Michigan Spine & Joint Center PC
Several Doctors, One Purpose...You

32500 23 Mile Rd
New Baltimore, MI 48047
Phone: 586.725.3100 Fax: 586.725.3155

Today's Date: _____

PERSONAL INFORMATION

Patient Name_____Date of Birth _____Age _____
First Middle Last
SS#_____ Sex __ Female __ Male Account #_____
Marital Status __ Single __ Married __ Separated __ Divorced __ Widowed
Address_____
City _____State_____Zip_____Phone ( ) _____
Cell phone ( ) _____e-mail address_____
Where do you prefer we contact you? __ Home __ Work __ Cell Other _____
Is there someone you wish us to share your medical information with if you are not available? __ No __Yes
Name_____Relationship_____
Spouse Name (if married) _____
Emergency Contact Person _____ Phone ( ) _____
Relation to You _____ ***(different from phone number listed above)***

JOB INFORMATION

Patient Occupation _____ Retired? __ Yes __ No
Patient Employer _____
Employer Address_____
City _____State_____Zip_____
Work Phone ( )_____Last Day Worked_____/_____/_____
Month Day Year

REFERRAL INFORMATION

Who referred you, or how did you hear about us?
Full name_____
Address _____
City _____State_____Zip_____Phone ( )_____
Who is your regular family physician?
Full name_____
Address _____
City _____State_____Zip_____Phone ( ) _____

Which other physician(s), if any, have you seen for this problem and what was their recommendation?

_____

I have personally reviewed this intake packet before dictating my report. _____
Physicians Signature Date

INSURANCE

Primary Insurance _____ Effective Date _____

Policy Number _____ Group Number _____

Insurance provided through ___ your employer ___ your spouse's employer ___ other

If other than your employer, list the following information for the primary card holder.

Name _____ Social Security Number _____

Date of Birth _____ Employer Name _____

Secondary Insurance _____ Effective Date _____

Policy Number _____ Group Number _____

Insurance provided through ___ your employer ___ your spouse's employer ___ other

If other than your employer, list the following information for the primary card holder.

Name _____ Social Security Number _____

Date of Birth _____ Employer Name _____

Is this a WORK related injury? ___ Yes ___ No ___ Not sure

If yes, Date of injury _____ Last date of work _____

Employer you worked for when injured _____

Is this an AUTO related injury? ___ Yes ___ No ___ Not sure

If yes, Date of injury _____ Last date of work _____

Is this another type injury? ____ Yes ___ No ___ Not sure

If yes, Date of injury _____ Last date of work _____

Where did injury take place? _____

How were you injured? _____

FOR WORK, AUTO, OR OTHER RELATED INJURY, PLEASE COMPLETE THE FOLLOWING:

Claim Number _____

Send Bill To:

Name _____

Address _____

City/State/Zip _____

Phone (____) _____

Your Caseworker

Name _____

Address _____

City/State/Zip _____

Phone (____) _____

Adjuster Name _____

Telephone (____) _____

Is there a lawsuit involved? ____Yes ____ No

Do you have an attorney? ____Yes ____ No

Your Attorney

Name _____

Address _____

City/State/Zip _____

Phone (____) _____

MEDICAL INFORMATION

Reason for office visit.(Please check)

