NAME: ______________________________ **DATE:** ____________________

MEDICAL HEALTH QUESTIONNAIRE

PHYSICIAN USE ONLY
HEIGHT __________
WEIGHT __________
BP __________ Pulse ________

I. CURRENT INFORMATION:

1. What is the major problem leading to this visit?

2. If you had an injury, how were you injured and what was the date of your injury?

3. If you had an injury, have you ever had similar symptoms prior to the injury? If yes, were you ever treated by a medical provider for your symptoms?

4. What activities make your pain worse (please circle):

Sitting **Standing** **Walking** **Bending** **Lifting** **Laying Down**

5. What activities make you pain better (please circle):

Sitting **Standing** **Walking** **Bending** **Lifting** **Laying Down**

6. Please list all medications you are currently taking. Please list the drug, dosage, and how often you need to take it:

7. Please list any medications you are allergic to:

Are you allergic to Iodine? Yes / No

8. Please circle any of the follow imaging that have been done related to your problem:

X-RAYS, EMG, Bone Scan, CT, MRI

PREVIOUS TREATMENT:

9. What type of treatment have you had ***prior*** to your visit with our office today?

Please circle any medications that you have tried in the past:

NSAIDS
Aspirin (ASA)
Ibuprofen (Advil, Motrin)
Acetaminophen (Tylenol)
Naproxen
Celebrex
Diclofenac
Nabumatone (Relafen)

MUSCLE RELAXANTS
Flexeril
Robaxin
Soma
Skelaxin
Baclofen
Zanaflex

SLEEP AIDS
Trazodone
Temezepam
Lunesta
Ambien

NERVE/MOOD STABILIZERS
Lidocaine patch
Gabapentin
Lyrica
Topamax
Amitriptyline
Nortriptyline

Effexor
Cymbalta
Savella

Seroquel

OPIOIDS
Hydrocodone/acetaminophen (Norco)
Oxycodone/acetaminophen (Percocet)
Fentanyl (Duragesic) Patch
Morphine
Oxycontin
Methadone
Butrans Patch
Nucynta

Suboxone

Please indicate what type of therapy you have had in the past:

	DATE:	NUMBER OF VISITS	HELPFUL Y/N
Physical Therapy			
Chiropractic Therapy			
Acupuncture			
Massage Therapy			
Pool Therapy			
Yoga/Stretching			
Meditation			
Functional Restoration Program			
Pain psychologist/ Cognitive Behavioral Therapy			
Ice pack			
Heat			
TENS unit			
H-wave			
Back brace			
SI (sacroiliac) joint belt			
Wrist brace			

Any other treatments (Bowen therapy, traction, prolotherapy, etc):

Please indicate what type of procedures you have had in the past:

Circle if applicable:		DATE:	NUMBER OF VISITS	HELPFUL Y/N
Epidural steroid injections	**(neck) (low back)**			
Facet joint injections	**(neck) (low back)**			
Radiofrequency ablation	**(neck) (low back)**			
Injections of the:	**(knee) (shoulder) (ankle)**			
SI (sacroiliac) joint injections				
Trigger point injections	**(neck) (low back)**			
Previous surgery---neck or back				
Spinal cord stimulation	**(neck) (low back)**			

Have you seen a Surgeon in the past for your symptoms? (please circle)

Yes No

II. PAST HISTORY:

1. Please list all past surgeries and all past hospitalizations. Please include the year for each.

2. Please circle any of the following that you have had in the past:

MENINGITIS, ENCEPHALITIS, POLIO, FAINTING, CONVULSIONS, EPILEPSY, HEAD INJURY, UNCONSCIOUSNESS, DIABETES, TUBERCULOSIS, LUNG DISEASE, HIGH BLOOD PRESSURE, HEART DISEASE, STOMACH DISEASE, LIVER DISEASE, KIDNEY DISEASE, NECK TROUBLE, BACK TROUBLE, A STROKE, CANCER, VENEREAL DISEASE, HEPATITIS, HIV, AIDS. OTHER:

III. SOCIAL HISTORY:

1. Please circle all of the following that apply to you:

MARRIED DIVORCED SINGLE WIDOW

EMPLOYED UNEMPLOYED RETIRED DISABLED

2. Where were you born?

3. What is your highest level of education?

4. Do you drink alcoholic beverages (wine, beer, cocktails)?
   If so, how often, how much, and for how long?

5. Do you currently use tobacco? Yes: ___ No: ____

   If yes: How long? ____________________ How much? ______________________

   What form of tobacco do you use? ____

   If you have previously used tobacco and quit, when did you quit? __________________

   How much, and in what form were you using? ________________________________

6. Do you have any history of drug use or drug abuse?
   Please explain.

7. Have you ever been discharged from another medical practice because of medication noncompliance or urine toxicology result? If Yes, please explain:

