Long Distance Consultation Information and Payment Form

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Diagnosis and Treatment of Spinal Disorders

Consults@NeckandBack.com

(888) 999-5310 (970) 688-9010

Name_____

Credit card type Visa MC Discover American Express (please circle card)

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Call back Phone Number_____

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_____

Donald S. Corenman, MD
New Patient Lumbar Spine History

Date: ☐☐ / ☐☐ / ☐☐☐☐

Please PRINT and fill out completely.

Shade circles like this: ●

Med record # ☐☐☐☐☐☐

Name _____ Age _____ yrs. D.O.B. _____

Height ☐ ft ☐☐ in Weight ☐☐☐ lbs Sex ○ Male ○ Female Are you or could you be pregnant? ○ Yes ○ No

Your Occupation _____ Employer _____

Who referred you to this office? If more than one, please note.
○ Dr. _____ ○ PA/NP _____
○ Friend/Word of Mouth _____ ○ Physical Therapist _____
○ Family Member _____ ○ Other _____

HISTORY OF CARE

Who is your primary care physician? _____ Location: _____
Address: _____ Phone: _____

Please list any other doctors, clinics, or hospitals you have seen for your current spinal problems:

Name	*City*	*Date of First Visit*	*Currently Continuing?*

HISTORY OF CURRENT SPINAL PROBLEMS

List your chief complaints or main problems with the most severe first:
1. _____
2. _____
3. _____

Describe all details of any accident, incident or the way these problems began:

_____
_____
_____
_____

CURRENT SYMPTOMS

What time of day is your pain at its worst? ○ Morning ○ Afternoon ○ Evening ○ Night ○ Not Applicable

Does the pain wake you up at night? ○ Yes ○ No

In the past six months have you experienced: ○ Fever ○ Weight Loss _____ lbs ○ Chills ○ Night Sweats

How would you describe your pain? ○ Constant ○ Constant, but worse with activity ○ Intermittent (comes and goes) ○ Intermittent, but worse with activity

Do you have full control of your bladder? ○ Yes ○ No

Do you have full control of your bowels? ○ Yes ○ No

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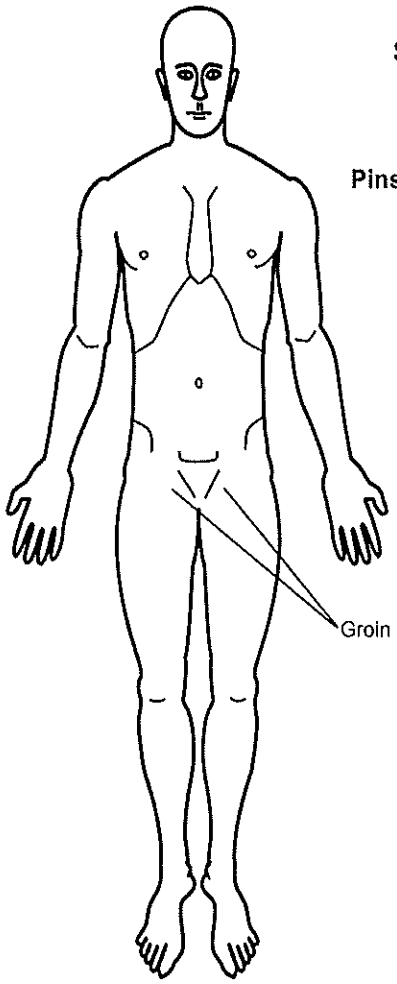
PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, include all affected areas.

For Doctor Use Only

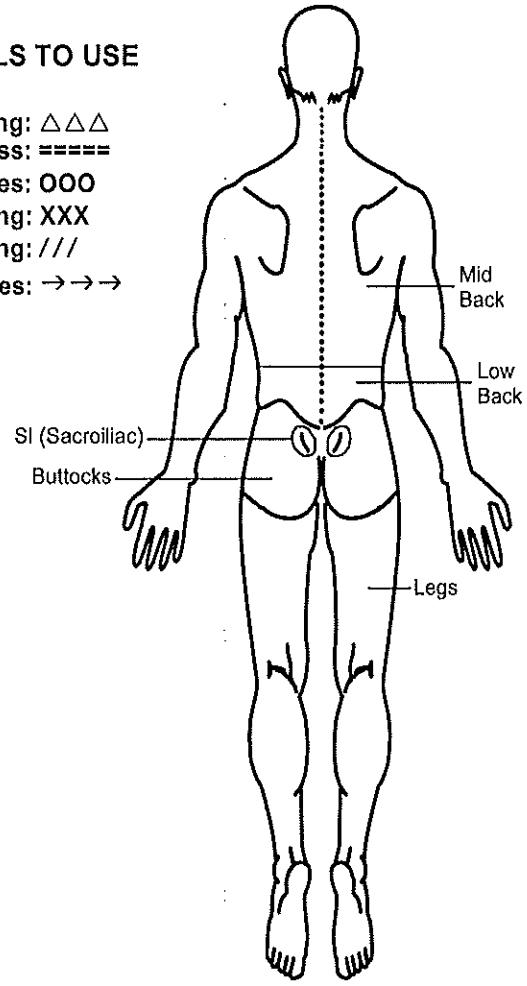
	R			L			Both/axial		
Head									
Neck									
Trap									
Scap									
Scp/ Arm									
Arm									
LB									
LB/SI									
SI									
Bt/Leg									
M Bk									
Groin									

Complex O Positional O



SYMBOLS TO USE

Aching: △△△
Numbness: =====
Pins & Needles: OOO
Burning: XXX
Stabbing: ///
Radiates: →→→



Mark where any symptoms (pain, numbness, weakness, etc.) exist on average (most of the time) and at their worst.

