Indiana Spine Group

WELCOME TO INDIANA SPINE GROUP! We are pleased that you have chosen us for your care. Indiana Spine Group is a center of excellence for comprehensive spine care –treating patients with back and neck; providing comprehensive care for patients with spinal disorders and abnormalities.

Please bring the following items to your first appointment:

New Patient Forms
Please complete all of the printed forms. The details and specifics of your overall medical history and condition are important. Please take the time to fully and accurately complete all of this information.

Listing of Medications with Dosage, Frequency and Reason
Make a list of all medications that you are taking; including the dosage, frequency, and the reason you are taking the medication. In this listing, also include all of the over-the-counter medications and herbal supplements you are taking. If you prefer, bring all of your medications in a bag, and we will make the list for you.

Prior Tests or Studies
If you have had any tests or studies completed prior to your appointment, such as X-rays, MRIs or other tests - bring these to your first appointment. This includes any tests from another physician, hospital or testing facility.

To obtain your films or test results, contact the facility where the films/tests were performed **several days prior to when you will pick them up.** Each facility will have their own procedure to obtain films/test results. You will need to hand carry your films and test results to your appointment. If you have difficulty or are unable to obtain your films, please call our office one week prior to your scheduled appointment at (317) 228-7000, and one of our staff will assist you.

Do not have the facility mail the films to us.

If you are unable to obtain your films for your appointment, please call our office, and we will reschedule your appointment.

Insurance Card(s) and Co-Pay
Indiana Spine Group participates in most health insurance plans. To bill your insurance company, we will need your insurance card. **If you fail to bring your insurance card, your appointment will be rescheduled**. Most insurance plans require a co-payment for office visits. If your insurance carrier requires a co-payment, we will collect this at the time of service. If you do not have health insurance, payment is expected at the time of service. For your convenience, we accept cash, checks, MasterCard or Visa.

Again, thank you for choosing Indiana Spine Group. If you have any questions, please call us at (317) 228-7000 or toll-free at (866) 947-7463.

The Physicians and Staff of Indiana Spine Group

For more information about Indiana Spine Group and spine education, visit us online at www.indianaspinegroup.com.

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DID YOU REMEMBER TO . . .

☐ Fill out your paperwork and medication sheet with your pill bottles in front of you?

☐ Pick-up your films/X-rays to bring to your appointment?

☐ Bring the reports from your test results to your appointment?

☐ Make plans to arrive at Indiana Spine Group 15 minutes before your appointment time?

☐ Bring your insurance card and co-pay to your appointment? We accept cash, check, Master Card and VISA.

☐ Bring a referral from your primary care physician, if required by your insurance.

Thank you,

Indiana Spine Group

Please Answer Every Question

Today's Date _____/_____/_____ Patient # _____(MD Office Use)

Patient Name _____ Date of Birth ____/____/____ Why Are We Seeing You? _____

How Long Have You Had This Problem? _____ Primary Care Physician _____ Phone ( ) _____

PAST PATIENT/FAMILY MEDICAL HISTORY (Circle all that are applicable)
Have you or members of your immediate family had the following illnesses or problems? (*Explain Further)
C=Patient currently receiving treatment P=Patient Past History – no current treatment F=Family History

C	P	F	Alcoholism		C	P	F	Rheumatic Fever		C	P	F	Kidney/Bladder Disorder*
C	P	F	Anemia		C	P	F	Cancer*		C	P	F	Diabetes (Type I)
C	P	F	Asthma		C	P	F	DVT (Blood Clot)		C	P	F	Diabetes (Type II)
C	P	F	Arthritis		C	P	F	Drug Abuse		C	P	F	Eczema, itching, rash
C	P	F	COPD		C	P	F	Heart Disease*		C	P	F	Hypertension/High Blood Pressure
C	P	F	Depression		C	P	F	Mental Illness*		C	P	F	Pulmonary Embolus (blood clot in lung)
C	P	F	Glaucoma		C	P	F	Seizure Disorder*		C	P	F	Uncontrolled Bleeding*
C	P	F	Tuberculosis		C	P	F	Thyroid Disease*		C	P	F	Stomach Ulcer
C	P	F	Stroke		C	P	F	Hepatitis		C	P	F	Immunodeficiency*

