O NEW O CHANGE Effective date: ____/_____/_________

PATIENT DEMOGRAPHIC INFORMATION

Personal Information:

____

Last Name First Name Middle Initial

O Male O Female DOB (mm/dd/yyyy): ___________________________ SSN: ____________________________

Address: ____

City: _________________________________ State: _________________________ Zip Code: ______________________

Home# ____________________________ O Preferred Work# ____________________________ O Preferred

Mobile# ___________________________ O Preferred E-mail: _______________________________________

Employer: __________________________________ Address: ____

Spouse's Name: ____________________________________ Spouse's Employer: _______________________________

Emergency Contact (not in the same household): ______________________________ Phone# ____________________

Referral Information:

Referring Doctor: ____ Phone# _________________________

Family Doctor: ____ Phone# _________________________

I agree to provide to my physician accurate and complete information, including, but not limited to, insurance information, cause of injury, medical history, etc. I understand that not providing accurate and complete information will result in the physician not receiving correct reimbursement from the appropriate insurance company and I agree to be responsible for all charges for services rendered.

_____________________________________ _____________________________

Signature Date

In accordance with HIPAA regulations, I authorize STAR to disclose my protected health information (PHI) to other healthcare providers as well as to the following individuals:

Name: ____ Relationship: _______________________________

Name: ____ Relationship: _______________________________

Name: ____ Relationship: _______________________________

_____________________________________ _________________________________

Patient's Signature Date

O NEW O CHANGE Effective date: ____/_____/_________

PATIENT INSURANCE INFORMATION

We will need to make a copy of your insurance card(s)

Patient Name:

Last Name First Name Middle Initial

Is this injury: O Work-Related? O Auto-injury? If so, please complete the information in this section:

Company Name: ____ Claim # _________________________________

Address: ____

City: ___________________________________ State: ___________________________ Zip Code: _______________________

Contact Person: ____ Phone # ____________________________

Date of Injury (mm/dd/yyyy): ______________________________ I have contacted an attorney: O Yes O No

Primary Insurance Information:

Insurance Company: ____ Phone #__________________________________

Address: ____

Contract# ________________________ Group# _______________________ Effective Dates: ________________________

Subscriber's Legal Name: ____ DOB (mm/dd/yyyy): _____________________

SSN: ___________________________ Subscriber's Relationship to patient: ____

Subscriber's Employer: ____ Phone# _______________________________

Secondary Insurance Information:

Insurance Company: ____ Phone# _________________________________

Address: ____

Contract# ________________________ Group# _______________________ Effective Dates: ________________________

Subscriber's Legal Name: ____ DOB (mm/dd/yyyy): _____________________

SSN: ___________________________ Subscriber's Relationship to patient: ____

Subscriber's Employer: ____ Phone# _______________________________

Prescription Insurance Information:

Do you have Prescription Coverage? O Yes O No

Name of Provider: ____ Phone# _________________________________

Contract# ________________________ Group# _______________________ Effective Dates: ________________________

O NEW O CHANGE Effective date: ____/_____/_________

PATIENT HISTORY ASSESSMENT

Patient Name:

Last Name	First Name	Middle Initial

Section A:

What is your primary complaint? ____

Category of pain (choose one): O A gradual onset without trauma, injury, or change in activity.
O An abrupt onset without trauma, injury or change in activity.
Date of onset (mm/dd/yyyy): __________________________

This injury is a... O Personal Injury (Continue to Section B)
O Worker's Compensation Injury (Continue to Section C)
O Automobile Injury (Continue to Section D)
O None of the Above (Continue to Section E)

Section B: Personal Injury

Date of Injury (mm/dd/yyyy): ___________________ Location (Ex. home, parking lot, etc.): _____________________

What happened? (Ex. fell of ladder, etc.): ____

Where have you been treated for your injury? ____

Has any legal action been taken? O Yes O No If yes, is the litigation still pending? O Yes O No

