Date: _______________ **Physician to be seen**: __________________

Name (First, MI, Last): ____

DOB: _____________________ Age: _______ **Gender (Circle One)**: MALE FEMALE

Primary Phone#: _________________________ **Secondary Phone#**: ___________________________

Address (Street, City, State, Zip): **Job/Occupation:**

_____________________________________ ____

_____________________________________ ____

SSN: ___________________ **Email Address**: ____

Emergency Contact Name: ____

Phone#: ___________________________ **Relation**: ____

Referring Physician: _____________________ **How did you hear about us?** _______________________

Primary Care Physician: ____

Pharmacy: ______________________________________ **Pharmacy Phone#**: ________________________

Please Circle One: SINGLE MARRIED DIVORCED WIDOWED

Race (Circle): ASIAN AFRICAN/AMERICAN HISPANIC INDIAN LATINO WHITE

OTHER: ______________________

Ethnicity (Circle One): Hispanic/Latino Non-Hispanic/Latino Refuse to Report

Is this a work related injury? (Circle) YES NO **Adjuster Name**: _____________ **Phone#**: _________

<u>Insurance</u> (Check which applies): Insurance ______ Self Pay ______

Primary Insurance Company: _______________________________ **Relationship to Insured**: __________

Policy Holder: _______________________________________ **Policy Holder DOB**: _________________

Member ID#: ____ **Group #**: __________________________

Secondary Insurance Company: ______________________________ **Relationship to Insured**: _________

Policy Holder: _______________________________________ **Policy Holder DOB**: _________________

Member ID#: ____ **Group #**: __________________________

*Please be advised that **Texas Spine Associates** does not treat injuries acquired by an accident where a third party entity is held liable for the incident (i.e. homeowner's insurance, auto insurance, etc.). **Texas Spine Associates** only files claims on personal insurance and worker's compensation and any appointments made under any other circumstances will be cancelled. I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.*

Patient (or Guardian) Signature: ________________________ **Date:** ________________________________

PLEASE FILL OUT COMPLETELY

Patient Name: ______________________________ Date of Birth: ____/____/______

Please list any known allergies and types of reactions:

____

____

Are you allergic to Latex: ❑ **Yes** ❑ **No**

Past Medical History and current medical condition: ☐ **None**

____

____

____

Please mark any of the following symptoms that you currently or chronically experiencing with a Yes or No:

Y	N	Constitutional Symptoms	Y	N	Eyes	Y	N	Gastrointestinal	Y	N	Genitourinary
		Fatigue			Vision loss			Diarrhea			Incontinence
		Fever/chills			Wears glasses/contacts			Heartburn/reflux			Kidney problems
		Recent weight gain	**Y**	**N**	**Endocrine**			Liver problems			Menopausal
		Recent weight loss			Always thirsty			Nausea/vomiting	**Y**	**N**	**Neurological**
Y	**N**	**Ear, Nose, Mouth, & Throat**			Appetite increase/decrease			Ulcers			Fainting/blackouts
		Dentures/bridges/braces			Sensitivity to heat/cold	**Y**	**N**	**Hematologic/Lymphatic**			Poor coordination
		Hearing loss			Thyroid disease			Anemia			Seizures
		Mouth lesions			Diabetes			Bleeding problems			Stroke/paralysis
		Nose bleeds	**Y**	**N**	**Cardiovascular**			DVT/blood clots			Weakness
		Ringing in ear			Ankle Swelling			Easy bruising	**Y**	**N**	**Psychiatric**
		Sinus infections			Chest pain/heart attack			Lupus			Anxiety
Y	**N**	**Integumentary (skin)**			High/low blood pressure	**Y**	**N**	**Musculoskeletal**			Depression
		Cancer			Irregular heartbeat			Broken bones			Substance dependence
		Itching	**Y**	**N**	**Respiratory**			Difficulty walking			Trouble sleeping
		Rash			Asthma			Joint pain			
		Skin-related problems			Bloody cough			Joint stiffness			
					Shortness of breath			Joint swelling			
					Sputum in cough			Uses cane/walker/wheelchair			
					Waking up short of breath						

Family Medical History: ☐ **No Known History**

____

____

____

____

Social Lifestyle:

Alcohol Use	❑	Y	❑	N	If yes, amount: ______________________
Illegal Drug Use	❑	Y	❑	N	If yes, what type: ____________________
Prescription Drug Abuse	❑	Y	❑	N	If yes, what type: ____________________
Tobacco Use	❑	Y	❑	N	If yes, amount daily __________ / yrs ________
Interested in quitting tobacco?	❑	Y	❑	N	

PLEASE FILL OUT COMPLETELY

Patient Name: ______________________________________ Date of Birth: ____/____/______

List of Medications and Dosage: ☐ **See list provided by patient**

____
____
____
____
____

List of Surgeries: ☐ **See list provided by patient**

Procedure	**Year**

Have you had any past problems with anesthesia? Y N
If yes, please explain: ____

____

Height: __________ Weight: __________

Chief Complaint:
Reason for your visit today: ____

Symptoms: ____

Date of Injury or when symptoms started: ____

Describe how the injury or problem occurred: _______________________________________