_ Positive for VRE _ Positive for MRSA
Explain _____
_____
_____

Previous Surgery	Date	Previous Surgery	Date

Problems with anesthesia? _ No _ Yes Explain _____
Previous blood transfusions? _ No _ Yes Adverse Reaction _____

SOCIAL HISTORY
Marital Status _ Married _ Single _ Divorced _ Widowed Children-Number and ages _____
I Live _ Alone _ With Someone _ In another facility _____
Alcohol Consumption _ None _ Occasional _ Regular _ Known Abuse Number of drinks per week _____
Tobacco Use _ None _ Yes Packs per day _____ Recreational Drug Use Type _____ Amount _____
Grade Completed _____ Primary language, if other than English _____
Special Medical Equipment/Supplies (ie. Dentures, hearing aid, wheelchair, walker, oxygen, Hickman, implanted device, etc.)
_____

SYSTEMS REVIEW (Check all that currently apply) _ Systems Review WNL, unless otherwise noted

General	**Eyes**	**Head/Mouth/Nose/Throat**	**Respiratory**	**Cardiovascular**	**GYN/Urology**
Weight loss	Pain	Sore Throat	Wheezing	Chest Pain	Dysuria
Weight gain	Discharge	Nasal Discharge	Cough	Diaphoresis	Frequency
Fever	Redness	Hoarseness	Shortness of Breath	Fainting	Hematuria
Fatigue	Itching	Ringing in Ears	Hemoptysis	Foot Swelling	Hesitancy
Chills	Light Sensitive	Nose Bleeds	Sputum		

Neurological	**Musculoskeletal**	**Skin/Breast**	**Endocrine**	**Gastrointestinal**
Headache	Joint Swelling	Rash	Menstrual Irregularity	Abdominal Pain
Confusion	Joint Pain	Itching	Excessive Sweating	Vomiting
Numbness	Joint Redness	Sores	Excessive Thirst	Diarrhea
Slurred Speech	Gait Difficulty	Abscess	Excess Hot	Bleeding
Dizziness	Atrophy	Breast Discharge	Excess Cold	Flank Pain
				Constipation

Hematologic/Lymphatic	**Allergy/Immune System**
Bleeding Tendencies	Severe Allergies
Abnormal Blood Cells	Immunosuppression
Lymph Node Swelling	

PAIN ASSESSMENT
Location/Description of Pain _____
Current pain level on a scale 1-10_____
What relieves pain? _____
What worsens pain?_____
Signature of person completing form _____

Today's Date _____/_____/_____

Patient Name _____ Date of Birth _____/_____/_____

List drug allergies and reactions_____

_____

List food and environmental allergies and reactions_____

Do you have a Latex allergy? _ Yes _ No

VACCINATIONS

List most recent vaccination dates:

Flu vaccine_____/_____/_____ Pneumonia vaccine_____/_____/_____ Tetanus vaccine_____/_____/_____

MEDICATIONS
List any over-the-counter medications, such as diet pills, allergy, herbals or supplements, taken in the last month_____

_____

Current Medication List

Medication	Dose	Route	Frequency	Condition Prescribed for	X=Resume on admission/post operatively

MD Signature_____Date_____/_____/_____(Signature and date required to resume home meds)

FOLLOW UP VISIT_____

_____

H&P REVIEW/REVISION
1. Noted changes in above_____
_____
_ No changes in above MD Signature_____ Date_____/_____/____
2. Noted changes in above_____
_____
_ No changes in above MD Signature_____ Date_____/_____/____
3. Noted changes in above_____
_____
_ No changes in above MD Signature_____ Date_____/_____/_____
4. Noted changes in above_____
_____
_ No changes in above MD Signature_____ Date_____/_____/_____

