Tri-Cities Spinal Decompression --- REGISTRATION

Date_________________________ Home Phone ___________________ Cell Phone______________________

Patient ____ ______________________________
Last First Initial e-mail address

Street Address____

City____ State ______________________ Zip ____________

Sex ☐M ☐F Age ________ Birth date__________________ ☐Single ☐Married ☐Widowed ☐Divorced

Social Security # _______________________________ Driver's License #________________________________

Insured's Name (if other than self) ____
Last First Initial

Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other Condition Related to: ☐illness ☐Employment ☐Auto ☐Other

PLEASE GIVE INSURANCE CARD(S) TO SECRETARY

EMPLOYER (OR INSURED GUARDIAN'S EMPLOYER)	Company Name__________________________________ Occupation________________ Address ____ Phone ___________________ City ___________________________________ State __________ Zip _______________
SPOUSE OR INSURED PARENT	Name____ Birth date _______________________ Social Security # __________________________ Employer Name _____________________________ Occupation ______________________ Address ____ Phone __________________ City___________________________________ State ________ Zip ___________________
MEDICAL & LEGAL INFORMATION **PLEASE GIVE INSURANCE CARDS TO SECRETARY**	Referred by _____________________________ Family Physician _____________________ Present Complaint _______________________ Address _____________________________ Known Medical Problems ________________ _______________________________________ ______________________________________ Phone _______________________________ Person to contact in emergency (Name & Phone #) ____________________________________ Pregnant ☐Yes ☐No Pacemaker ☐Yes ☐No _____________________________ Is this due to an auto accident? ☐Yes ☐No If yes, DATE OF ACCIDENT ______________ Auto Insurance Company______________________ Claim #___________________________ Address ______________________________________ Adjuster _________________________ ____ Phone # __________________________
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with ___________________________________ and assign directly to Dr. Kevin Fielden all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. _______________________________________ ______________________________________ Signature of Insured/Guardian Date

Name____

1. **Chief Complaint:** ____

Complaint began (approx. date)__________________gradually / suddenly. Is pain getting: Better / Worse / Staying the Same

Describe how it began:____

How frequent is complaint present, how long does it last?_________________________________

What activities make the complaint better?____

What activities make the complaint worse?____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint?

____

____

____

3. Past Health History: Previous serious illnesses / injury / or trauma you've had in your life?____________________

____

Have you ever broken any bones? Which?____

A. **Medications:** (additional space on back of this page, if needed)

Medications	Reason for taking
____________________	______________________________
____________________	______________________________
____________________	______________________________
____________________	______________________________

B. **Allergies**:____

C. **Surgeries:** Date: (or approx. year) Type of Surgery (use back page, if needed)

Date: (or approx. year)	Type of Surgery (use back page, if needed)
____________________	______________________________
____________________	______________________________
____________________	______________________________

D. **Females/Pregnancies and outcomes**: Pregnancies/Year of Delivery (example: boy, 1980, natural, or C-Section)

____________________	______________________________
____________________	______________________________

What was the date of the beginning of your last menstrual period?_____________________________

4. Family Health History: Associated health problems of immediate relatives:____________________

____

Deaths in immediate family: Cause of parents or siblings death	Age of death
____________________	______________________________
____________________	______________________________

5. **Social and Occupational History:** Job description:______________________________

Work Schedule:______________________ Recreational Activities:______________________

Level of exercise, describe:____

Alcohol_____________ Tobacco (packs per day)_____________ Are you on a diet program?________________

Other:____

PAIN DISABILITY INDEX QUESTIONNAIRE

Name____ Date____________________

Primary Complaint:

How long have you had this pain? _________________ Pain Intensity (0=none, 10= worst pain ever)___________