If yes, who is your attorney? ____

PLEASE CONTINUE TO **SECTION E.**

SECTION C: Workman's Compensation (WC)

Date of Injury (mm/dd/yyyy): ___________________

Has your employer filled the claim? O Yes O No State where claim was filled: ______________________

Briefly explain the cause of your injury: ____

Is the WC claim still open? O Yes O No If no, date closed (mm/dd/yyyy): __________________________

If yes, do you have an attorney? O Yes O No If yes, who is your attorney? _________________________

PLEASE CONTINUE TO **SECTION E.**

SECTION D: Automobile Injury (AA)

Date of accident (mm/dd/yyyy): ______________________ Do you have an open auto claim? O Yes O No

If yes, do you have an attorney? O Yes O No If yes, who is your attorney? _________________________

Any open litigation? O Yes O No If yes, please explain: _______________________________________

Mark all that apply: O Driver O Passenger O Pedestrian O Wearing Seat Belt O Not Wearing Seat Belt
O Rear-ended O Head-On O Side-swiped O T-boned O Single Auto-accident

PLEASE CONTINUE TO **SECTION E.**

O NEW O CHANGE Effective date: ____/_____/_________

SECTION E: Disability

Are you on Social Security Disability? O Yes O No If yes, do you have Medicare Part D? O Yes O No

Are you on Short Term (Sick Leave) Disability through your employer? O Yes O No

If yes, state the last day you worked: ______________________ Doctor that authorized it: _________________________

Are you on Long Term (Sick Leave) Disability through your employer? O Yes O No

If yes, state the last day you worked: ______________________ Doctor that authorized it: _________________________

A Functional Capacity Evaluation (FCE) is an assessment tool utilized for those who have suffered an injury that may affect employment. It is a standardized way to collect information regarding physical abilities to determine whether or not you can return to your previous job duties. You may be asked to have an FCE if off work for an extended period of time.

Have you had an FCE? O Yes O No If yes, state the date and place: __________________________________

SECTION F: Education and Employment Status

What is the highest grade you have completed in education? ____

Employment Status: O Employed O Unemployed O Disability O Sick Leave O Retired

If employed, what is your occupation? ___________________________ For how many years? ____________________

If retired, what was your occupation? ___________________________ For how many years? ____________________

If you are currently unemployed, on disability or on sick leave, please describe briefly why you are unable to work:

____

SECTION G: Social History

Marital Status: __________________________ # of children: _____________ Household Occupancy: ______________

SECTION H: Family History

Please list any condition that your family members have or have been treated for:

Family Member	Condition
____________________________	_____________________________
____________________________	_____________________________
____________________________	_____________________________

Is there any family history of osteoporosis (brittle bone)? O Yes O No

SECTION I: Past Medical History I (check yes or no)

SKIN	YES	NO	EYES, EARS, NOSE AND THROAT	YES	NO
Skin Infections	___	___	Foreign object in eyes	___	___
Decubitus Ulcer	___	___	Visual Disturbances	___	___
Skin Ulcers	___	___	Ringing in ears	___	___
Scars	___	___	Mouth Sores	___	___
Incisions	___	___	Nose Drainage	___	___
Rashes	___	___	Hearing Loss	___	___
			Double Vision	___	___

O NEW O CHANGE Effective date: ____/_____/_________

SECTION J: Past Medical History II (mark all that apply)

