RODERICK SANDEN, M.D.
Advanced NeuroSpinal Care
3609 Mission Ave, Ste F
Carmichael, CA 95608
Spine Surgery and Neurological Surgery
Phone: 916-484-4444 Fax: 916-484-4447

Dear _____,

We are pleased your doctor has referred you to our neurosurgical office for care. To ensure we provide you with the best quality of care, we request your assistance and cooperation with the following.

1. *Please fill out the New Patient Questionnaire forms enclosed. Please complete all the forms. Failure to complete these forms may result in cancellation of your new consult appointment.*
2. *Please bring all x-ray films, MRI films, CT films or Cd's pertaining to your condition with you at the time of your new patient appointment. If you do not have your films/cd, your appointment may be cancelled. It is important you have your films/cd at your new patient appointment so Dr. Sanden is able to review them with you at your appointment.*
3. *Please be prepared to pay your co-pay or your deductible payment at the time of your appointment.*
4. *If you are a lower back (lumbar) patient, please bring a pair of shorts to change into during your physical examination.*

You are scheduled for a new patient consultation appointment in our neurosurgical office to discuss your:

___ *Cervical Spine* ___ *Lumbar Spine* ___ *Carpal Tunnel* ___ *Ulnar Nerve*

You are scheduled for a consultation on _____ at _____ am/pm.

We look forward to meeting you and serving your health care needs.

Respectfully,

Roderick Sanden M.D. *Brittany Tremblay, NP, RFA*

YOU MUST HAND CARRY MRI, CT, XRAYS FILMS OR CD'S TO APPOINTMENT

**** Please note we NO longer see auto/personal injury cases unless workers comp related.**

Roderick Sanden, M.D.

3609 Mission Ave, Ste F Carmichael, CA 95608

916-484-4444

Please answer Yes or No to the following questions:

1. Have you and/or your family been in close contact with anyone who has traveled domestically or internationally in the last 14 days?

YES NO

2. Have you engaged any events/gatherings with more than 10 people in the last 14 days?

YES NO

3. Have you been in close contact with a person known to have

Novel Coronavirus or Covid-19?

YES NO

4. Have you and/or any family been asked to self-quarantine?

YES NO

5. Do you currently have a fever, cough, runny nose,

respiratory symptoms such as cough or shortness of breath?

YES NO

If you answer yes to any of the above questions please call the office to reschedule your appointment.

Sign:_____**Date:**_____

Roderick Sanden, M.D.

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Due to the Covid-19 virus we are only seeing the patient in the office we will not allow family member in the office they are welcome to wait outside for the safety of other patients and staff.

We ask that you come alone unless you require a translator then we will allow the patient and the translator only.

We ask that you wear some type of face covering during your visit.

If you are coming in for Lumbar/low back injury please wear shorts or sweats that you are able to pull up above the knee.

If you have a fever, runny nose, coughing, headache, sore throat you will not be seen and will be rescheduled.

PLEASE BE SURE AND BRING YOUR IMAGING ON A CD WE HAVE RECEIVED THE REPORT BUT NOT THE IMAGES.

Sorry for any inconvenience and we look forward to meeting you.

Dr Sanden & Staff

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Patient Registration Form – Page 1

Date: _____

First Name: _____ Last Name: _____

Address: _____City: _____ State: _____Zip:_____

Home Ph: _____Cell Ph: _____Work Ph: _____

Date of Birth: _____ Age: _____ Drivers License #: _____ State: _____Expires: _____

Email: _____ Social Security# _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

*With whom do you live with?*_____

Emergency Contact:

Last Name: _____ First Name: _____Phone #:_____

Relationship to Patient:_____

Pharmacy: Name_____ Address: _____

Phone: _____ Fax: _____

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Private insurance:

Subscriber's Last Name: _____ First Name: _____

Relationship to subscriber: Self ___ Spouse ____

Insurance Company: _____ ID # _____

Subscriber's date of birth: _____ Subscriber's Social Security #: _____

I authorize the release of any information requested by my insurance company necessary to process this claim.
I authorize assignment and payment of medical benefits to Roderick Sanden, M.D.
I authorize the release of my medical records from other provider's hospital's or imaging facilities to be provided to Roderick Sanden, M.D. upon request to help facilitate my care>

Patient, Parent or Guardian's Signature: _____

Supplemental insurance for Medicare Patients Only:

Subscriber's Last Name: _____ First Name: _____

Relationship to subscriber:_____ Subscriber's Date of Birth: _____

Subscriber's Social Security #: _____ Insurance Company: _____

ID#: _____

Medicare Patient's Only:

"Signature on File" Claim Authorization Form

Patient's Last Name: _____ **First Name:** _____

I request that payment of authorized medicare benefits be made either to me or on my behalf to Roderick Sanden, M. D. for any services furnished to me by Roderick Sanden, MD. I authorize any holder of medical information about me to release to the health care financing administration and it's agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim, if Item 9 on the HCFA 1500 Claim form or elsewhere on other approved claim forms or electrionically submitted claims., my signature authorizes releasing of the information to the insurer or agency shown. In medicare assigned cases, the physician or supplier agrees to accept the charge determination of the responsible only for the deductible, co insurance, and non-covered services. Co insurance and deductible are based upon the charge determination of the medicare carrier.

It is mandatory that you tell our office if you know that another party is responsible for paying for your treatment. Sections 1128B of the Social Security Act and 31 USC 3801-3812M assess penalties for withholding this information.

Beneficiary Signature: _____ **Date:** _____

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Patient Registration Form-3

Workers' Compensation Information:

Workers' Comp Insurance Company: _____ Claim #:

_____

Date of Injury: _____ Employer at the time of the injury: _____

Adjuster's Name: _____ Fax #: _____Phone #:_____

Nurse Case Manager Name: _____ Fax: _____ Phone:_____

Do you have a Workers' Comp Attorney: Yes ___ No ___

If yes, please provide our office with the information below:

Attorney's Name: _____ Address: _____

Phone #: _____ Fax: _____

Accident Related Injury:

Is your injury, pain or symptoms in any way related to litigation or a law suit regarding an accident involving a third party?

(for example: an automobile accident, a motorcycle accident, a delivery truck accident, a slip and fall accident, etc)

Yes___ No ___

If yes, you will be requested to sign a medical legal lien agreement with our office regarding this litigation.

In the event a third party is financially responsible for your medical treatment, you, as the patient, hereby grant Roderick Sanden, M.D. a lien on any and all payment or other recovery received from such a third party to secure payment for Roderick Sanden, M.D.'s services. You, as the patient, hereby authorizes and instructions the patient's attorney to pay direction to Roderick Sanden, M.D. out of any proceeds received as a settlement or by reason of a judgement, the entire amount of the bill for services incurred by Roderick Sanden, M.D. in connection with the care and treatment received by the patient.

By my signature, I agree to abide by the above terms and conditions.

Print Name: _____

Patient's Signature: _____

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Patient Registration Form – Page 4

AGREEMENT FOR MEDICAL TREATMENT ,
PATIENT FINANCIAL RESPONSIBILITY
IMPORTANT NOTICES

The undersigned, in seeking medical care and treatment from Roderick Sanden, M.D. office of Advanced NeuroSpinal Care, acknowledges and agrees to the following:

Patient General Responsibilities:

1. *Insurance coverage for medical matters is very complex and can change unexpectedly. The patient understands and agrees it is the responsibility of the patient to determine, prior to scheduling an appointment with our office, what services are covered by their medical plan, what restrictions and limitations apply to that coverage and what authorizations or referrals are required in order to consult with or be treated by our office. Failure to do so may result in the patient having to pay for these services or procedures.*

2. *The patient will notify our neurosurgical office immediately of any changes in his or her medical coverage or medical insurance.*

3. *The patient must physically bring any films to his or her appointment. Failure to do so may result in rescheduling your appointment.*

4. *Our office may charge the patient a full office visit fee for an office visit not canceled within 24 hours of a scheduled office appointment time. Our office may also charge a full office visit fee for a "no show appointment". We sincerely care about our patients and ask each of our patients to give at least 24 hours notice of a cancellation so that we may reschedule another patient who needs care in that available appointment time slot.*

5. *Roderick Sanden, M.D., Office of Advanced NeuroSpinal Care is primarily a neurosurgical office. Patients who are not found to have a neurosurgically treatable condition may be asked to return to their primary treating physician or primary care physician for future non-surgical management. Our office will not be responsible for ongoing care, including prescriptions of patients seen only for a consultation.*

6. ***Our office will only prescribe medications, including pain medication anti-inflammatories or muscle relaxants, post operatively (after your surgery)**. Our office will not prescribe any medications prior to your surgery. It is your responsibility to obtain any pain medication or any other medications from your primary treating physician, primary care physician or referring physician. There will be absolutely no exceptions.*