Is this your first episode of pain? Yes____________ No______________

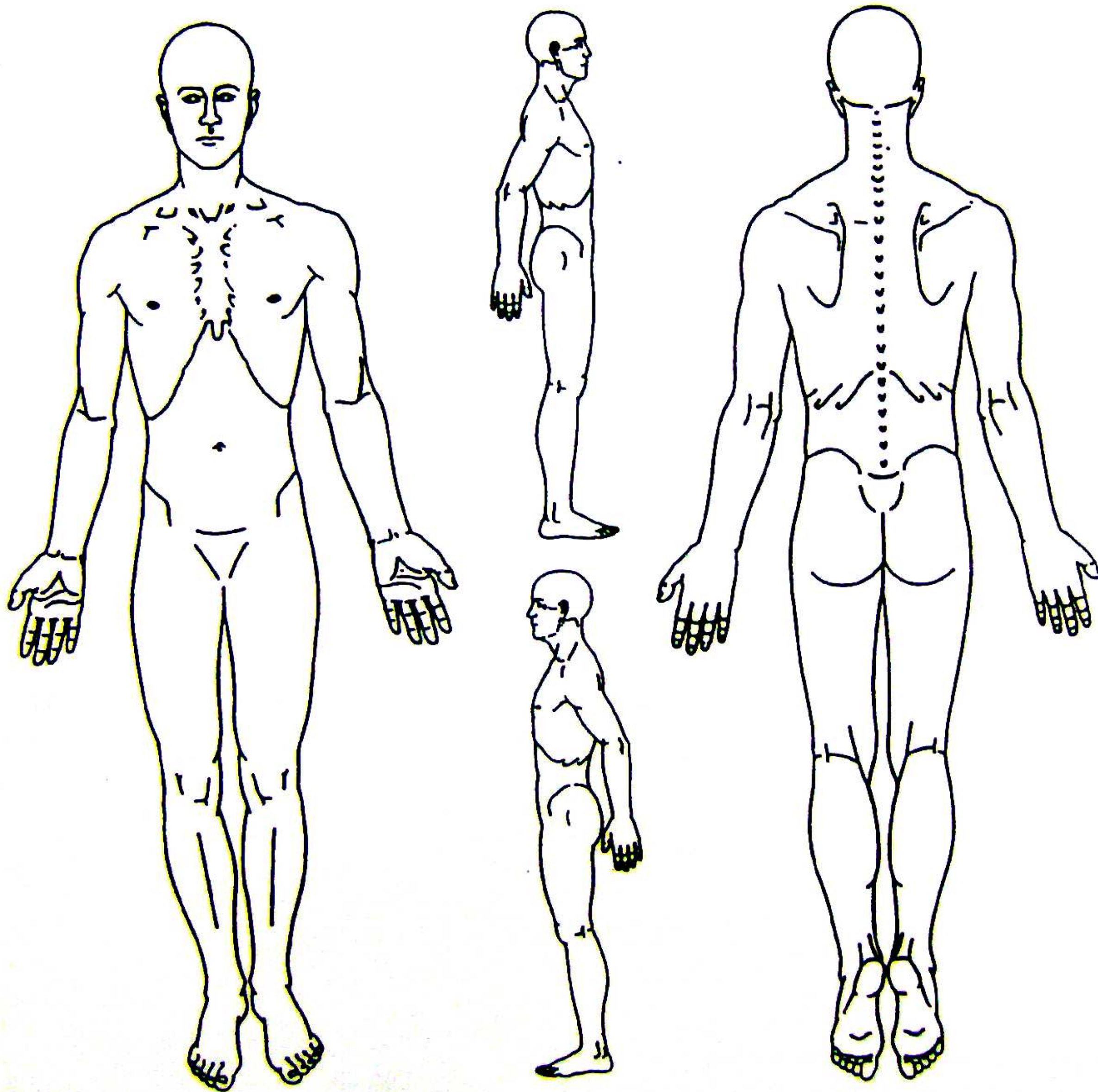
Secondary Complaint:

How long have you had this pain? _________________ Pain Intensity (0=none, 10= worst pain ever)___________

Is this your first episode of pain? Yes____________ No______________

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR COMPLAINT

KEY	A=ACHE	B=BURNING	N=NUMBNESS
	P=PINS & NEEDLES	S=STABBING	O=OTHER__________



FUNCTIONAL RATING INDEX

In order to properly assess our condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

Item	0	1	2	3	4
1. Pain Intensity =	No pain	mild pain	moderate pain	severe pain	worst possible pain
2. Sleeping =	Perfect Sleep	mildly disturbed sleep	moderately disturbed sleep	greatly disturbed sleep	totally disturbed sleep
3. Personal Care = (washing, dressing, etc.)	No pain; No restrictions	mild pain; no restrictions	moderate pain need to go slowly	moderate pain; need some assistance	severe pain; need 100% assist.
4. Travel = (driving, etc)	No pain on Long trips	mild pain on long trips	moderate pain on long trips	moderate pain on short trips	severe pain on short trips
5. Work =	Can do usual Unlimited extra	can do usual no extra work	can do some usual work	can do a few usual work	cannot work
6. Recreation =	Can do all activities	can do most activities	can do some activities	can do a few activities	cannot do any activities
7. Frequency = (of pain)	No Pain	occasional pain; 25% of day	intermittent pain 50% of day	frequent pain 75% of day	constant pain; 100% of day
8. Lifting =	No pain; with Heavy weight	increased pain heavy weight	increased pain moderate weight	increased pain light weight	increased pain with any weight
9. Walking =	No pain any Distance	increased pain after 1 mile	increased pain after ½ mile	increased pain after ¼ mile	increased pain with all walking
10. Standing =	no pain after several hours	increased pain after several hrs.	increased pain after 1 hour	increased pain after ½ hour	increased pain with any standing

Patient Signature____ Date____________________