

**NEURO-SPINE SOLUTIONS
NEW PATIENT PACKET**

PATIENT INFORMATION

Patient Name	
Social Security #	
Birth Date	Male/Female
Address	
City, State, Zip Code	
Home Phone	
Cell Phone	

EMERGENCY CONTACT INFORMATION

Emergency Contact (outside of home)	
Contact Phone	
Relationship to Patient	

EMPLOYMENT

Employment Status	
Occupation	
How Long	
Employer Name	
Employer Address	
Employer Phone	

SPOUSE OR GUARDIAN INFO (if patient is a minor)

Spouse or Guardian & Social Security #	
Birth Date	
Spouse or Guardian Employer	
Employer Address	
Employer Phone	

FAMILY AND REFERRING PHYSICIAN INFORMATION

Referring Physician	
Complete Address	
Phone	
Family Physician	
Address	
Phone	

PHARMACY INFORMATION

Pharmacy Name	
Address	
Phone	

Is your illness/injury due to a work-related incident? If so, please answer the questions below.

Accident Location	
Date of Injury	
Date Last Worked	
Worker's Comp. Carrier	
Carrier Address	
Carrier Phone	
Attorney	
Attorney Address	
Attorney Phone	

Use this area to briefly describe how you were injured:

Is your illness/injury due to an automobile accident? If so, please answer the questions below.

Date of Accident	
Accident Location	
Fault of Another Party (Yes/No)	
Insurance Carrier	
Name of Insured	
Policy Number	
Claim Number	
Attorney	
Attorney Address	
Attorney Phone	

SURGICAL HISTORY

SURGERY	YES	NO	DATE	SURGERY	YES	NO	DATE
Tonsils				Uterus Removed			
Appendix				Bladder Surgery			
Brain Surgery				Kidney Surgery			
Neck Arteries				Hemorrhoids			
Eye Surgery				Blood Vessels			
Lung Surgery				Hip Surgery			
Heart Surgery				Leg/Arm Surgery			
Gall Bladder				Disc Rupture (Neck)			
Colon Surgery				Disc Rupture (Back)			
Prostate				Hernia Repair			
Tubal Ligation				Other			

In the PAST have you had any of the following medical conditions?

CONDITION	YES	NO	CONDITION	YES	NO
Heart Disease			Kidney Stones		
Lung Disease			Prostate Problems		
Thyroid Disease			Kidney Disease		
Liver Disease			Weight Loss		
Stomach Ulcers			Weight Gain		
Cancer			Poor Appetite		
Seizures			Serious Illnesses		
Stroke			Psychiatric Care		
Diabetes			Irritable Bowel		
High Blood Pressure			Gout		
Headaches/Migraines			Contact Lenses/Glasses		
Anemia			Bleeding Disorders		
Painful Joints			Other		

Do You CURRENTLY Have Any of the Following Medical Conditions?

CONDITION	YES	NO	CONDITION	YES	NO
Heart Disease			Kidney Stones		
Lung Disease			Prostate Problems		
Thyroid Disease			Kidney Disease		
Liver Disease			Weight Loss		
Stomach Ulcers			Weight Gain		
Cancer			Poor Appetite		
Seizures			Serious Illnesses		
Stroke			Psychiatric Care		
Diabetes			Irritable Bowel		
High Blood Pressure			Gout		
Headaches/Migraines			Contact Lenses/Glasses		
Anemia			Bleeding Disorders		
Painful Joints			Other		

TREATMENT FOR MY CURRENT MEDICAL PROBLEMS HAS INCLUDED:

Plain X-Rays		Hot/Cold Packs		Limiting Activities	
MRI		Electronic Stimulation		Part-Time Work	
CT Scans		Myostim		Stopping Work	
EMG/NVC		Massage		Bed Rest	
Bone Scan		Pool Therapy		Anti-Inflammatory Meds	
Bone Density Test		Stationary Bike		Muscle Relaxants	
Myelogram		Strength Exercises		Pain Medications	
Ultrasound		Stretching Exercises		No Treatment to Date	
Chiropractor		Epidural Steroid Injection		Other	

FAMILY HISTORY

Relation	Alive	Deceased	Age at Death	Know Medical Problems
Mother				
Father				
Brother/Sister				

PATIENT HISTORY

Please list all of the medications you are currently taking:

1.	5.
2.	6.
3.	7.
4.	8.

Are You:

Left Handed _____

Right Handed _____

Height _____

Weight _____

BP _____

SOCIAL HISTORY

Do you smoke? _____ If so, packs per day: _____

Do you drink alcoholic beverages? Yes _____ No _____

Do you use recreational drugs? Yes _____ No _____

Have you ever had a blood transfusion? Yes _____ No _____

Do you now or have you ever had any know HIV risks? Yes _____ No _____

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Number of living children _____

NO SHOW POLICY: Effective 7/1/06 there will be a \$20.00 No-Show/ Late Cancellation Fee. Appointments must be cancelled by 3:00 PM of the previous day or by 3: PM on Friday for a Monday appointment. The patient/guardian will be responsible for this fee. It will not be billed to your insurance company.