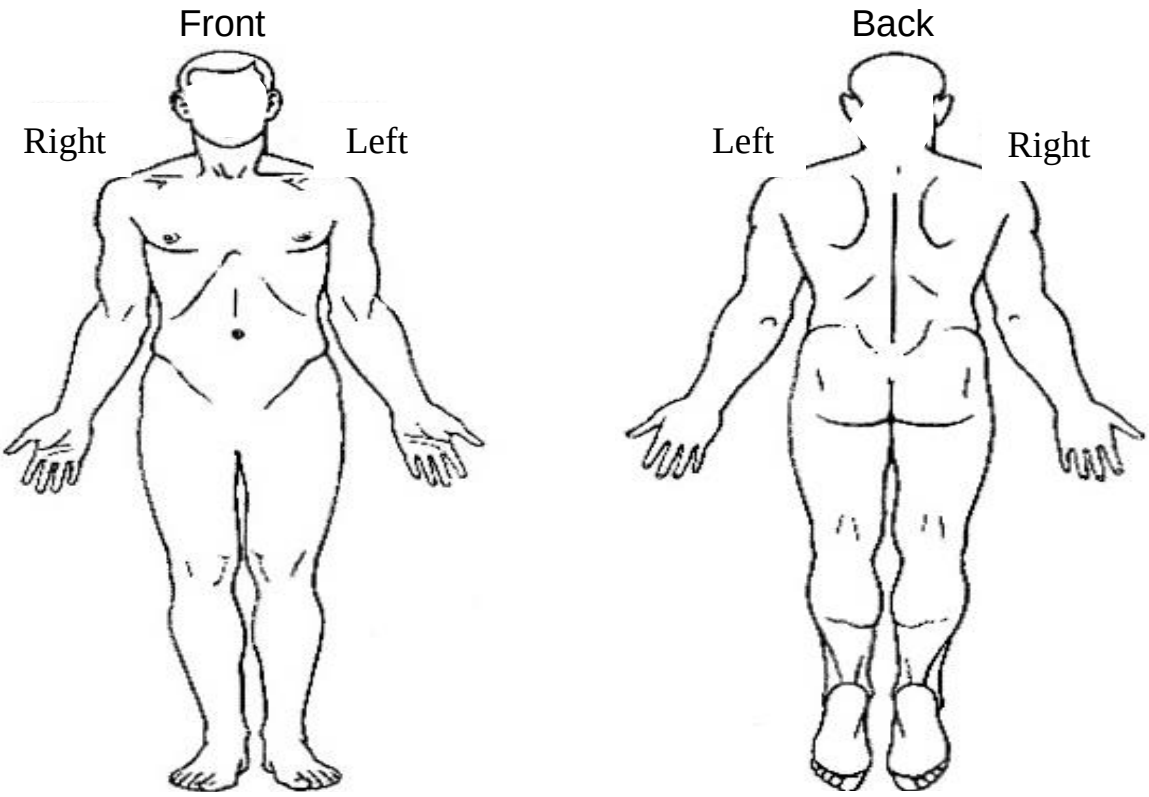
Bay Area Spine Care

PAIN DIAGRAM

Name:_____ Date: _____

Using the symbols below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Major Pain – XXX	Tingling – YYY
Secondary Pain – ///	Burning – ZZZ
Numbness – OOO	Draw a line for radiating pain



Instructions: Please place a mark on the line by the number that best describes how you feel right now. If you have more than one complaint, please answer the question for each individual complaint and indicate the score for each.

No pain _____ **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

Health Questionnaire

NAME: _____ DATE: _____

Age:	Height:	Weight:	Right handed: ❒	Left-handed: ❒	Ambidextrous: ❒

PAST MEDICAL HISTORY: Have you ever had (circle No or Yes)

Diabetes No Yes
Stroke No Yes
Cancer No Yes
High Blood Pressure No Yes
Heart Problems No Yes
Myocardial Infarction (Heart Attack) No Yes
Rheumatic Fever No Yes
Tuberculosis No Yes
Hepatitis (A B C, please specify) No Yes
Anemia No Yes

Do you have new or in the past, any other serious illness or chronic medical condition that we should be aware of? No Yes

If yes, describe _____

_____

Have you ever been hospitalized or been under medical care (other than surgery) for any period? No Yes

If yes, for what reason? _____

_____

Injuries:

Have you had any broken bones? No Yes If yes, briefly describe _____

_____

Have you had any head concussions or injuries? No Yes If yes, briefly describe _____