What treatment have you already tried? : ____

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient (or Guardian) Signature: __________________________ Date: ___________________________

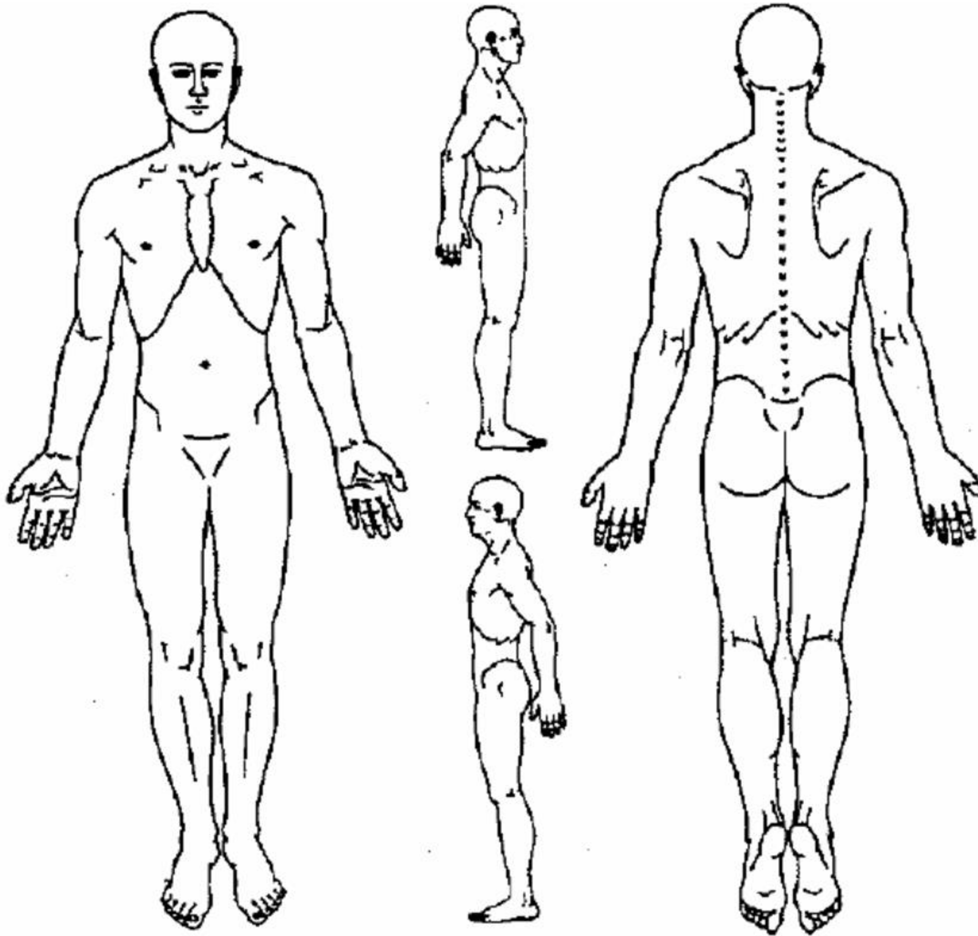
Physician Signature: ____________________________________ Date: ___________________________

PLEASE FILL OUT COMPLETELY

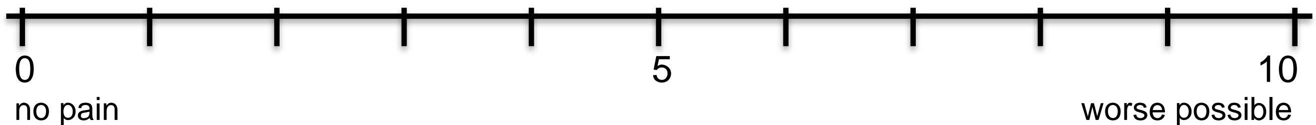
Pain Diagram

Please mark the area of injury or discomfort on the chart below using the appropriate symbols.

Numbness	Pins & Needles	Burning	Aching	Stabbing
– – – – –	o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
– – – – –	o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
– – – – –	o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗

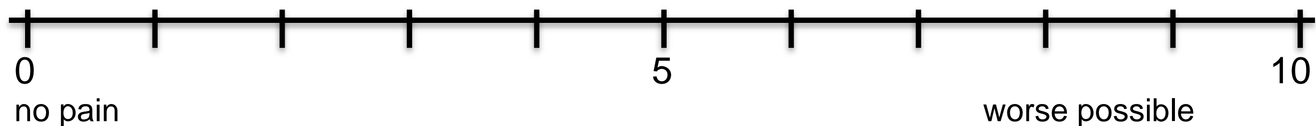


PLEASE MARK ON THE LINE: **How bad is your neck/back pain now?**



0 no pain 5 10 worse possible

How bad is your arm/leg pain now?



0 no pain 5 10 worse possible