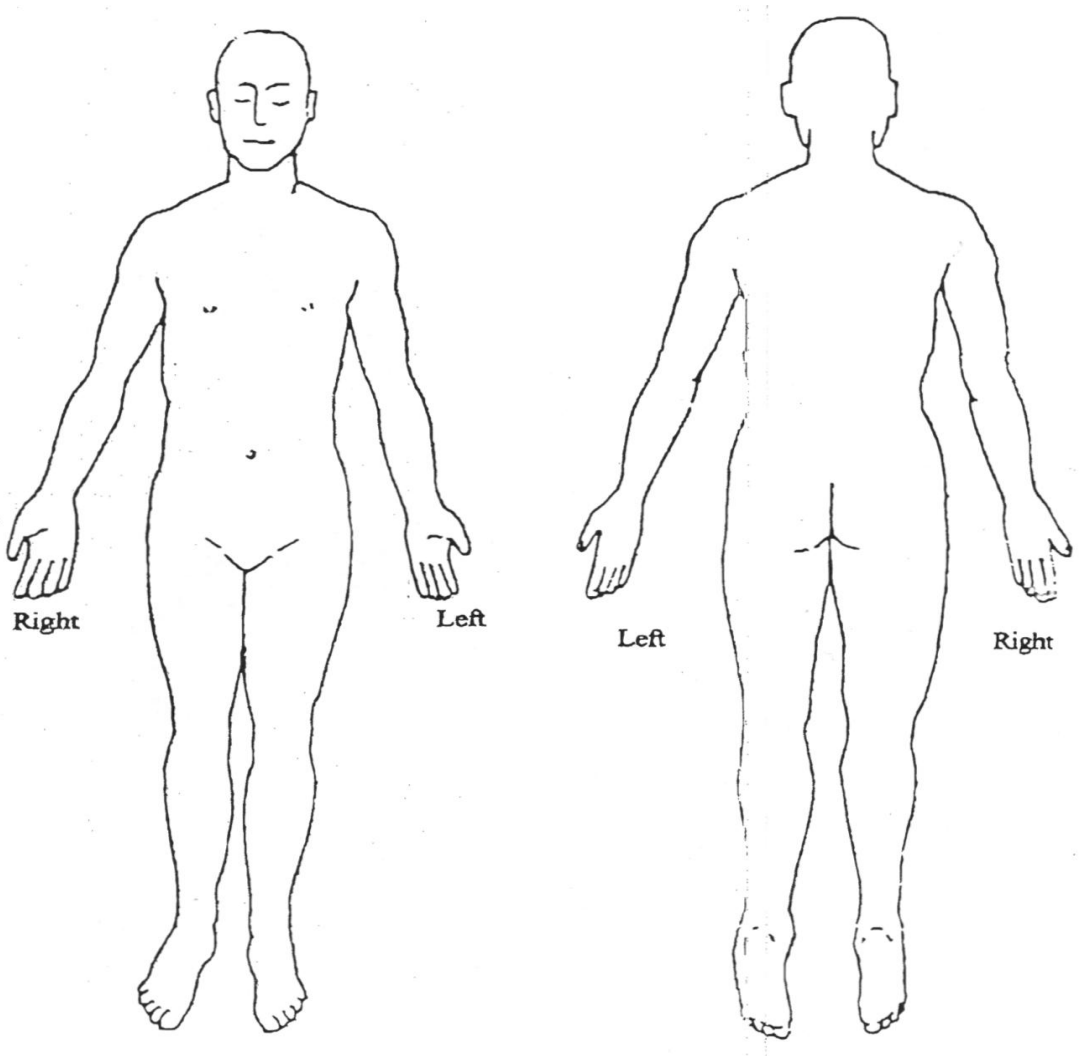
____ Continuation of care
____ New onset of symptoms, please explain _____

_____

____ Follow up with new testing
____ Other _____

Using the patterns below, show exactly where on the body you are having problems.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
/////	BBBBB	XXXXX	= = = = =	ZZZZZ	OOOOO
///	BBB	XXX	= = =	ZZZ	OOO
/	B	X	=	Z	



How would you rate your pain now?
(Circle the number you would give it if 1 being no pain and 10 being the worst pain ever.)