7. *Please arrive at least 15 minutes prior to your scheduled appointment time.*
8. *If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule your appointment.*

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9. If you are sick or think you are becoming sick, have a fever, a cough, a runny nose, sinus congestion or any flu or cold like symptoms, please **do not** come to your scheduled appointment. Please call the office and reschedule your appointment for we do not want other surgical patient's to be exposed. If is suspected you are ill upon your arrival of your scheduled appointment, you will be asked to reschedule. It is extremely important to not expose illnesses to other patient's, our staff or the doctor. Post surgical patients are more suseptible to infections and illnesses and we would like to minimize their exposure at our office. Thank you in advance for your cooperation.

Copayments and Deductibles:

1. Each patient is responsible for his or her copayment or deductible. If a patient's deductible has been met, our office will bill the patient's medical insurance. If a patient's deducible has not been met, payment is required at the time of service. Copayments are collected at the time of each scheduled office visit. We accept Mastercard, Visa, checks or cash. There will be a $35.00 fee for a returned check.

Payment Arrangements:

1. A patient may pay Roderick Sanden, M.D. in full for services, treatments or/and procedures not covered by his or her medical insurance plan. Payment arrangements can be discussed and arrange on a case by case bases. It is at the sole discretion of Roderick Sanden, M.D. to authorize any arrangement. In the event payments are not made, your bills will be turned over to a collection agency.

Workers' Compensation:

1. If a patient's injury is a result of a work related injury, or a patient's thinks it might be, and a claim has not been established, please notify our office immediately for assistance. This is to ensure properbilling.

Collection Fee's / Attorney Fee':

1. Should a patient's account be referred to an attorney or an outside collection agency/company for collection of unpaid medical fees, the patient will be responsible for fees and costs incurred.

Copy of medical records, medical forms, disability forms or letters:

1. There is a $15.00 charge for each form needing to be completed and signed by our office. Copies of medical records are subject to a charge of $15.00. We require one week's notice to copy records as we may need to request charts from an outside storage facility. When requesting copies of medical records, we will only release records from our office. If a dictated letter is needed by the doctor or nurse practitioner, a customary fee is involved.

Patient's Signature: _____ **Date:** _____

Print Name: _____

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AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

This is a agreement between _____ and Roderick Sanden, M.D governing the terms and conditions under which controlled substances will be prescribed for my medical condition which has not responded to other lesser forms of non-invasive and or invasive therapies.

I understand the treatment goal is to improve my ability to function and/or work, not be abolish all pain. To try to achieve this goal, I understand I am being given potent medication that may have undesirable side effects if not used as prescribed and instructed, and I therefore, agree to help myself by following better health habits, specifically involving the areas exercise, healthy nutrition/dietary intake, weight control and the use of alcohol and tobacco. I understand only through following a healthier lifestyle can I hope to have a successful outcome of my treatment program.

Prior to entering into this contract, I have been informed by Roderick Sanden, M.D. and his staff, in terms I understand, the potential psychological and physical dependence (addiction) to prescribed controlled substances, which although rare, is a possible outcome of my treatment program. I have been informed some patients may develop a tolerance, which is the need to increase the dose of prescribed controlled substances to achieve the same level of pain control, and I am completely aware that, as a result of my medical treatment, I may become physically dependent on the prescribed controlled medication.

When I no longer require the prescribed controlled medication or the medication is discontinued for any other reason, I am aware I must slowly reduce the dose, under medical supervision or I may have withdrawl symptoms. I am aware I may be referred to a pain management specialist during this period of time.

If I require the use of a prescribed controlled substance medication for longer than 12 months post operatively, I will be referred to a pain management specialist for management of my prescribed controlled pain medications. Roderick Sanden, M.D.'s office will then no longer be prescribing my controlled substance medications.

I, alone, am responsible for my controlled substance medication. If the prescription or medication is lost, misplaced, stolen, destroyed or used up sooner than prescribed, I understand my medication will not be replaced under any circumstances. I am also aware it is my sole responsibility to report stolen medication to the police.