CARDIO	RENAL	URO/GYN	PULMONARY
O Coronary Artery Disease	O Kidney Stones	O Endometriosis	O COPD/Emphysema
O Congestive Heart Failure	O Kidney Cysts	O Tubal Pregnancy	O Asthma
O High Blood Pressure	O Kidney Failure	O Pelvic Inflammatory Disease	O Sleep Apnea
O Peripheral Vascular Disease	O Kidney Transplant	O History of Ovarian Cancer	O Recurrent Pneumonia
O Heart Murmur	O Kidney Disease	O History of Testicular Cancer	O History of Pulmonary Embolism
O History of Heart Attack	O History of Kidney Cancer	O Erectile Dysfunction	**GASTROENTEROLOGY**
ENDOCRINOLOGY		**PSYCHIATRIC**	O Heartburn/Reflux
O Diabetes (w/insulin)	**HEMATOLOGY**	O Depression	O Systemic Lupus
O Diabetes (w/o insulin)	O Anemia	O Bipolar Disease	O Colitis
O Hypothyroidism	O Leukemia	O Anxiety	O Chronic Diarrhea
O Low Testosterone	O Lymphoma	O Social Phobia	O Chronic Constipation
O Addison's Disease	O Bleeding Disorder	O History of Suicide Attempt	O Irritable Bowel Syndrome
DERMATOLOGY	O History of Blood Clotting	O Psychosis	O Celiac Disease- Gluten Sensitive
O Skin Lupus			O Crohn's Disease
O Eczema	**RHEUMATOLOGY/ORTHO**	**NEUROLOGY**	O Ulcers
O Psoriasis	O Rheumatoid Arthritis	O Seizure Disorder	O Bleeding Ulcers
O History of Skin Cancer	O Systemic Lupus	O Multiple Sclerosis	O History of Colon Cancer
INFECTIOUS DISEASES	O Osteoarthritis	O Neuropathy	O Barrett's Esophagus
O Shingles	O Psoriatic Arthritis	O Myasthenia Gravis	OTHER CONDITIONS
O Lyme Disease	O Osteoporosis	O Polymyositis	
O HIV/Aids	O Osteopenia	O Carpal Tunnel Syndrome	
	O Fibromyalgia		

SECTION K: Previous Medication (mark all that apply)

O Amerge	O Frova	O Norgesic Forte	O Soma
O Amrix	O Gabitril	O Neurontin	O Talwin
O Arthrotec	O Ibuprofen	O Opana ER	O Topamax
O Avinza	O Imitrex	O Oxycodone	O Trazadone
O Axert	O Indocin	O OxyContin	O Treximet
O Celebrex	O Kadian	O Pamelor	O Tylenol
O Celexa	O Keppra	O Panlor SS	O Tylox
O Cymbalta	O Klonopin	O Parafon	O Ultracet
O Darvocet	O Lexapro	O Paxel	O Ultram ER
O Darvon	O Lodine	O Pennsaid	O Valium
O Daypro	O Lortab	O Percocet	O Vicodin
O Depakote	O Luvox	O Prestiq	O Voltaren
O Dilaudid	O Lyrica	O Prozac	O Wellbutrin
O Duragesic	O Maxalt	O Relafen	O Zanaflex
O Effexor	O Methadone	O Relpax	O Zoloft
O Elavil	O Mirapex	O Remeron	O Zomig
O Embeda	O MS-Contin	O Requip	O Zonegran
O Exalgo	O MSIR (morphine)	O Robaxin	O ____________________
O Fentora	O Naprosyn	O Ryzolt	O ____________________
O Flexeril	O Norflex	O Senokot	O ____________________

O NEW O CHANGE Effective date: ____/_____/_________

SECTION L: Current Medication

MEDICATION	DOSE	FREQUENCY	EFFECTIVENESS (high, medium, low)

SECTION M: Allergies (mark all that apply)

O No Known Drug Allergies O Dye/Contrast Allergy O Iodine Allergy O Seafood/Shell Fish Allergy

ALLERGEN	REACTION

STAR
SPINE TECHNOLOGY AND REHABILITATION

O NEW O CHANGE Effective date: ____/_____/_________

SECTION N: Nature of Symptoms: RATE the affective areas according to severity (1st being highest priority)

