/Dialysis
☐	☐	Cardiac Angioplasty/Stent	☐	☐	Osteoarthritis/Rheumatoid
		(When?	☐	☐	Aneurysm
☐	☐	Atrial Fibrillation	☐	☐	Other _____

FAMILY HISTORY:

Father	Mother	Brother	Sister	Son	Daughter	
☐	☐	☐	☐	☐	☐	**Diabetes?**
☐	☐	☐	☐	☐	☐	**Stroke?**
☐	☐	☐	☐	☐	☐	**Heart Disease?**
☐	☐	☐	☐	☐	☐	**Cancer?**
☐	☐	☐	☐	☐	☐	**Brain Tumor?**
☐	☐	☐	☐	☐	☐	**Aneurysm - brain?**
☐	☐	☐	☐	☐	☐	**Aneurysm - other?**

Signature _____ Date

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Review of Systems

Please circle the symptoms you have been experiencing recently. If none apply, select "None."

General	Weight loss Night sweats	Fatigue	Unsteadiness	Fever	Chills		None
HEENT:	Vision changes	Hearing loss	Ringing in ears	Nose bleeds			None
Neck:	Pain/difficulty swallowing	Sore throat	Lumps/masses in neck	Hoarseness			None
Respiratory:	Shortness of breath	Wheezing	Dry cough	Productive cough			None
Cardiac:	Palpitations	Chest pain	Swelling in legs				None
GI:	Nausea/ vomiting Weight loss	Difficulty swallowing	Indigestion	Change in bowel habits	Blood in stools		None
GU:	Difficulty urinating Sexual dysfunction	Pain on urinating	Prostate problems	Urinating multiple times at night	Blood in urine	Incontinence	None
Vascular:	Pain in calves when walking	Clots in legs					None
Musculo-skeletal:	Pain/stiffness in bones or joints	Arthritis	Gout	Muscle weakness			None
Neurologic:	Numbness/ weakness Headaches	Tingling	Tremors	Seizures	Blackouts		None
Hematologic:	Easy bruising/ bleeding						None
Endocrine:	Heat/cold intolerance	Excessive thirst					None
Skin:	Skin, hair or nail changes	Rashes	Sores				None
Psychiatric:	Depression	Anxiety	Thoughts of suicide				None

What makes your pain better? _____

_____

What makes your pain worse? _____

_____

Which of the following treatments have you had:

Yes	No		
☐	☐	Physical therapy (Facility?_____,	
☐	☐	Chiropractic (Facility?_____,	
☐	☐	Traction/Spinal decompression (Facility?_____,	
☐	☐	Injections (Facility?_____,	
☐	☐	Orthopedic consult (Where?_____,	
☐	☐	Neurosurgical consult (Where?_____,	
☐	☐	Surgery consult (Where?_____,	
☐	☐	Pain medication	☐ NSAIDs _____ ☐ Muscle relaxants _____ ☐ Narcotics _____ ☐ Other _____

How do the following activities affect your pain?

Better	Worse	No change	
☐	☐	☐	Lying down
☐	☐	☐	Sitting
☐	☐	☐	Standing
☐	☐	☐	Walking
☐	☐	☐	Bending
☐	☐	☐	Lifting
☐	☐	☐	Straining/coughing/sneezing

Patient name: _____ DOB: _____ Date: _____

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