MR#:

Patient Information DOCTOR OF RECORD: Jesse P. Butler, M.D., CIME **CONFIDENTIAL**

Patient Name:	Patient ID:	Home Phone:	Second Phone: (Work)	Third Phone: (Cell)
Address:	Date Of Birth:	Social Security #:	Sex:	Marital Status:
City, State, Zip:	Age:	Emergency Contact:		Contact Phone: Cell: Home:
Employer:			Patient Email Address:	
Primary Care Doctor Name & Address:		Pharmacy:		

Responsible Party

Responsible Party Name:	Home Phone:	Second Phone: (Work)	Third Phone: (Cell)
Address:		Date Of Birth:	Social Security Number:
City, State, Zip:		Sex:	Patients Relation To Res:
Employer:			Responsible Party ID:

Primary & Secondary Insurance Company (Insured's Information)

Primary Insurance Company Name:		Secondary Insurance Company Name:	
Primary Insurance Company Address :		Secondary Insurance Company Address:	
Primary Insurance Company City, State, Zip:		Secondary Insurance Company City, State, Zip:	
Primary Insurance Company Phone:		Secondary Insurance Company Phone:	
Policy Number:	Group Number:	Policy Number:	Group Number:

Workers' Compensation (Insured's Information)

Workers' Compensation Case Number:	Employer's Workers' Compensation Group Number:
Insurance Company Name:	Insurance Company Address :
	Insurance Company City, State, Zip:

Authorization and Acknowledgement

I/We hereby state that the above information is true and correct to the best of my/our knowledge. I/We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payers as required for certain claims filed.

I/We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

I/We hereby understand the physician's right to change the medical group's privacy policy. I acknowledge that I have received a copy of the practice's notice of privacy practices. I understand I can request a copy of the current Notice of Privacy Practice at any time and I may contact the practice manager to have my questions or complaints regarding my privacy rights at any time.

Signature of Patient / Parent / Guardian / Insured : Printed Name: Date:

MR#:

Spine Consultants, LLC
www.spineconsultants.org

Follow-Up Medical History Form

First Name, Middle Initial Last Name

Today's Date: _____

Date of Birth: Height _____ Weight _____ pounds

VISUAL ANALOGUE SCALE PAIN ASSESSMENT Please circle the number that best answers the question.

What is your pain RIGHT NOW?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

What is your TYPICAL or AVERAGE pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

OSWESTRY DISABILITY INDEX Please circle the number of the answer that best describes your condition.

Pain Intensity

5—Pain medication has no effect on the pain and I do not use.
4—Pain medication gives very little relief from pain.
3—Pain medication gives moderate relief from pain.
2—Pain medication gives complete relief from pain.
1—Pain is bad but I manage without taking pain medication.
0—I can tolerate the pain I have without taking medication.

Personal Care

5—I do not get dressed; wash with difficulty and stay in bed.
4—I need help every day in most aspects of self care.
3—I need some help but manage most of my personal care.
2—It is painful to look after myself; I am slow and careful.
1—I can look after myself normally but it causes extra pain.
0—I can look after myself normally without causing extra pain.

Lifting

5—I cannot lift or carry anything at all.
4—I can lift only very light weights.
3—Pain prevents me from lifting heavy weights, but I can manage medium weights if they are conveniently positioned.
2—Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned.
1—I can lift heavy weights but it causes extra pain.
0—I can lift heavy weights without extra pain.

Walking

5—I am in bed most of the time and have to crawl to the toilet.
4—I can only walk using a stick or crutches.
3—Pain prevents me walking more than 0.25 miles.
2—Pain prevents me walking more than 0.5 miles.
1—Pain prevents me walking more than 1 mile.
0—Pain does not prevent me walking any distance.

Sitting

5—Pain prevents me from sitting at all.
4—Pain prevents me from sitting more than 10 minutes.
3—Pain prevents me from sitting more than 0.5 hours.
2—Pain prevents me sitting more than 1 hour
1—I can only sit in my favorite chair as long as I like.
0—I can sit in any chair as long as I like.

Standing (Remember standing is not walking)

5—Pain prevents me from standing at all.
4—Pain prevents me from standing for more than 10 minutes.
3—Pain prevents me from standing for more than 30 minutes.
2—Pain prevents me from standing for more than 1 hour.
1—I can stand as long as I want but it gives me extra pain.
0—I can stand as long as I want without extra pain.

Sleeping

5—Pain prevents me from sleeping at all.
4—Even when I take medicine I have less than 2 hours of sleep.
3—Even when I take medicine I have less than 4 hours of sleep.
2—Even when I take medicine I have less than 6 hours of sleep.
1—I can sleep well only by using medicine.
0—Pain does not prevent me from sleeping well.

Sex Life (by pain of fear of causing pain)

5—Pain prevents any sex life at all.
4—My sex life is nearly absent because of pain.
3—My sex life is severely restricted by pain.
2—My sex life is nearly normal but very painful.
1—My sex life is normal but causes extra pain.
0—My sex life is normal and causes no extra pain.

Social Life

5—I have no social life because of pain.
4—Pain has restricted my social life to my home.
3—Pain has restricted my social life and I do not go out as often.
2—Pain has no significant effect on my social life apart from limiting energetic interest such as dancing.
1—My social life is normal but increase the degree of pain.
0—My social life is normal and give me no extra pain.

Traveling

5—Pain prevents me from traveling except to the doctor or home.
4—Pain restricts me to short necessary journeys under 30 minutes.
3—Pain restricts me to journeys of less than 1 hour.
2—Pain is bad but I manage journeys over 2 hours.
1—I can travel anywhere but it gives me extra pain.
0—I can travel anywhere without extra pain.

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REVIEW OF SYSTEMS (are you currently having problems with any of the following:

Denies All ☐ Denies All (Select this option if you wish to deny all of the selections below)

General ☐ Denies
☐ Chills ☐ Fatigue ☐ Fever ☐ Weight change

Skin ☐ Denies
☐ Breast lump ☐ Hair change ☐ Nail change ☐ Rash/itching/psoriasis

HEENT ☐ Denies
☐ Blurred vision ☐ Eye disease ☐ Glaucoma ☐ Hearing loss/ringing ☐ Nose bleeds
☐ Sinus problems ☐ Sore throat

Respiratory ☐ Denies
☐ Bronchitis ☐ Cough ☐ Short of breath ☐ Wheezing

Cardiovascular ☐ Denies
☐ Chest pain ☐ Heart trouble ☐ Palpitations ☐ Swelling

Gastrointestinal ☐ Denies
☐ Bowel problem/colitis ☐ Nausea/vomit ☐ Rectal bleeding ☐ Stomach pain

Genitourinary ☐ Denies
☐ Blood in urine ☐ Foul odor/cloudiness ☐ Frequency ☐ Kidney stones ☐ Menstrual problems ☐ Retention
☐ Sexual problems ☐ Testicle pain

Musculoskeletal ☐ Denies
☐ Joint pain ☐ Joint swelling ☐ Pain/cramps ☐ Trouble walking

Neurological ☐ Denies
☐ Headaches ☐ Numbness ☐ Seizures ☐ Tremors ☐ Weakness

Psychiatric ☐ Denies
☐ Confusion ☐ Depression ☐ insomnia

Endocrine ☐ Denies
☐ Excessive urination ☐ Hormone problem ☐ Thyroid disease

Hematologic ☐ Denies
☐ Bruise easily ☐ Enlarged glands ☐ Slow to heal

Patient/Guardian Statement: to the best of my knowledge, the above information is accurate and complete.

Name of person completing the form_____ Relationship to patient_____

Signature of person completing the form_____ Date _____