I WILL NEITHER REQUEST NOR ACCEPT CONTROLLED SUBSTANCE MEDICATION FROM ANY OTHER PHYSICIAN, PROVIDER OR INDIVIDUAL WHILE I AM RECEIVING SUCH CONTROLLED SUBSTANCE MEDICATION FROM RODERICK SANDEN, M.D. I am aware such action is not only illegal, but may seriously endanger my health. If I accept any controlled substance medication from any other physician, provider or individual, I, under no circumstance, will continue to receive prescribed controlled substance medication prescriptions from Roderick Sanden, M.D. The only exception to this contract is if such medication is prescribed while I am hospitalized.

Patient's Signature: _____ Date: _____

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REFILL POLICY FOR PRESCRIBED CONTROLLED SUBSTANCES

As a patient in our neurosurgical practice, I alone, am responsible for my prescribed controlled substance medication. If the prescription or medication is lost, misplaced, stolen, destroyed, or used up sooner than prescribed, I understanding it will not be replace under any circumstances. I am also aware it is my sole responsibility to report stolen prescriptions or medications to the police.

I understand refills will only be made during regular office hours, 8:00 am to 5:00 Monday through Thursday.

If you need a refill, please contact your pharmacy and request a prescription refill to be faxed to our office. Please allow one week for prescriptions to be refilled. Refills will not be made at night, after business hours, on holidays, or on weekends or by other physicians covering for Roderick Sanden, M.D. Refills will not be made if you finish you prescribed medication early. There are no exceptions.

I understand I am fully responsible for taking my medication as prescribed and for keeping track of the amount of medication I have.

I understand refills will not be made as an "Emergency" such as a Friday afternoon because I suddenly realized that I will "run out" tomorrow or over the weekend or over a holiday". I must keep track of my own medication and plan ahead. This includes vacations and periods when either I or the doctor will be out of town.

I understand if I violate any of the above conditions of this contract or am arrested for the sale of narcotics, controlled substances or prescriptions, my controlled substance prescriptions and/or treatment by Roderick Sanden, M.D. will be immediately terminated. If the violation involves obtaining controlled substances from another individual, as described above, I will be reports to my primary and/or referring physician, local medical facilities, and/or authorities having jurisdiction in this area.

Patient Signature: _____ Date: _____

Print Name: _____

Please provide our office with a complete list of medications you are currently taking. It is imperative we know if you are on medications for your heart, blood pressure, cholesterol, lung conditions, kidney conditions, liver conditions and most importantly any anti-thrombotics (blood thinners) such as Coumadin, Plavix, Lovenox, Heparin, Aspirin, etc. We must also know if you are taking any nonsteroidal anti inflammatories, or muscle relaxants.

PLEASE KNOW THE NAME, DOSAGE, AND FREQUENCY OF THE MEDICATIONS YOU ARE TAKING.
We thank you for taking time to provide an accurate list of medications you take so we may treat you accordingly.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services.

_____
Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's Signature (Date)

_____
Print Patient's Name

By: _____
(Date)

By: _____
Patient's Representative's Signature (Date)

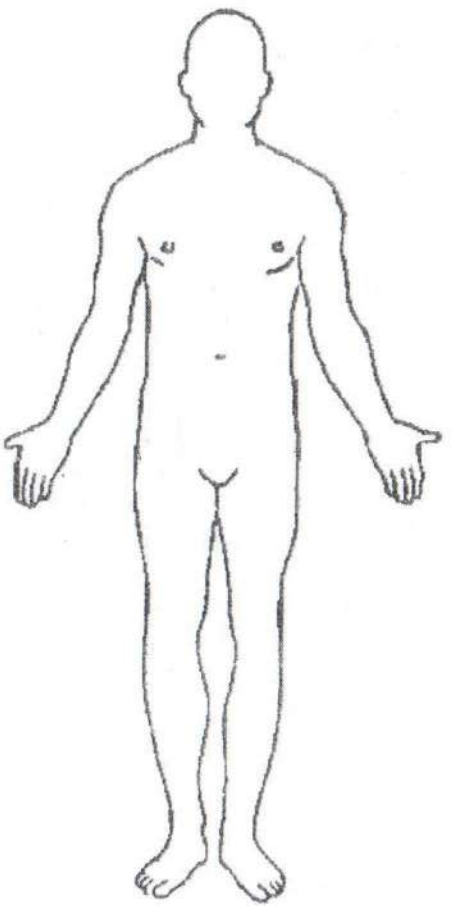
_____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

Name: _____ Date: _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, draw in your face.