____ Neck	____ Right Elbow	____ Right Ankle
____ Mid-Back	____ Left Elbow	____ Left Ankle
____ Low Back	____ Right Wrist	____ Right Foot
____ Buttock	____ Left Wrist	____ Left Foot
____ Right Arm	____ Right Hand	____ Chest Wall
____ Left Arm	____ Left Hand	____ Abdominal
____ Right Leg	____ Right Hip	____ Pelvic
____ Left Leg	____ Left Hip	____ Headaches
____ Right Shoulder	____ Right Knee	____ Tail Bone
____ Left Shoulder	____ Left Knee	____ Other: ____________________

SECTION O: Review of Symptoms (choose all that apply)

O Weakness	Where? ____________________	O Numbness	Where? ____________________
O Tingling	Where? ____________________	O Burning Pain	Where? ____________________
O Shooting Pain	Where? ____________________	O Stabbing Pain	Where? ____________________
O Achy Pain	Where? ____________________	O Muscle Spasms	Where? ____________________
O Loss of Bladder	O Loss of Bowels	O Pain disrupts sleep	O Pain disrupts housework
O Pain disrupts my job	O Pain disrupts my ability to care for myself/family		

Pertaining to Headaches (choose all that apply)

O Left-Sided	O Head and Eyes	O Double vision	O Worse when lying down
O Right-Sided	O Nausea	O Runny Nose	O Better when lying down
O Behind the head	O Vomiting	O Eyes Watering	O Awaken by headache
O Forehead	O Sensitive to light	O Ear Drainage	O History of TMJ
O Facial Pain	O Sensitive to sound	O Nasal Congestion	O Grinding Teeth
O Sides of head	O Dizziness	O Metallic taste in mouth	O Other: _______________
O Top of head	O Blurred vision	O Worse when standing/sitting	

SECTION P: Review of Symptoms II

ACTION	PAIN LEVEL		
When I first get out of bed	O Worsens Pain	O Relieves Pain	O No change
Sitting	O Worsens Pain	O Relieves Pain	O No change
Leaning forward	O Worsens Pain	O Relieves Pain	O No change
Lying on side	O Worsens Pain	O Relieves Pain	O No change
Lying on back	O Worsens Pain	O Relieves Pain	O No change
Lying on stomach	O Worsens Pain	O Relieves Pain	O No change
Lifting	O Worsens Pain	O Relieves Pain	O No change
Bending backwards	O Worsens Pain	O Relieves Pain	O No change
Getting up	O Worsens Pain	O Relieves Pain	O No change
Standing	O Worsens Pain	O Relieves Pain	O No change
Walking	O Worsens Pain	O Relieves Pain	O No change
Driving	O Worsens Pain	O Relieves Pain	O No change
Coughing	O Worsens Pain	O Relieves Pain	O No change
Stooping	O Worsens Pain	O Relieves Pain	O No change
Twisting	O Worsens Pain	O Relieves Pain	O No change
Other: _________________	O Worsens Pain	O Relieves Pain	O No change

O NEW O CHANGE Effective date: ____/_____/_________

SECTION Q: Diagnostic Testing (choose all that apply)

O X-RAY Region: ____________________ Date : ______________________
O MRI Region: ____________________ Date : ______________________
O Myelogram Region: ____________________ Date : ______________________
O Discography Region: ____________________ Date : ______________________
O Bone Scan Region: ____________________ Date : ______________________
O Spinal Tap Region: ____________________ Date : ______________________
O EMG Region: ____________________ Date : ______________________
O Arthrogram Region: ____________________ Date : ______________________
O Other: ____________________ Region: ____________________ Date : ______________________

SECTION R: Previous Treatments (choose all that apply)