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

MEDICAL INFORMATION continued

When did the pain start? (Specify date if you know) _____

What were you doing when it started? _____

Did it occur: __ Suddenly __ Gradually

Where is the pain worse? __ Back __ Neck __ Hips __ Legs

Is the pain: __ On the surface __ Deep inside __ Hard to tell

Does the pain go anywhere? (Example: Does it shoot down arms or legs?) __ Yes __ No
If YES, describe the path of the pain _____

_____

Is your pain: __ Getting better __ Getting worse __ Comes and goes __ Always there

What time of day is your pain worse? _____

How long does it last? _____

What makes your pain BETTER?
__ Lying down __ Manipulation __ Muscle relaxants
__ Sitting __ Physical therapy __ Heat
__ Standing __ Aspirin __ Cold
__ Walking __ Pain pills
__ Other _____

What makes your pain WORSE?
__ Exercise __ Walking __ Bending forward
__ Sitting __ Coughing __ Bending backward
__ Standing __ Sneezing __ Lying down
__ Other _____

Does your pain keep you from doing any of the following?
__ Working __ Exercising __ Having sex
__ Sports __ Sleeping __ Driving
__ Showering __ Dressing __ Shopping
__ Having fun __ Leaving the house
__ Does not stop activities

Do you need to rest during the day because of your pain?
__ No __ A little __ Half the day __ Over half the day

Do you have any numbness? __ No __ Yes
If YES, where? _____

Do you have any weakness? __ No __ Yes If YES, where?_____
Do you have any problems with: __ Bowel function __ Bladder function __ Sexual function

Have you received any of the following treatments:

	Physical Therapy	Chiropractic	Injections	Other
When:				
How often:				
How many:				

MEDICAL INFORMATION continued

Circle all medical conditions for which you are under a Doctor's care

Asthma *Heart problems* *Cancer* *Diabetes* *High blood pressure* *Hepatitis* *HIV*
Stroke *Pulmonary* *Kidney* *Other* _____

Tests done (Circle)

MRI *CT Scan* *EMG* *XRAY* *Other* _____

Dates taken: ____ _____ ____ _____ _____

Medications: List the medications you are currently taking including any over the counter medications (E.g.: aspirin, ibuprofen, anti-histamines etc.)

Name of medicine	Strength	How often?	What are you taking it for?	Name of Dr. who ordered medicine

Do you use nutritional supplements (Vitamins, Ginkgo-Biloba, Ginseng, St. John's Wort) or diet aids (i.e.: Pondimin, Fastin, OBY-TRIM, Zantryl etc.) on a regular basis? __ Yes __ No

If yes, please list_____

_____

Allergies to Medicines: ___ yes ___ no If yes, what medicines? _____

_____

Do you have an allergy or a reaction to Latex? ___ yes ___ no

Allergies to substances <u>other than</u> medicines? ___ yes ___ no If yes, list what you are allergic to (e.g. tape, pollen, bees, grass, etc.) _____

State any life style changes in the last year _____

Comments or other changes_____

_____

Do you have any questions for the doctor? _____

_____

Signature _____ **Date** _____

PAST MEDICAL HISTORY

1. **Major Medical Illnesses:**
   Check any major medical illnesses listed below that you have suffered from or currently have:

   ___Asthma ___cancer___diabetes___heart attack ___ heart disease_____ hepatitis ____HIV

   _____High or low blood pressure____ stroke

   Other major illnesses_____

List hospitalizations for surgery or major medical illnesses:

Hospital Physician	Date/Year	Reason for admission

2. **Transfusions, anesthesia:**
   Have you encountered any problems with transfusions or anesthesia in the past? __ Yes __ No
   If yes, give details. _____
   _____

3. **Serious Injuries:** List any serious injuries you have sustained any time in the past.
   (E.g. auto accident, falls, gunshot/stab wound, work injury) _____
   _____

4. **Are you claustrophobic or feel 'panicky' or heart races when in confined spaces like an elevator?**
   __ yes __ no

5. **Do you have any metal anywhere in your body?** __ yes __ no
   If yes, where is it? _____

   If yes, what is it? (metal filing, shrapnel, bullet etc)_____

6. **Allergies to Medicines:** __ yes __ no
   If yes, what medicines? _____

7. **Do you have an allergy or a reaction to Latex?** __ yes __ no

8. **Allergies to substances other than medicines?** __ yes __ no If yes, list what you are allergic to, (e.g. tape, pollen, bees, grass, etc.) _____
   _____