IV. EMPLOYMENT HISTORY:

1. Are you currently employed?

2. What is your job title?

3. How long have you been employed at this job?

4. If you are not currently working:

   What was your last job? ______________________________

   When did the job end? ______________________________

   Why did the job end? ______________________________

   How long were you employed there? ____________________

5. Please list past jobs, and the length of time employed at each:

6. Please list your activities of interest:

IV. FAMILY HISTORY:

1. Are there any diseases that run in your family? If yes, please list:

2. Is there a history of back or neck problems in your family?
   If so who?

IMMEDIATE FAMILY HISTORY

	AGE, OR AGE AT DEATH	CAUSE OF DEATH	HEALTH	MAJOR DISEASES
FATHER				
MOTHER				
BROTHERS				
SISTERS				
CHILDREN				

V. REVIEW OF SYSTEMS (Please circle appropriate answer):

Do you have problems with:

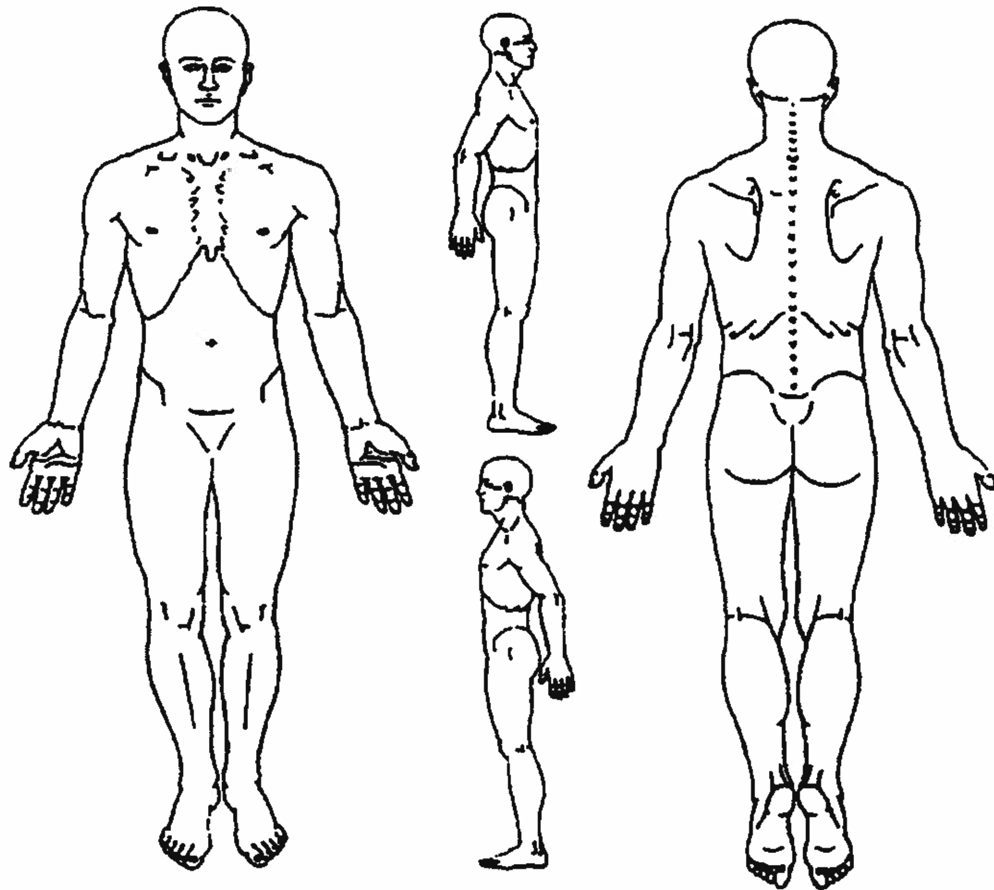
Cardiovascular	Chest Pain	Rapid Heartbeat	Leg/Ankle Swelling	Irregular Heartbeat		
Constitutional	Weight Loss/gain	Fever	Chills	Night Sweats	Fatigue	
Eyes	Blurry Vision	Eye Pain	Eye Discharge	Dry Eyes	Decreased Vision	
Gastrointestinal	Nausea/Vomiting	Stool incontinence	Blood in /black stool	Constipation	Heart burn	Diarrhea
Genitourinary	Bladder incontinence	Urinary Tract Infections	Trouble Urinating			
Musculoskeletal	Joint Pain	Muscle Pain	Joint Swelling	Muscle Weakness	Muscle Spasm	Stiffness
Neurological	Migraines	Numbness	Dizziness	Headaches	Loss of Balance	
Psychological	Depression	Anxiety	Insomnia			
Respiratory	Short of Breath	Cough	Wheezing	Pain with Breathing		
Skin	Rash	Sores	Itching	Easily bruises	Easily scars	

VI. PAIN DIAGRAM

Please mark you areas of pain:

Use the following descriptors to describe the quality of your pain:

Aching ^^^^ Numbness oooo Pins and Needles .... Burning **xxxx** Stabbing ////



Please number and mark the severity of pain you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

PAIN LEVEL WITHOUT MEDICATIONS :

0 1 2 3 4 5 6 7 8 9 10

PAIN LEVEL WITH MEDICATIONS :

0 1 2 3 4 5 6 7 8 9 10

TREATMENT AGREEMENT

We are delighted that you have chosen Spine & Nerve Diagnostic Center for treatment of your pain. Our mission is to help our patients improve their quality of life through an active and independent lifestyle. The following is our Pain Medication/Treatment Agreement. Please review this with your provider who can answer any questions you have about it.