Front



Numbness
ll ll ll ll

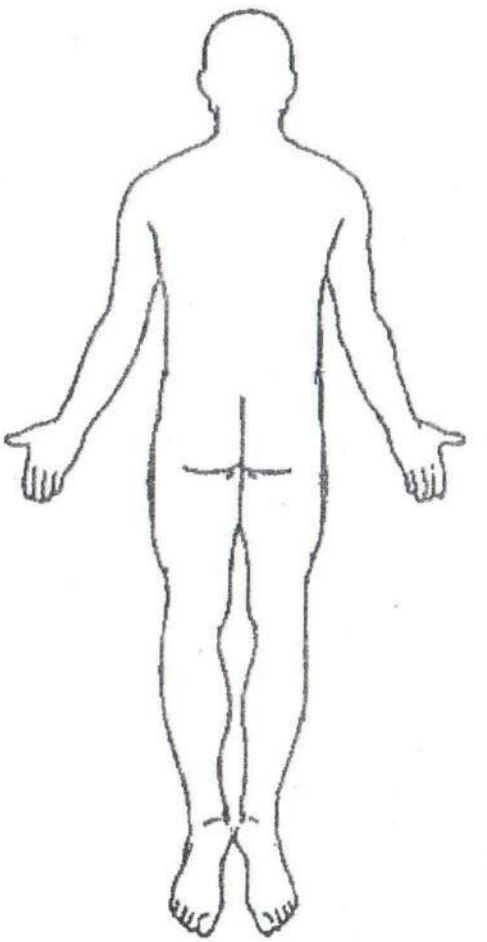
Pins and Needles
00000

Burning
xxxxx

Stabbing
//////

Ache
^^^^

Back



Roderick Sanden, M.D.

Brittany Tremblay, N.P., RFA

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Lumbar Spine Questionnaire-PAGE 1

Patient Name: _____

Please describe how your injury, pain and symptoms occurred:

_____

_____

*What is your current occupation?*_____ *Who is your employer?* _____

Are you retired ? Yes ___ No ___ Date you retired & Employer: _____

What is the level of education you have completed?
High school ___ 2 year College ___ 4 year College___ Graduate school ___

Does your job require lifting, bending, twisting, prolonged sitting or standing? Yes ___ No ___

Pain and symptoms assessment:

Are you having back pain?	Yes ___ No ___	
Describe the location of your back pain.	Right side ___ Middle of back ___ Left Side ___	
Are you having radiating pain?	Yes ___ No ___	
If yes, where does your pain radiate	Right hip ___	Left Hip ___
	Right buttock ___	Left buttock ___
	Right leg___	Left leg ___
	Right foot___	Left foot ___
	Right toes___	Left toes___

With regards to your back pain and leg pain, Is the pain more in your back or more in your legs
Back ___ Leg___
If you are having leg pain, buttock pain or hip pain, is the pain more on the right or more on the left?
Right ___ Left ___

Do you have back pain bending forward at the waist? Yes ___ No ___
Do you have back pain bending backwards at the waist? Yes ___ No ___
Which is more painful, bending forwards or bending backwards? Forward ___ Backwards ___
When you are having pain, is it generally

___ Minimal – annoying but does not interfere with sleep or daily activities or working
___ Slight – tolerable, but interferes with some daily activities, sleep and working
___ Moderate – pain is daily, social activities are severe limited, sleep is affected, taking pain medication and missing some days of work
___ Severe – pain precludes doing daily activities, sleep is disrupted, social and recreational activities are impossible, taking pain medication which does not result in complete pain relief, unable to work

Lumbar Spine Questionnaire – PAGE 2 Patient Name _____

How often are you having pain?
Occasionally ___ Frequently___ Constantly___

Describe your back pain?
Dull ache ___ Muscle spasms___ Sharp____

Describe your leg pain, hip pain or buttock pain?
Dull ache___ Muscle spasms___ Sharp, shooting, electrical, stabbing___ Burning ___Numbness/tingling___

What makes your pain worse?
___ Bending ___ Lifting ___ Twisting ___ Prolonged sitting ___ Prolonged standing ___ Driving
___ Walking ___ Getting in and out of a car ___ Getting in and out of bed

What makes the pain better?
___ Rest ___ Heat/Ice ___ Lying down ___Pain medication ___ Nothing _____

When did your pain begin?
___Started years ago, recurring and persistent since that time, give approximate date _____
___ Started within the last year, give date _____
___ Started within a couple of months or weeks ago, give date _____