For Dr. Use Only		None										Unbearable
MB O Positional	Current **mid back** pain **Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
LB O Positional	Current **low back** pain **Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
SI O Positional	Current **SI** pain **Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
Buttock O Positional	Current **buttock** **Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
Gr O Positional	Current **groin** pain **Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
Lg O Positional	Current **leg** pain **Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10

PAST MEDICAL HISTORY

Check if you currently are being treated for or have been diagnosed with:

	When?		*When?*
○ High Blood Pressure		○ Osteoporosis	
○ Diabetes		○ Kidney Disease/Problem	
○ Liver Disease		○ Seizures	
○ Heart Disease or Attack		○ Arthritis	
○ Stroke		○ Thyroid	
○ Cancer		○ Tuberculosis	
○ High Lipids (cholesterol, etc.)		○ Psoriasis	
○ Ulcer Disease		○ Polio	
○ Gastritis		○ Rheumatic Fever	
○ Reflux Disease (GERD)		○ Gout	
○ Asthma		○ Herpes Simplex	
○ Depression		○ **Other**	
○ Bipolar Disease			
○ Other Psychiatric			

Have you ever had a history of blood clots or pulmonary embolus? ○ Yes ○ No

SURGERIES

Please list all *spine* surgeries you have had in the past:

Type of Surgery	*Date*	*Surgeon*

Please list all *other* surgeries you have had in the past:

Type of Surgery	*Date*	*Surgeon*

MEDICATIONS

Please list ALL medications you are *currently* taking, including prescription and over the counter:

Medication	*Dosage*	*Frequency (how many pills in a 24 hours)*

ALLERGIES

Please list any *allergies or adverse reactions* you have to medications:

Medication	*What Happened?*

FAMILY HISTORY

Is your father alive? ○ Yes ○ No IF YES, age and any major medical problems? _____

IF NO, age at time of death? _____ What major medical problems did he have? _____

Is your mother alive? ○ Yes ○ No IF YES, age and any major medical problems? _____

IF NO, age at time of death? _____ What major medical problems did she have? _____

Any siblings? ○ Yes ○ No How many? _____

SOCIAL HISTORY

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Living with other

Education level achieved: ○ Grade School ○ Jr. High ○ High School ○ College ○ Post. Graduate

***DO* you currently smoke cigarettes?** ○ Yes ○ No **Number of Years Smoked:** ☐☐ **For Dr. Use Only** p yrs ☐☐☐

Packs per Day: *(Please choose the closest)* ○ < 1/2 ○ 1/2 ○ 1 ○ 2 ○ > 2

***DID* you smoke cigarettes in the past?** ○ Yes ○ No **Number of Years Smoked:** ☐☐ **Quit Date:** ☐☐ / ☐☐ / ☐☐☐☐

Packs per Day: *(Please choose the closest)* ○ < 1/2 ○ 1/2 ○ 1 ○ 2 ○ > 2

Do you use any other tobacco products? ○ Yes ○ No **What kind?** _____ **Quantity:** _____

Do you use any recreational drugs? ○ Yes ○ No **What kind?** _____

Do you drink alcohol? ○ Yes ○ No **Drinks per Day:** ☐☐ **Drinks per Week:** ☐☐ **Years:**

***DO YOU HAVE OR HAVE YOU HAD* an unhealthy relationship with alcohol?** ○ Yes ○ No

Type of alcohol consumption: ○ Beer ○ Wine ○ Mixed Drinks

WORK HISTORY

Are you currently: ○ employed ○ unemployed ○ retired ○ on sick leave ○ on disability ○ a stay at home parent

Has your job changed since your symptoms started? ○ Yes ○ No ○ Not Working

If you are at a different job or not working, did your symptoms play a role in your job change or decision not to work? ○ Yes ○ No

If you are working, are you on: ○ Normal duties ○ Light duties

If you are on light duty, did your current symptoms play a role? ○ Yes ○ No

Are you applying for disability? ○ Yes ○ No

Please describe your job _____

WORKMAN'S COMPENSATION HISTORY

IS THIS A WORKERS COMPENSATION CASE? ○ Yes ○ No

Have you had any PRIOR workers compensation injuries? ○ Yes ○ No **If yes, how many?** ☐☐

Please list any prior workers compensation cases/injuries:

Date	*Area Injured*	*Time off Work*	*Who Treated You?*

Were you at work when your symptoms began? ○ Yes ○ No

Did you have a specific accident or injury while at work to cause your symptoms? ○ Yes ○ No

What is the company name? _____

Prior to your WC injury, how long had you been employed by that company? ☐☐ **months OR** ☐☐ **years**

Do you currently have an attorney for this episode? ○ Yes ○ No

CAR ACCIDENTS

WERE YOUR SYMPTOMS CAUSED BY A CAR ACCIDENT? ○ Yes ○ No

Have you had any PRIOR car accidents? ○ Yes ○ No If yes, how many? ☐☐

Please list:	*Date*	*Area Injured*	*Time off Work*	*Who Treated You?*

Do you currently have an attorney for this episode? ○ Yes ○ No

REVIEW OF SYSTEMS

Check No or Yes in the following areas. If "Yes," please describe:

1. CONSTITUTIONAL
   - A. Recent weight change? ○ Yes ○ No _____
   - B. Change or loss of appetite? ○ Yes ○ No _____
   - C. Fevers? ○ Yes ○ No _____
   - D. Chills? ○ Yes ○ No _____
   - E. Night sweats? ○ Yes ○ No _____
   - F. Weakness fatigue ○ Yes ○ No _____
2. EYES
   - A. Vision change? ○ Yes ○ No _____
   - B. Glasses/contacts? ○ Yes ○ No _____
   - C. Glaucoma? ○ Yes ○ No _____
   - D. Eye infections (iritis)? ○ Yes ○ No _____
   - E. Loss of vision? ○ Yes ○ No _____
3. EARS, NOSE, AND THROAT
   - A. Decrease or loss of hearing? ○ Yes ○ No _____
   - B. Ear ache or infection? ○ Yes ○ No _____
   - C. Tinnitus (ringing in ear)? ○ Yes ○ No _____
   - D. Nasal stuffiness/discharge? ○ Yes ○ No _____
   - E. Nosebleeds? ○ Yes ○ No _____
   - F. Sore throat? ○ Yes ○ No _____
   - G. Hoarseness? ○ Yes ○ No _____
   - H. Dental problems? ○ Yes ○ No _____
   - I. Dentures? ○ Yes ○ No _____
   - J. Difficult swallowing? ○ Yes ○ No _____
4. CARDIOVASCULAR
   - A. Chest pain? ○ Yes ○ No _____
   - B. Shortness of breath? ○ Yes ○ No _____
   - C. Palpitations? ○ Yes ○ No _____
   - D. Swelling in the legs? ○ Yes ○ No _____
   - E. PLEASE LIST MOST RECENT HEART TESTS WITH NAME OF FACILITY, DATE, AND CONTACT PHONE NUMBER

     _____
5. RESPIRATORY
   - A. Cough? ○ Yes ○ No _____
   - B. Wheezing/asthma? ○ Yes ○ No _____
   - C. Pneumonia or bronchitis? ○ Yes ○ No _____
   - D. Shortness of breath? ○ Yes ○ No _____

6. GASTROINTESTINAL

A. Abdominal pain?	O Yes	O No	
B. Nausea or vomiting?	O Yes	O No	
C. Constipation?	O Yes	O No	
D. Diarrhea?	O Yes	O No	
E. Heartburn/acid reflux?	O Yes	O No	
F. Rectal bleeding or black, tarry stools?	O Yes	O No	

7. GENITOURINARY

A. Increase frequency of urination?	O Yes	O No	
B. Pain/burning when you urinate?	O Yes	O No	
C. Frequent infection of urine?	O Yes	O No	
D. Incontinence (loss of control)?	O Yes	O No	
E. Reduced force of urination?	O Yes	O No	

8. MUSCULOSKELETAL

A. Muscle aches?	O Yes	O No	
B. Joint pains/stiffness (arthritis)?	O Yes	O No	
C. Swelling of joints?	O Yes	O No	

9. SKIN

A. Rash?	O Yes	O No	
B. Lumps or sores?	O Yes	O No	
C. Changes in hair or nails?	O Yes	O No	
D. Dryness?	O Yes	O No	
E. Ulcers?	O Yes	O No	
F. Abnormal scars?	O Yes	O No	

10. NEUROLOGICAL

A. Headaches?	O Yes	O No	
B. Fainting/blackouts?	O Yes	O No	
C. Tremors/involuntary movements?	O Yes	O No	
D. Numbness, tingling?	O Yes	O No	
E. Dizziness?	O Yes	O No	
F. Muscle weakness?	O Yes	O No	

11. PSYCHIATRIC

A. Depression?	O Yes	O No	
B. Mood swings?	O Yes	O No	
C. Anger?	O Yes	O No	
D. Nervousness/anxiety?	O Yes	O No	

12. ENDOCRINE

A. Excessive thirst or hunger?	O Yes	O No	
B. Hot/cold intolerance?	O Yes	O No	
C. Hot flashes?	O Yes	O No	

13. HEMATOLOGICAL

A. Easy bruising or bleeding?	O Yes	O No	
B. Past blood transfusions?	O Yes	O No	