PERSONAL, SOCIAL AND FAMILY HISTORY

1. Diet: Are you on any special diet? _____
2. Activity: Do you regularly exercise? _____
   Do you participate in sports or athletic activity? _____
   What are your hobbies and leisure activities? _____
3. Current weight: _____ Weight one year ago: _____ Height: _____
4. Handedness: ___ Right handed ___ Left handed ___ Equally skilled in both hands
5. Tobacco use: Do you smoke cigarettes? __ Yes __ No # cigarettes in a day _____
   Do you use other tobacco? __ Yes __ No Type: _____ Times in a day? ____
6. Alcohol use: Do you drink? __ Yes __ No What? _____ Amount in a day? _____
7. Drugs: Have you ever used street drugs? __ Yes __ No
   Do you still? __ Yes __ No
   What drugs? _____
   Do you __ swallow __ smoke __ snort __ inject
   How often? _____

9. Religious beliefs: Do you wish to express any of your personal religious beliefs that will impact on your health care? (e.g.: objection to blood transfusions) _____

10. Emotional status: How is your emotional health _____

FAMILY HISTORY

Do you know of any genetic illness in your family? ____ Yes ____ No

If yes, what illness? _____

1. List any of the following health problems in your near relatives in the table below:
   diabetes, high blood pressure, high cholesterol, stroke, heart attack, tuberculosis, cancer, arthritis, kidney disease, anemia, allergies, asthma, headaches, epilepsy, mental illness, alcoholism, drug addiction

	LIVING		DECEASED	
Relationship	**Age**	**Health Problems**	**Age at death**	**Cause of Death**
Father				
Mother				
Grandparents				
Sister/ Brother				

REVIEW OF SYSTEMS

Please go over the following list of medical problems and circle only those that pertain to you now or in the past.

HEAD AND NECK
- frequent headaches
- migraine
- head injury
- dizziness or fainting

EYES
- impairment of eyesight
- double vision
- blurred vision
- spots
- flashing lights
- cataracts

NECK
- swollen glands
- goiter
- pain or stiffness

EARS
- hearing difficulty
- ringing/buzzing
- earaches
- discharge from ears
- use of hearing aid(s**)**

NOSE AND SINUSES
- frequent colds
- nasal stuffiness
- nose bleeds
- sinus problems

MOUTH AND THROAT
- bleeding gums
- frequent sore throat
- hoarseness

BREASTS
- nipple discharge
- lumps

RESPIRATORY
- cough up phlegm
- blood in sputum
- shortness of breath
- bronchitis
- emphysema
- tuberculosis (TB)

CARDIOVASCULAR
- irregular heart beat
- racing heart
- heart murmur
- chest pain
- palpitations
- cold feet
- swollen feet/ankles

GASTROINTESTINAL
- loss of appetite
- nausea, vomiting
- heartburn
- recent change in bowel habits
- black stools
- rectal pain
- rectal bleeding
- jaundice
- hepatitis
- gall bladder trouble

URINARY
- frequency of urination
- burning
- urgency
- bloody urine
- passage of stones
- dribbling

GENITAL - MALE
- discharge from penis
- HIV
- hernias
- testicular swelling

GENITAL - FEMALE
- irregular menses
- painful menses
- post-menopausal bleeding
- use of birth control items

MUSCULOSKELETAL
- aching muscles/joints
- swollen joints
- muscle weakness
- fibromyalgia

SKIN
- itching, scaling
- rashes

ENDOCRINE
- weight change
- impotence
- always feel hot
- always feel cold
- drink a lot of fluids
- change in size of gloves/shoes

NERVOUS SYSTEM
- weakness
- numbness
- seizures
- speech impairment
- shaking
- change in handwriting
- difficulty walking

PSYCHIATRIC
- depression
- suicidal ideas
- trouble sleeping
- panic attacks
- nervousness
- memory impairment

ADDITIONAL INFORMATION

Do you wish to provide any additional helpful information that was not covered in the previous pages, or for which you did not have enough space to fill in.