Indiana Spine Group

CONFIDENTIAL PATIENT INFORMATION FORM

Patient Information:

Name: (First) _____ (MI) _____ (Last) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ ( ) Home ( ) Work ( ) Other

Phone: _____ ( ) Home ( ) Work ( ) Other

Date of Birth: _____ Sex: ___ Male ___ Female

Social Security Number: _____

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed

Insurance Information:

Primary Insurance: _____ ID#_____ Group# _____

Insurance Subscriber Name: _____ DOB: _____

Subscriber's Social Security Number: _____

Insurance Subscriber Employer: _____

Secondary Insurance: _____ ID# _____ Group# _____

Insurance Subscriber Name: _____ DOB: _____

Subscriber's Social Security Number: _____

Insurance Subscriber Employer: _____

Patient Employment:

Work Status: ( ) Employed ( ) Unemployed ( ) Retired ( ) Student ( ) Other

Employer Name: _____

Employer Phone Number: _____

Occupation: _____

Is your visit due to an injury suffered on the job? ( ) Yes ( ) No

Is your visit due to an automobile accident? ( ) Yes ( ) No
(Indiana Spine Group will only file auto insurance claims if a letter of responsibility from the auto insurance company is presented at the initial visit. Indiana Spine Group will bill auto insurance until all benefits are exhausted, and any remainder will be billed directly to health insurance or to the patient.)

Physician Information:

Name of Physician who referred you to our Group: _____

Referring Physician's phone number: _____

Name of your Family Physician: _____

Family Physician's phone number: _____

Emergency Contact:

Name of person to contact in case of emergency: _____

Emergency contact phone number: _____

Emergency contact's relationship to patient: _____

I Verify All Information On This Form Is Accurate & Correct.

Patient (or guardian) Signature: _____ Date: _____

Date: ____/____/____ **Name:** _____

Physician: _____

Neck Disability Index

Please Read:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section related to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of my self care.
- ☐ I do not get dressed. I was with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I can not read at all.

Section 5 – Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come in-frequently.
- ☐ I have moderate headaches which come in-frequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all of the time.

Section 6 - Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I can not concentrate at all.

Section 7 - Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 - Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 - Sleeping
- ☐ I have no problem sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1 – 2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2 – 3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3 – 6 hrs. sleepless).
- ☐ My sleep is completely disturbed (5 – 7 hrs. sleepless).

Section 10 - Recreation
- ☐ I am able to engage in all my recreation activities with no neck pain.
- ☐ I am able to engage in all my recreation activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

DISABILITY INDEX SCORE: _____%

OSWESTRY (BACK INDEX)

Name: _____

Doctor_____ **Date:** _____

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which most closely describes your problem right now.

Section 1 – Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate. .
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

Section 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I an unable to do any washing and dressing without help.
F. Because of the pain I an unable to get dressed, I wash with difficulty and I stay in bed.

Section 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on the table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

Section 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than ? mile.
D. Pain prevents me from walking more than ? mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ? hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

Section 6 - Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I can't stand for longer than 1 hour without increasing pain.
D. I can't stand for longer than ? hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increase pain right away.

Section 7 - Sleeping

A. I have no pain in bed.
B. I have pain in bed, but it does not prevent me from sleeping.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

Section 8 – Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have no social life because of pain.

Section 9 - Traveling

A. I have no pain while traveling
B. I have some pain while traveling, but none of my usual forms of travel make it any worse
C. I have extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel
E. Pain restricts all form of travel.
F. Pain prevents all forms of travel except that done by lying down.