_____

Have you had any auto accidents? No Yes If yes, briefly describe _____

_____

PAST PSYCHOLOGICAL HISTORY:

Have you ever had psychiatric care? No Yes describe _____

Have you ever been given a psychiatric diagnosis? No Yes describe _____

Have you ever been advised to undergo psychiatric care but not followed through? No Yes

If yes, briefly describe _____

PAST SURGICAL HISTORY: Have you had any surgery? No Yes

If yes, list all procedures and dates of surgeries

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____
6. _____ Date: _____
7. _____ Date: _____
8. _____ Date: _____
9. _____ Date: _____
10. _____ Date: _____

SOCIAL HISTORY:

Circle one: Single Married Divorced Widowed

Are you living with your husband/wife? No Yes
Do you have dependents at home? No Yes
Do you drink alcoholic beverages? No Yes
Amount and frequency: per day: _____ per week: _____ per month: _____
Do you smoke cigarettes? No Yes How many packs a day? _____ How long? _____
Have you ever smoked? _____ How many packs a day? _____ How long? _____ Last smoked_____
Is there any history of illegal drug abuse? No Yes
Is there any history of prescription drug abuse? No Yes
Are you currently working? No Yes

Circle one: Full Time Part Time On disability Unemployed Retired Medically retired

FAMILY HISTORY:

❒If you are adopted and have no knowledge of your family history, please check this box and proceed to the Section #6.

BIOLOGICAL FAMILY HISTORY	IF LIVING		IF DECEASED	
	Age	Health	Age (at death)	Cause
Father				
Mother				
Brother				
Sister				
Son				
Daughter				

GENERAL MEDICATIONS:

Have you taken any of these medication in the last six months (circle No or Yes or Don't Know):

Cortisone	No	Yes	Don't know
Anticoagulants	No	Yes	Don't know
Tranquilizers	No	Yes	Don't know
Hypotensives (high blood pressure medications)	No	Yes	Don't know

List ALL MEDICATIONS you are ***currently*** taking.

1. _____ Dose (mg): _____ Frequency: _____
2. _____ Dose (mg): _____ Frequency: _____
3. _____ Dose (mg): _____ Frequency: _____
4. _____ Dose (mg): _____ Frequency: _____
5. _____ Dose (mg): _____ Frequency: _____
6. _____ Dose (mg): _____ Frequency: _____
7. _____ Dose (mg): _____ Frequency: _____
8. _____ Dose (mg): _____ Frequency: _____
9. _____ Dose (mg): _____ Frequency: _____
10. _____ Dose (mg): _____ Frequency: _____

ALLERGIES AND SENSITIVITIES:	**Describe Reaction**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

❒ No Known Drug Allergies

REVIEW OF SYSTEMS:

Do you have, or have you had, any of the following:

General:

Recent weight gain No Yes
Have you been in good health No Yes

Head-Eyes-Ears-Nose-Throat:

Blurry vision/double vision No Yes
Cataracts No Yes
Contact lenses/glasses No Yes
Dizziness No Yes
Ear problems No Yes
Eye problems No Yes
Hearing loss No Yes
Loss of balance No Yes
Neck stiffness No Yes

Cardiac:

Angina No Yes
Cardiac surgery No Yes
Chest pain No Yes
Murmur No Yes
Palpitations No Yes
Shortness of breath No Yes
Swelling of extremities No Yes

Pulmonary:

Asthma No Yes
Frequent cough No Yes
Pain with breathing No Yes
Wheezing No Yes

Urologic:

Dribbling No Yes
Dysuria (pain with urination) No Yes
Frequency No Yes
Incontinence No Yes
Hematuria (blood in urine) No Yes
History of stones No Yes
Infection No Yes
Nocturia (night time urination) No Yes
Stress incontinence No Yes
Urgency No Yes

Gastrointestinal:

Abdominal pain No Yes
Appetite change No Yes
Blood in stool No Yes
Change in bowel habits No Yes
Constipation No Yes
Diarrhea No Yes
Gallbladder problems No Yes
Indigestion/heartburn No Yes
Hemorrhoids or piles No Yes
Nausea/vomiting No Yes
NSAID intolerance No Yes
Rectal bleeding No Yes
Ulcers No Yes

Neurological:

Dizziness/fainting spells No Yes
Headaches No Yes
Loss of consciousness No Yes
Memory loss No Yes
Paralysis No Yes
Seizures No Yes

Vascular:

Abnormal bleeding or bruising No Yes
Aneurysm No Yes
Are you a Jehovah's Witness No Yes
Phlebitis No Yes
Varicose veins No Yes

Endocrine:

Blood transfusion No Yes
Hormone therapy No Yes
Thyroid problems No Yes
Varicose veins No Yes

Immune System:

AIDS No Yes
Diabetes No Yes
History of infections No Yes
Immunosuppressive disorders No Yes

Surgery:

Anesthetic allergy/problem No Yes
Iodine allergy No Yes
Postoperative infections No Yes
Postoperative complications No Yes
Suture reaction No Yes
Tape allergy No Yes
Severe nausea/vomiting after general Anesthesia No Yes
Waking-up problem after Anesthesia No Yes

Musculoskeletal:

Any other problems other than your reason For your visit today No Yes
Arthritis No Yes
Joint pain No Yes
Joint swelling No Yes
Osteopenia No Yes
Rheumatoid arthritis No Yes

Michael W. Cluck, MD, PhD
Orthopaedic Spine Surgeon

Surgery of the Neck and Back
Minimally Invasive Spinal Surgery
Spinal Reconstructive Surgery
Spinal Deformity Surgery
Spine Fractures and Trauma Surgery
Spinal Decompression Surgery

2516 Samaritan Drive
Suite B
San Jose, CA 95124

Tel: (408) 295-2200
Fax: (408) 295-2202

PATIENT INFORMATION

Name of Patient _____ Date of Service_____

Address_____
Number Street City State Zip Code

Home Phone_____ Cell/Alternate Phone_____

Email Address: _____ Social Security Number _____-_____-_____

Date of Birth_____ Age_____ Sex: Female_____ Male_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Injury_____ Date Last Worked_____

Name of Employer at Time of Injury_____

Address of Employer at Time of Injury_____

Occupation at Time of Injury_____

Length Employed at Time of Injury_____

Name of Current Employer_____

Current Occupation_____

Referred by_____

Current and/or Most Recent Primary Treating Physician for this Injury_____

Preferred Pharmacy: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES

Adjuster: _____ Date of Injury: _____

Name of Insurance Company_____

Address_____

Claim Number_____ Insurance Company Phone_____
Fax_____

Name of Attorney_____ Phone_____
Fax_____

Address_____

Nurse Case Manager_____ Phone_____
Fax_____

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Bay Area Spine Care Medication Refill Policy

- Refills will be made only during regular office hours.
- Allow 2-3 business days for all refill requests to be processed.
- Refills will not be made at night, on holidays or weekends.
- Refills will not be made if I "run out early."
- I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- **All refill requests must be faxed by your pharmacy by 10:00am Friday, anything faxed after that time will not be filled.**
- Refills will not be made as an "emergency" on Friday afternoon.
- Prescriptions will not be filled by the on-call physician.

Please have your pharmacy fax a refill request to our office. Refills will be processed within 2-3 business days and faxed to your pharmacy.

Certain medications require a hand written scrip every time a refill is needed. In this case please call our office and let us know 2-3 business days before you run out so the physician will be able to write a new prescription for you.

Remember, your physician is in surgery 2-3 days a week and will not always be able to write the new prescription/refill your medication on the day it is requested.

I have been fully informed and will comply with the medication refill policy established by Bay Area Spine Care.

Patient Name: _____

Patient Signature: _____ Date: _____

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PATIENT DESIGNATION OF PRIMARY TREATING PHYSICIAN

(California Labor Code section 4601)

Date: _____

Patient Name: _____

Date of Birth: _____

I DO DO NOT know who my Primary Treating Physician is.
(Circle one)

My Primary Treating Physician's name is: _____

TO CHANGE YOUR PRIMARY TREATING PHYSICIAN PLEASE COMPLETE BELOW.

I hereby request the following physician of Bay Area Spine Care as my "Primary Treating Physician" pursuant to section 4601 of the California Labor Code.

_____Michael W. Cluck, MD, PhD

PATIENT SIGNATURE: _____

OFFICE ONLY

_____I *will accept* this patient as their Primary Treating Physician.
_____I *will not accept* this patient as their Primary Treating Physician.
_____I will continue to treat this patient on a consulting basis ONLY.
_____I will no longer see or treat this patient.

Physician Signature: _____

Recommendations for new Primary Treating Physician (if applicable):_____

_____

The physician retains the right to assume medical care for the patient or refer the patient to another Primary Treating Physician for continued treatment at any time.