PACIFIC HEIGHTS SPINE CENTER
Premier Comprehensive Spine Care

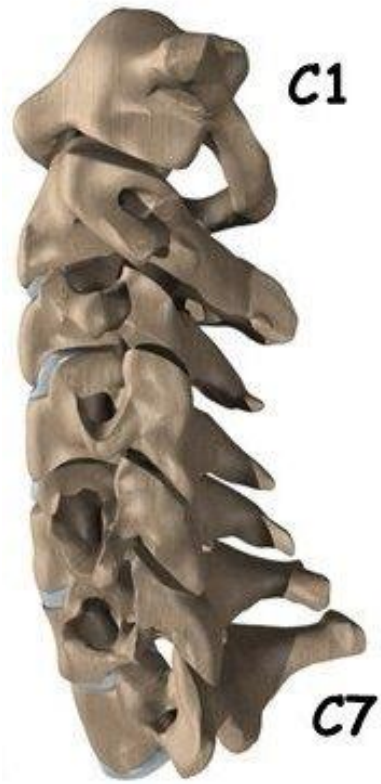
www.phspine.com

RAY OSHTORY, MD, MBA
Cervical, Complex and
Minimally Invasive Spine Surgery

KONRAD H. NG, MD
Multidisciplinary and
Interventional Pain Management

Cervical Spine

New Patient Forms



2100 Webster Street, Suite 314 • San Francisco, CA 94115
1580 Valencia Street, Suite 703 • San Francisco, CA 94110
T: 415.737.0555 F: 415.737.0595

PACIFIC HEIGHTS SPINE CENTER
2100 Webster Street, Suite 314 • San Francisco, CA 94118
1580 Valencia Street, Suite 703 • San Francisco, CA 94110
Tel: (415) 737-0555 • Fax: (415) 737-0595

Confidential Intake Form – New Patient

TODAY'S DATE	TYPE OF APPOINTMENT ☐ NEW-PATIENT CONSULTATION ☐ SECOND OPINION	PREFERRED LANGUAGE

Contact Information

LAST NAME	FIRST NAME (INITIALS, NICKNAMES)		MALE ☐	FEMALE ☐
HOME ADDRESS		HOME TELEPHONE	CELL	
		WORK TELEPHONE	FAX	
EMPLOYED ☐ / OCCUPATION / UNEMPLOYED ☐ / RETIRED ☐		EMAIL		
IF EMPLOYED, EMPLOYER NAME AND ADDRESS		☐ EMPLOYED PART-TIME ☐ EMPLOYED FULL-TIME	☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ PARTNERED ☐ DIVORCED	
		☐ STUDENT ☐ PART-TIME ☐ FULL-TIME	SPOUSE/PARTNER NAME	
		DATE OF BIRTH / AGE	SOCIAL SECURITY NUMBER	
DIAGNOSIS/PROBLEM/SYMPTOMS				

Primary Insurance

INSURANCE CARRIER (COMPANY NAME)		TYPE ☐ HMO ☐ PPO ☐ SELF-PAY	GROUP NUMBER
ADDRESS OF INSURANCE CARRIER		SUBSCRIBER'S ID NUMBER	PLAN CODE
		SUBSCRIBER'S NAME	DATE OF BIRTH
BENEFITS/CUSTOMER SERVICE TELEPHONE		SUBSCRIBER'S ADDRESS	
AMOUNT OF DEDUCTIBLE $	DEDUCTIBLE HAS BEEN MET ☐ YES ☐ NO		
AMOUNT OF COPAYMENT $		SUBSCRIBER'S TELEPHONE	RELATIONSHIP TO SUBSCRIBER

Secondary Insurance

INSURANCE CARRIER (COMPANY NAME)		TYPE ☐ HMO ☐ PPO ☐ SELF-PAY	GROUP NUMBER
ADDRESS OF INSURANCE CARRIER		SUBSCRIBER'S ID NUMBER	PLAN CODE
		SUBSCRIBER'S NAME	DATE OF BIRTH
BENEFITS/CUSTOMER SERVICE TELEPHONE		SUBSCRIBER'S ADDRESS	
AMOUNT OF DEDUCTIBLE $	DEDUCTIBLE HAS BEEN MET ☐ YES ☐ NO		
AMOUNT OF COPAYMENT $		SUBSCRIBER'S TELEPHONE	RELATIONSHIP TO SUBSCRIBER

Referral Information

REFERRED BY	RELATIONSHIP TO PATIENT (E.G. PRIMARY DOCTOR)	TELEPHONE

In Case of Emergency

CONTACT PERSON	RELATIONSHIP TO PATIENT	TELEPHONE

Assignment of Benefits/Financial Responsibility/Authorization to Release Medical Information

I hereby assign medical and/or surgical payments – including major medical benefits to which I am entitled, private insurance, and proceeds from any other health plan – to Rayshad Oshtory, M.D. and/or Konrad H. Ng, M.D., for services he provides. This assignment shall remain in effect until I submit a written revocation to them. I understand that I am financially responsible for all charges for the provided services, whether or not they are paid for by such insurance. I hereby authorize assignee to release any of the above information and/or any medical information necessary to secure payment. A copy of this assignment shall be as valid as the original.