Before this current injury, have you ever had any of the following injuries in the past? If you have, please indicate the year.
_____ Prior motor vehicle accident or injury
_____ Sports injury-high school, college, or in adult sports recreation
_____ Injury with a disability claim
_____ Claim for workers' comp industrial injury
_____Falling injury

Are you having weakness in your legs?
_____ Right leg_____Left leg_____Both legs

Are you having difficulty walking?	Yes ___ No ___
Are you limping?	Yes ___ No ___
Are you dragging your leg or foot?	Yes ___ No ___
If yes, you are dragging your leg or foot which side?	Right leg/foot ___ Left leg/foot ___
Are you having difficulty with balance?	Yes ___ No ___
Have you fallen from leg weakness?	Yes ___ No ___
Do you have problems climbing stairs or walking on uneven ground?	Yes ___ No ___
Are you having difficulties with bowel habits or control?	Yes ___ No ___
Are you having problems with urinary incontinence?	Yes ___ No ___
Are you having difficulties achieving or maintaining an erection?	Yes ___ No ___
Are you having difficulties achieving an orgasm?	Yes ___ No ___

Are you using an assistive device to help with walking? Cane ___ Walker ___ Wheelchair ___

Name:_____

Height: _____ Weight:_____ Do you smoke cigarettes? Yes ____ No _____in the past_____

Age:_____ Right of Left handed:_____Height:_____Weight:_____

Do you smoke? If yes, How many packs per day? _____What age did you start?_____

If you stopped smoking , at what age did you stop?_____

Do you consume alcohol? Yes__ No__ how much_____ how often:_____

Do you use recreational drugs? Yes ___ No ____Prior_____ when did you stop_____

Marital Status:
Single _____Married _____Divorced _____Widowed _____

Past/Present Medical History:
Do you have or have you ever had any of the following: Please circle

Heart Problems	Yes	No	Cirrhosis	Yes	No
Heart attack	Yes	No	Liver Problems	Yes	No
Congestive Heart Failure	Yes	No	Hepatitis	Yes	No
High Blood Pressure	Yes	No	Stomach/Intestine Problems	Yes	No
Pacemaker	Yes	No	Ulcers	Yes	No
Heart Stent	Yes	No	Arthritis	Yes	No
Chest Pains	Yes	No	Rheumatoid Arthritis	Yes	No
Stroke	Yes	No	Diabetes or high blood sugar	Yes	No
Migraine Headaches	Yes	No	Bleeding Disorder	Yes	No
Seizure Disorder	Yes	No	History of Blood clots	Yes	No
Lung Problems	Yes	No	AIDS	Yes	No
Asthma	Yes	No	MRSA	Yes	No
COPD	Yes	No	Are you pregnant	Yes	No
Pneumonia	Yes	No	Kidney Stones	Yes	No
Tuberculosis	Yes	No	Kidney Problems	Yes	No
Wearing Oxygen at home	Yes	No	Dialysis	Yes	No
Reaction to Anesthesia	Yes	No	Clotting disorders	Yes	No

Past Surgical History:
Please list any surgeries you have had:
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

Past Family History:
Do any medical problems run in your family?
Mother:_____
Father:_____
Brother/Sister:_____
Children:_____

Allergies:
Are you allergic to any medications? Yes ___ No ___
If yes, please list the medications you are allergic to and also include sensitivities you may have and list them as a sensitivity not an allergy.
1. _____ Reaction _____
2._____ Reaction _____
3._____ Reaction _____
Are you taking any medications? Yes ___ No ___
If yes, please list all the medications you are currently taking. Please include the dosage and how often you are taking the medications. Please include any vitamins, minerals, birth control, herbs etc.

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Lumbar Spine Questionnaire-PAGE 4 Patient Name _____

Have you had any of the follow conservative nonsurgical therapies?

___ Physical Therapy Dates _____ to _____
___ Pool Therapy Dates _____ to _____
___ Chiropractic Treatments Dates _____ to _____
___ Acupuncture Dates _____to _____
___ Epidural steroid injections Dates _____
___ Nerve root block Dates_____

Were any of these conservative non-surgical therapies helpful? If so, which one/s?

_____

Are you participating in a regular exercise program currently? Yes ___ No ___
If yes, what is your exercise routine? _____

_____

I, _____, have answered the above questions on the new patient questionnaire to the best of my ability.

Print Name: _____

Patient's Signature: _____

Date: _____