TREATMENTS	DATES (mm/dd/yyyy-mm/dd/yyyy)	RESPONSE (+ or -)		
O Massage Therapy	___________________	________		
O Medications	___________________	________		
O Chiropractic Care	___________________	________		
O Acupuncture	___________________	________		
O Traction	___________________	________		
O Tens Unit	___________________	________		
O Facet Injections	___________________	________		
O Sacroiliac Joint Injection	___________________	________		
O Joint Injections	___________________	________	# of times:	___________
O Epidurals	___________________	________	Type:	___________
O Home Exercise	___________________	________	# per week:	___________
O Physical Therapy	___________________	________	# of sessions:	___________
O Back School	___________________	________	# of sessions:	___________
O Brace/Splint	___________________	________	# of sessions:	___________
O Radiofrequency Ablation	___________________	________		

SECTION S: Previous Surgeries (choose all that apply)

SURGERIES	YEAR	RESPONSE		
O Spinal Cord Stimulator	___________________	________	# of times:	___________
O Low Back Surgery	___________________	________	Type/Levels:	___________
O Neck Surgery	___________________	________	Type/Levels:	___________
O Extremity Surgery	___________________	________	Type:	___________
O Vertebroplasty/Kyphoplasty	___________________	________	Type/Levels:	___________
O Other: ___________________	___________________	________	Type:	___________
O Other: ___________________	___________________	________	Type:	___________
O Other: ___________________	___________________	________	Type:	___________

STAR SPINE TECHNOLOGY AND REHABILITATION

O NEW   O CHANGE   Effective date: ____/_____/_________

SECTION T: Tobacco, Alcohol and Illicit Drug Use

Tobacco Use:

O Never
O Chewing Tobacco   # times a day: ______   Age you started: ______
O Cigarettes   # of packs a day: ______   Age you started: ______
O Cigars   How many a day? ______   Age you started: ______
O Quit   How long ago? ______

Alcohol Use: O Never   O Drinks per day? ______   O Drinks per week? ______

O Currently attending AA   O History of rehab

Do you have any history of alcohol abuse?   O Yes   O No   if yes, when? _______________

Do you have any past or current legal issues with alcohol usage?   O Yes   O No

If yes, please explain: ____

Illicit/Illegal Drug Use:

	Currently Using	Past regular use	Tried it	Never
Marijuana	O	O	O	O
Cocaine	O	O	O	O
Methamphetamine	O	O	O	O
Heroin	O	O	O	O
PCP	O	O	O	O
LSD	O	O	O	O

Prescription drugs (not prescribed): ____

Other: ____

Do you have any past or current legal issues with drug usage?   O Yes   O No

If yes, please explain: ____

____

As a patient at STAR, what is your goal?

____

____

____

____

Please mark an **X** along the line from 0% to 100% to express the degree that your pain has affected your life:

STAR SPINE TECHNOLOGY AND REHABILITATION

O NEW O CHANGE Effective date: ____/_____/_________

Opioid Risk Tool:

The Opioid Risk Tool (ORT) addresses the need to predict who is at risk for opioid abuse before opioid therapy is initiated. This gives physicians a better opportunity to monitor moderate to high risk patients rather than waiting until treatment has begun to check for abuse. Dr. Lynn R. Webster designed the ORT to be used as a point of care tool for providers prescribing opioids during the initial visit for pain treatment. The ORT is a five-question, self-administered assessment that takes fewer than five minutes to complete and can accurately predict which patients are at the highest and lowest risk for displaying aberrant drug-related behaviors associated with abuse or addiction.

Mark Each Box That Applies		Female	Male
Family History Of Substance Abuse	• Alcohol	O	O
	• Illegal Drugs	O	O
	• Prescription Drugs	O	O
Personal History Of Substance Abuse	• Alcohol	O	O
	• Illegal Drugs	O	O
	• Prescription Drugs	O	O
Age (Mark Box If 16-45 Years Old)		O	O
History Of Preadolescent Sexual Abuse		O	O
Psychological Disease	• ADD, OCD, bipolar disorder, schizophrenia	O	O
	• Depression	O	O
None of the above apply to me		O	
	TOTAL		

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005; 6(6): 432-442.