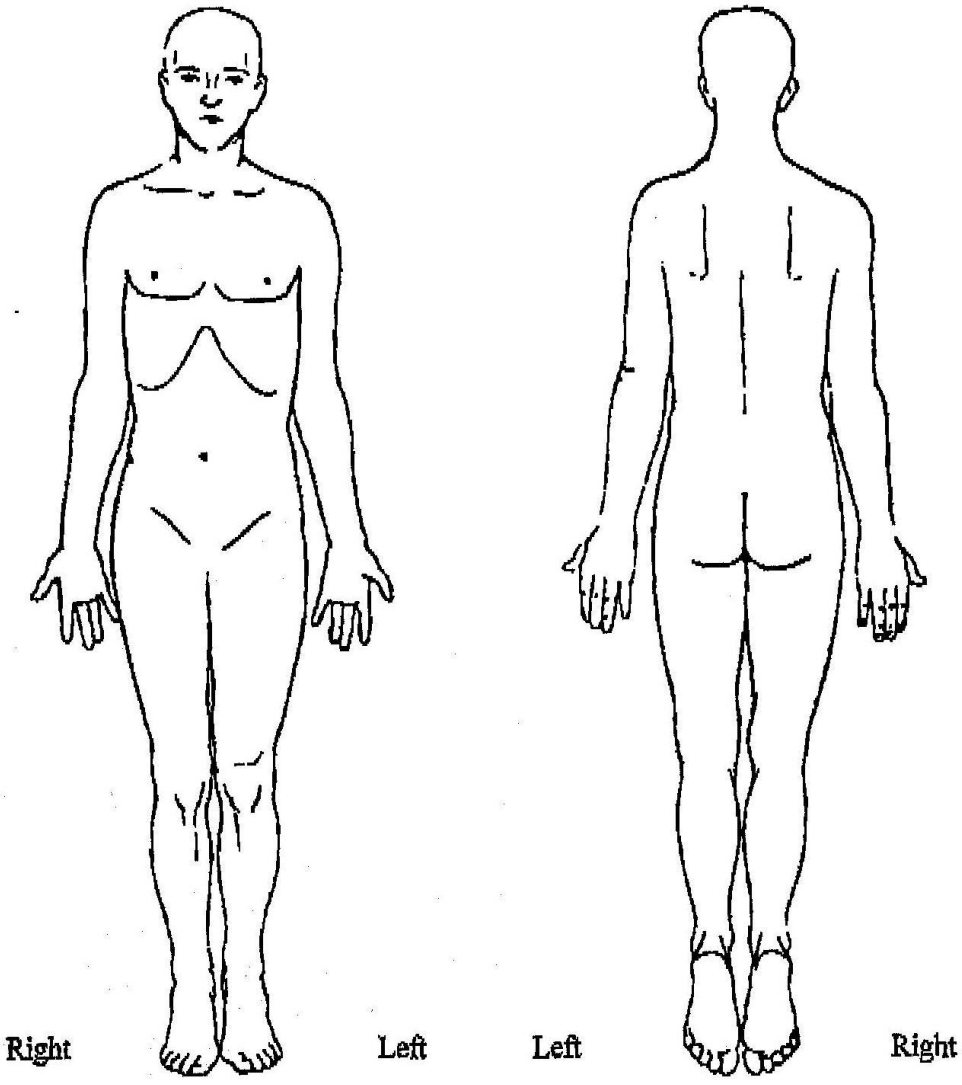
Date: _____ Patient Acknowledgement (Signature): _____

Name:_____ **Date:**_____

Pain Drawing

This pain drawing will help us understand the pain you have been experiencing. Using the diagrams below, use the symbols listed below to indicate what type of pain you are having and where it is located:

- - -	Numbness
□□□	Pins and needles
○○○	Burning pain
ΔΔΔ	Stabbing pain
×××	Aching pain



Name:_____ **Date:**_____

Date of Birth:_____ Sex: ☐M ☐F

What is your Height: _____ What is your Weight: _____

Who referred you here: _____

MAJOR Complaint: (if both neck and arm please give a PERCENTAGE in each)