Section 10 – Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better or worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

DISABILITY INDEX SCORE: _____%

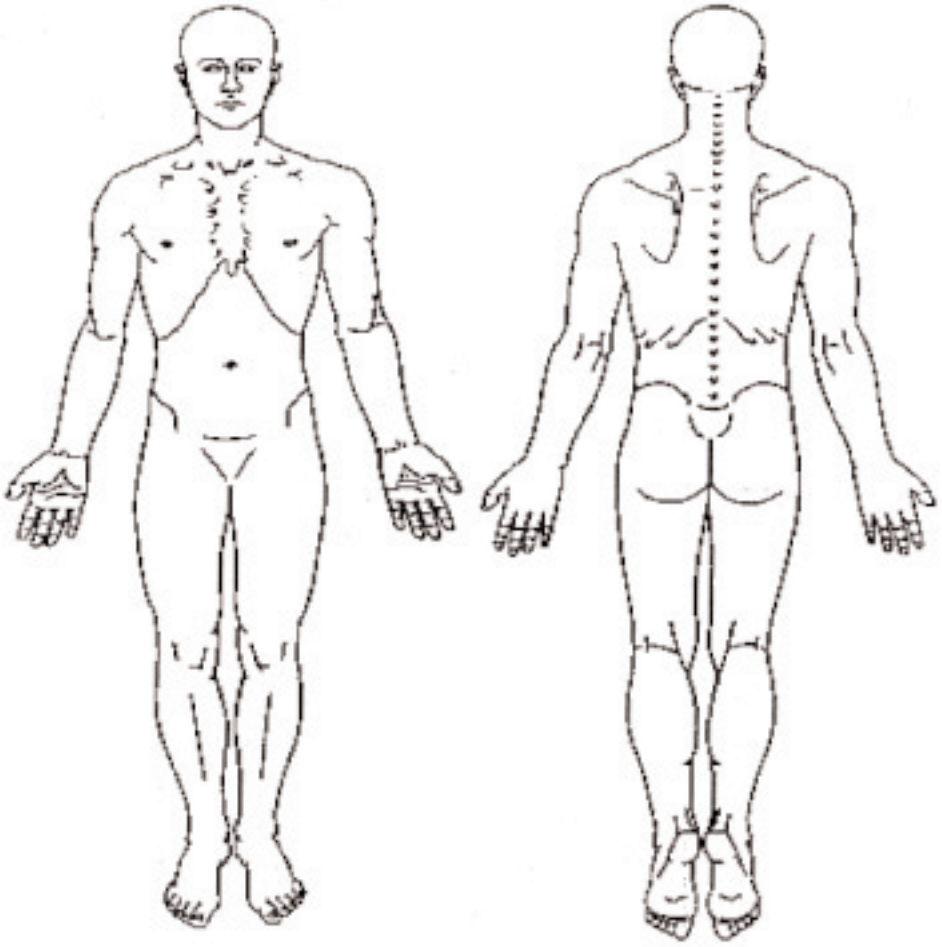
Indiana Spine Group

DESCRIPTION OF YOUR BACK OR NECK PAIN

Name: _____ Date: _____ Duration of Symptoms: _____

On the diagram below, please use the letters to indicate your symptoms and where you are experiencing them.

A=ACHE	**B=BURNING**	**N=NUMBNESS**
P=PINS & NEEDLES	**S=STABBING**	**O=OTHER**



If you have NECK/OR ARM PAIN, please indicate the following:

Percent of neck pain: _____%
Percent of arm pain: _____%
Total = 100%

If you have BACK/OR LEG PAIN, please indicate the following:

Percent of back pain: _____%
Percent of leg pain: _____%
Total = 100%

Please rate the intensity of the pain in your NECK OR BACK by placing a mark on the line below:

No Pain _____ Severe Pain
0 1 2 3 4 5 6 7 8 9 10

Please rate the intensity of the pain in your ARM(S) OR LEG(S) by placing a mark on the line below:

No Pain _____ Severe Pain
0 1 2 3 4 5 6 7 8 9 10