SPINE AND ORTHOPEDIC PAIN CENTER, P.C.
WINIFRED D. BRAGG, M.D.

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial) ______________________ Gender (M/F) __________

Home Address ______________________ Phone (Home) __________

City_________________ State________________ Zip code______________ Phone (Work) __________

Marital Status [ ] Single, [ ] Married, [ ] Divorced, [ ] Widowed DOB __________ Phone (Cell) __________

Email __________

Date of Injury, if applicable __________ Work Related Injury [ ] Yes, [ ] No SSN __________

Employer Name / Address ______________________ Age __________

Current Problem ______________________ Primary Physician __________

SPOUSE / GUARANTOR INFORMATION

Spouse / Guarantor ______________________ Phone (Home) __________

Phone (Work) __________

Home Address ______________________ Phone (Cell) __________

Relationship to Guarantor: [ ] Self, [ ] Spouse, [ ] Dependent Child, [ ] Other __________ SSN __________

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

Insurance Company Name ______________________ Subscriber Name ______________________

Subscriber Date of Birth __________ Subscriber SSN __________ Subscriber Gender: [ ] Male [ ] Female

Patient's Relationship to Insured: [ ] Self, [ ] Spouse, [ ] Dependent Child, [ ] Other __________

Policy # __________ Group # __________ Plan # __________ Effective Date __________

SECONDARY MEDICAL INSURANCE COMPANY

Insurance Company Name ______________________ Subscriber Name ______________________

Subscriber Date of Birth __________ Subscriber SSN __________ Subscriber Gender: [ ] Male [ ] Female

Patient's Relationship to Insured: [ ] Self, [ ] Spouse, [ ] Dependent Child, [ ] Other __________

Policy # __________ Group # __________ Plan # __________ Effective Date __________

WORKERS' COMPENSATION / THIRD PARTY PAYER

Insurance Company Name ______________________ Employer's Name ______________________

Billing Address ______________________

Patient's Relationship to Insured: [ ] Self, [ ] Spouse, [ ] Dependent Child, [ ] Other __________

Claim No. __________ DOI __________ Body Part __________ Effective Date __________

IS THIS AN ACCIDENT? DATE:__________ Fall? __________ Motor Vehicle Accident? __________

ATTORNEY'S NAME AND ADDRESS: ______________________

IN CASE OF EMERGENCY, CONTACT: ______________________ RELATIONSHIP __________

TELEPHONE __________

______________________ ______________________ __________

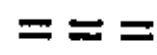
Patient/Guarantor Signature Witness Date