Pain in: Neck_____ Arm_____ Left_____ Right_____

Please indicate the severity of the pain as it is *most* of the time by marking the line with a **SINGLE vertical line " | "** (0=no pain, 10=worst pain)

Neck

[----------]
0 10

Arm

[----------]
0 10

Duration of current symptoms: _____Weeks _____Months _____Years

Date of initial onset (if known): _____

Is there numbness and/or tingling associated with the pain: ☐Yes ☐No

Is there weakness in the affected arm or hand: ☐Yes ☐No

Have you noticed bowel or bladder problems (e.g. incontinence): ☐Yes ☐No

What have you tried for your symptoms thus far:

☐Physical Therapy	☐Traction	☐Exercise
☐Acupuncture	☐Chiropractic	☐TENS unit
☐Injections	☐Medications	☐Other:_____

Indicate which activities WORSEN your symptoms:

☐Sitting	☐Standing	☐Walking
☐Lying down	☐Bending forward	☐Bending backward

Indicate which activities IMPROVE your symptoms:

☐Sitting	☐Standing	☐Walking
☐Lying down	☐Bending forward	☐Bending backward

Name:_____ **Date:**_____

Is your pain worse:
☐In the morning ☐Mid-day ☐In the evening ☐Other: _____

Is your pain better:
☐In the morning ☐Mid-day ☐In the evening ☐Other: _____

Which studies of your back or neck, if any, have you had in the last 2 years:
☐Regular X-rays ☐Bending X-rays ☐MRI ☐CT Scan
☐Myelogram ☐EMG ☐Discogram ☐CT Myelogram

Indicate any Medical History you have:
☐High blood pressure ☐Heart ☐Lung ☐Diabetes
☐Thyroid ☐Kidneys ☐Liver ☐Stomach
☐Hepatitis C ☐HIV
☐Other (Please list):_____

_____

Have you ever had neck or back surgery before: ☐Yes ☐No

Please list ALL prior surgeries (Spine AND Non-Spine) with dates (Month/Year):

_____

_____

List (or include a list) of all current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

Are you Allergic to any medications: ☐Yes ☐No

If yes, please list Medication(s) and Reaction(s):_____

_____

Name:_____ **Date:**_____

Do you smoke or use Tobacco products: ☐Yes ☐No

If yes, for how long: _____
Packs smoked per day: ☐<½ ☐½ ☐1 ☐2 ☐3 ☐4

Do you drink Alcohol: ☐Yes ☐No
If yes, drinks per day: ☐<1 ☐1 ☐2 ☐3 ☐4 ☐5 ☐>5

Do you use any other Drugs: ☐Yes ☐No If yes, which drugs:_____

Are you on Disability: ☐Yes ☐No If yes, Date started:_____

Is there a lawsuit associate with this injury: ☐Yes ☐No

Is this a worker's compensation claim: ☐Yes ☐No

If yes, When was the date of injury:_____

BRIEFLY describe the mechanism of injury:_____

_____

Are you currently: ☐Employed ☐Unemployed ☐Student ☐Retired

If employed, what is your occupation: _____

Are you presently working: ☐Yes ☐No

If no, what is the last date worked:_____

Are you: ☐Married/Partnered ☐Single ☐Divorced/Separated ☐Widowed

Number of Children, if any: _____

List any family member, with history of heart, lung, liver or kidney disease; arthritis, gout, glaucoma, or cancer; neck or back problems:

Relationship:_____ Disease:_____

Relationship:_____ Disease:_____

Relationship:_____ Disease:_____

Relationship:_____ Disease:_____

Relationship:_____ Disease:_____

Name:_____ **Date:**_____

EXTENDED REVIEW OF SYSTEMS: Do you presently have any problems or symptoms in the following areas? If "Yes", please explain briefly:

	Yes	No	Explanation:	Provider Comments:
1. General				
Good health	☐	☐		
Fever, chills, sweats	☐	☐		
2. Eyes				
Wear glasses or contact lenses	☐	☐		
Vision problems (blurred, double, or loss of vision)	☐	☐		
3. Ears/Nose/Mouth/Throat				
Change in hearing or ringing in ears	☐	☐		
Chronic sinus problems	☐	☐		
4. Cardiovascular				
Heart trouble or heart attack	☐	☐		
Chest pain/angina (sharp, crushing, or heaviness)	☐	☐		
Heart racing/palpitations/arrhythmia	☐	☐		
Blood clots	☐	☐		
5. Respiratory				
Asthma, wheezing, shortness of breath	☐	☐		
Cough	☐	☐		
6. Gastrointestinal				
Heartburn	☐	☐		
Bleeding ulcers	☐	☐		
Nausea/Vomiting	☐	☐		
7. Endocrine				
Thyroid problems	☐	☐		
8. Hematologic/Lymphatic				
Easy bruising	☐	☐		
Frequent bleeding	☐	☐		
9. Skin and breasts				
Rashes or sores	☐	☐		
Skin cancer or melanoma	☐	☐		
Non-healing wounds	☐	☐		
10. Allergic/Immunologic				
Allergic reaction to drugs	☐	☐		
Recent cold or flu	☐	☐		
11. Genitourinary				
Painful or burning urination	☐	☐		
Blood in urine	☐	☐		
Bladder infection/other infections	☐	☐		
Sexually transmitted disease	☐	☐		
12. Musculoskeletal				
Joint stiffness or pain	☐	☐		
Back pain	☐	☐		
Neck pain	☐	☐		
13. Neurological				
Numbness or tingling in arms or legs	☐	☐		
Weakness in arms or legs	☐	☐		
Stroke	☐	☐		
14. Psychiatric				
Depression	☐	☐		
Anxiety	☐	☐		
15. Other (Please write in):				
_____				

Name:_____ **Date:**_____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire has been designed to give us information as to how your neck or arm pain is affecting your ability to manage in everyday life. Please answer each section by checking the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CHECK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity	***SECTION 6 - Concentration***
☐ I have no pain at the moment. ☐ The pain is very mild at the moment. ☐ The pain is moderate at the moment. ☐ The pain is fairly severe at the moment. ☐ The pain is very severe at the moment. ☐ The pain is the worst imaginable at the moment.	☐ I can concentrate fully when I want to with no difficulty. ☐ I can concentrate fully when I want to with slight difficulty. ☐ I have a fair degree of difficulty in concentrating when I want to. ☐ I have a lot of difficulty in concentrating when I want to. ☐ I have a great deal of difficulty in concentrating when I want to. ☐ I cannot concentrate at all.
SECTION 2 -Personal Care (Washing, Dressing, etc.)	***SECTION 7 - Work***
☐ I can look after myself normally without causing extra pain. ☐ I can look after myself normally, but it causes extra pain. ☐ It is painful to look after myself and I am slow and careful. ☐ I need some help, but manage most of my personal care. ☐ I need help every day in most aspects of self care. ☐ I do not get dressed, I wash with difficulty and stay in bed.	☐ I can do as much work as I want to. ☐ I can only do my usual work, but no more. ☐ I can do most of my usual work, but no more. ☐ I cannot do my usual work. ☐ I can hardly do any work at all. ☐ I cannot do any work at all.
SECTION 3 - Lifting	***SECTION 8 - Driving***
☐ I can lift heavy weights without extra pain. ☐ I can lift heavy weights, but it gives extra pain. ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. ☐ I can lift very light weights. ☐ I cannot lift or carry anything at all.	☐ I can drive my car without any neck pain. ☐ I can drive my car as long as I want with slight pain in my neck. ☐ I can drive my car as long as I want with moderate pain in my neck. ☐ I cannot drive my car as long as I want because of moderate pain in my neck. ☐ I can hardly drive at all because of severe pain in my neck. ☐ I cannot drive my car at all.
SECTION 4 - Reading	***SECTION 9 - Sleeping***
☐ I can read as much as I want to with no pain in my neck. ☐ I can read as much as I want to with slight pain in my neck. ☐ I can read as much as I want to with moderate pain in my neck. ☐ I cannot read as much as I want because of moderate pain in my neck. ☐ I cannot read as much as I want because of severe pain in my neck. ☐ I cannot read at all.	☐ I have no trouble sleeping. ☐ My sleep is slightly disturbed (less than 1 hour sleepless). ☐ My sleep is mildly disturbed (1-2 hours sleepless). ☐ My sleep is moderately disturbed (2-3 hours sleepless). ☐ My sleep is greatly disturbed (3-5 hours sleepless). ☐ My sleep is completely disturbed (5-7 hours).
SECTION 5 - Headaches	***SECTION 10 - Recreation***
☐ I have no headaches at all. ☐ I have slight headaches which come infrequently. ☐ I have moderate headaches which come infrequently. ☐ I have moderate headaches which come frequently. ☐ I have severe headaches which come frequently. ☐ I have headaches almost all the time.	☐ I am able to engage in all of my recreational activities with no neck pain at all. ☐ I am able to engage in all of my recreational activities with some pain in my neck. ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck. ☐ I am able to engage in a few of my recreational activities because of pain in my neck. ☐ I can hardly do any recreational activities because of pain in my neck. ☐ I cannot do any recreational activities at all.