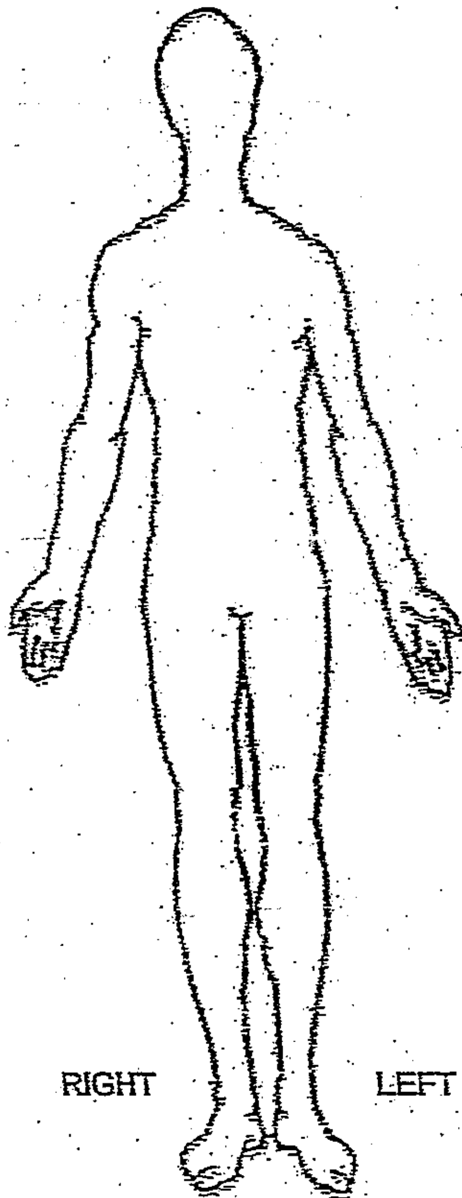
INITIAL MEDICAL QUESTIONAIRRE

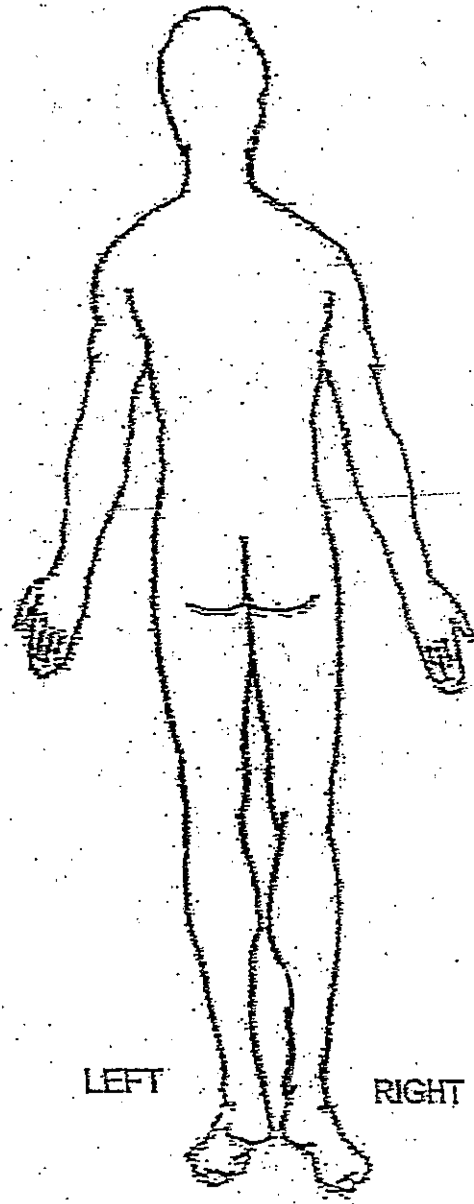
Patient:__________________________Date:__________________ Chart No.:_________

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.

ACHING	NUMBNESS	PINS AND NEEDLES	BURNING	STABBING
				





HOW BAD IS YOUR PAIN NOW?

Please mark with an **X** on the pain drawing where the pain is worst now.

Where is the pain today? ____

Is your pain today: Same Better Worse compared to when it began?

What activities make it worse? (Please Circle)

Exercise (during)	Standing	Bending backward	Reaching
Exercise (after)	Walking	Coughing	Lifting
Sitting	Bending forward	Sneezing	
Driving			

What reduces the pain? (Please Circle)

Lying down	Manipulation	Muscle relaxant pills
Sitting	Home exercises	Aspirin/Anti-inflammatory pills
Standing	Exercises in physical therapy	Nothing
Walking	Pain pills	Heat / Ice
Injections for pain	Other ____________________	

What is the time interval between attacks of pain?

Constantly Daily Weekly Monthly Yearly

Have you been in constant pain since it began or is your pain intermittent? Describe ______________________

Have you noticed any: Numbness Tingling

Do your arms/legs get weak with your pain? ____

Do you have full control of your bladder and bowels? ____________________________________

Do you experience pain with sexual activity? Yes NO

Choose the number of the word which best describes your pain:

0	2	4	6	8	10
NONE	MILD	DISCOMFORTING	DISTRESSING	HORRIBLE	EXCRUCIATING

PATIENT ____________________________ DATE _____________ CHART # _______________

PAST MEDICAL HISTORY

CIRCLE IF YOU CURRENTLY HAVE OR PREVIOUSLY SUFFERED FROM:

HIGH BLOOD PRESSURE …………	YES	NO	WHEN ______________________________
DIABETES ……………………………..	YES	NO	WHEN ______________________________
THYROID CONDITION…………….....	YES	NO	WHEN ______________________________
SEIZURES …………………………….	YES	NO	WHEN ______________________________
LIVER DISEASE ……………………...	YES	NO	WHEN ______________________________
HEART DISEASE …………………….	YES	NO	WHEN ______________________________
STROKE ……………………………….	YES	NO	WHEN ______________________________
ARTHRITIS …………………………….	YES	NO	WHEN ______________________________
CANCER ……………………………….	YES	NO	WHEN ______________________________
TUBERCULOSIS …………………….	YES	NO	WHEN ______________________________
PSORIASIS …………………………..	YES	NO	WHEN ______________________________
POLIO ………………………………….	YES	NO	WHEN ______________________________
RHEUMATIC FEVER ……………….	YES	NO	WHEN ______________________________
HEART ATTACK …………………….	YES	NO	WHEN ______________________________
ULCER DISEASE …………………….	YES	NO	WHEN ______________________________
GASTRITIS …………………………..	YES	NO	WHEN ______________________________
HEPATITIS…………………………….	YES	NO	WHEN ______________________________
HIV/AIDS……………………………….	YES	NO	WHEN ______________________________
OTHER ……………………………….	YES	NO	WHEN ______________________________

LIST ANY SURGERIES:

DATE:	TYPE OF SURGERY:
________________	____
________________	____
________________	____
________________	____

DATE OF MOST RECENT:

COLONOSCOPY ____________________ MAMMOGRAM____________________

PAP SMEAR ________________________ MENSTRUAL CYCLE______________

PSA/ PROSTATE EXAM ______________

ANY OTHER HOSPITALIZATIONS? YES NO IF YES, LIST DATES AND REASONS:

________________ ____

________________ ____

________________ ____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES NO

What medications?	What happened?
________________	____
________________	____
________________	____

ARE YOU TAKING ANY CURRENT MEDICATIONS? YES NO

Please list, including dosage and times per day:

____

____

____

I AUTHORIZE THE REVIEW OF ANY REPORT GENERATED UNDER MY NAME IN THE VA PRESCRIPTION MONITORING PROGRAM. _____________ (INITIAL HERE)

WHO IS YOUR CURRENT PRIMARY CARE PHYSICIAN?

Name: _________________________________ Location: ____

FAMILY HISTORY:

Arthritis (RA/OA)	Y/N	HTN	Y/N
Heart Disease	Y/N	Endocrine	Y/N
Muscular Disease	Y/N	Diabetes	Y/N
Cancer	Y/N		

SOCIAL HISTORY: Single/Married/Widow/Separated; Children Y/N and ages _______________________________;

Living Situation ____

Alcohol Use (amount & type) _______; Drug use (amount & type) _________; Tobacco use ____ppd x ____years

Education (years & degrees) ____________________; Employment (describe) ____________________________

Circle any that apply:

Constitutional Symptoms:

Fever/Chills
Weight Loss
Fatigue

Eyes:

Double Vision
Blurring
Trauma
Glasses/Contacts

ENT & Mouth

Deafness
Sinusitis
Tinnitus
Hoarseness
Vertigo

Cardiovascular:

Chest Pain
Palpitations
HTN
Irregular Beats

Hematologic/Lymphatic:
Bleeding Tendency
Lymph Node Pain/Enlargement
Anemia

Respiratory:

Shortness of Breath
Asthma
COPD
Cough
Coughing up Blood

GI:
Loss of Appetite
Weight Change
Diarrhea
Constipation
Abdominal Pain
Bloody Stools

GU:

Incontinence
Pain with urination
Sexual Dysfunction
Hesitancy

MS:
Fracture
Sprains
Pain
Swelling
Arthritis
Stiffness
Muscle Wasting

Skin/Breast:

Lesions
Scars
Masses

Neuro:

Speech/Swallowing
TIA/CVA
Numbness/Tingling
Seizures
Weakness
Balance/Incoordination
Memory

Psych:

Depression/Anxiety
Hallucinations
Sleep Disturbances

Endocrine:

Increase in thirst/appetite
Hypo/Hyperactivity
Growth/Hair Changes