****

I, ______________________________________ (Patient Name), understand that I have a right to comprehensive pain management. I wish to enter into a Pain Medication/Treatment Agreement ("Agreement") with Spine & Nerve Diagnostic Center. I understand that my treatment may or may not include the use of prescription pain medication. **I understand that failure to follow this Agreement in any manner may result in Spine & Nerve Diagnostic Center discontinuing prescription drug treatment and/or no longer providing any care to me.** This Agreement is to provide me with information regarding my treatment which may include prescription medications, and to ensure that I and my medical providers are complying with state and federal regulations concerning the taking and prescribing of prescription medications.

I understand that a trial of pain medicine which may include opioids can be considered for moderate to severe pain with the intent of reducing pain and increasing function. Spine & Nerve Diagnostic Center's goal is for me to have the best quality of life possible given the reality of my clinical condition.

I understand that if I have an opioid or prescription medication agreement with another provider or if I am receiving opioids (pain medications) from another provider, Spine & Nerve Diagnostic Center **will not** prescribe opioid medications to me.

(If applicable) The name of the provider prescribing opioids to me is:

____

Patient Initials: ________

1. I understand that I have the following responsibilities regarding my treatment:
    a. I will not come to the clinic without an appointment unless it is to pick up paperwork left for me by a provider.
    b. I will treat all Spine & Nerve Diagnostic Center staff and providers with respect and I will refrain from verbally abusive behavior. I understand that if I become abusive or harassing to Spine & Nerve Diagnostic Center staff and/or providers, that I will be discharged.
    c. I will provide 24 hour advance notification if I am unable to keep my appointment. I understand that failure to provide advanced notification or missing two (2) appointments without notification in a six-month period may result in my discharge from Spine & Nerve Diagnostic Center.
    d. I agree to be on time for my appointments. I understand that failure to be timely for appointments may result in my discharge from Spine & Nerve Diagnostic Center.
    e. I will take medications only at the dose and frequency prescribed.
    f. I agree to use one pharmacy for my prescription medications. I will inform Spine & Nerve Diagnostic Center if my pharmacy changes in the future. The name of my pharmacy is:

       ____
    g. I will not increase or change medications without the approval of a Spine & Nerve Diagnostic Center provider.
    h. I will not request opioids or any other pain medicine from physicians or providers other than from Spine & Nerve Diagnostic Center.
    i. I agree to participate in psychiatric or psychological assessments, if necessary.
    j. I understand that I will consent to random drug screening. A drug screening is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. The drug screen helps monitor my compliance with my pain control program.
    k. I will inform the providers at Spine & Nerve Diagnostic Center of all other medications that I am taking.
    l. I will keep my prescription medications in a safe place and away from minors. I understand that lost or stolen medications will not be replaced by Spine & Nerve Diagnostic Center providers.
    m. I will not take illegal, controlled substances such as methamphetamines, cocaine, heroin, etc.
    n. I will not give or sell my prescription medications to anyone.

2. I authorize Spine & Nerve Diagnostic Center to cooperate fully with any City, State or Federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medications. I authorize Spine & Nerve Diagnostic Center to provide a copy of this Agreement to my

Patient Initials: __________

pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

3. I understand that the providers at Spine & Nerve Diagnostic Center may stop prescribing opioids, change the treatment plan, or discharge me from their care if:

   a. I do not show any improvement in pain from opioids or my physical activity has not improved.
   b. My behavior is inconsistent with the responsibilities outlined in paragraphs 1, 2 and 3 of this Agreement.
   c. I develop rapid tolerance or loss of improvement from the treatment.
   d. If an addiction problem is identified as a result of prescribed treatment of any other addictive substance.

4. I am aware that there are potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. I am also aware about the possible danger associated with the use of opioids while operating heavy equipment or driving. I understand that the following are potential side effects of opioids:

   a. Confusion or other change in thinking abilities.
   b. Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles.
   c. Nausea or vomiting.
   d. Sleepiness or drowsiness.
   e. Constipation.
   f. Worsening of depression.
   g. Dry mouth.
   h. Breathing too slowly – overdose can stop your breathing and lead to death.

5. I understand that the potential side effects as outlined in paragraph 4 above may be made worse if I mix opioids with other drugs, including but not limited to alcohol and benzodiazepines. The following are the risks:

   a. Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:
      i. Runny nose; difficulty sleeping for several days; diarrhea; abdominal cramping; sweating; goose bumps; rapid heart rate; and/or nervousness.
   b. Psychological dependence. This means that it is possible that stopping the drug will cause me to miss or crave it.
   c. Tolerance. This means that I may need more and more opioids to get the same effect..

Patient Initials: ________

d. Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors.

e. Problems with pregnancy. If I am pregnant or contemplating pregnancy, I will discuss the use of opioids with my physician and OB/GYN.

I have read this document and have had all my questions answered satisfactorily. I understand that Spine & Nerve Diagnostic Center may terminate this Agreement at any time if there is cause to believe that I am not complying with the terms of this Agreement, or believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this Agreement. I understand that I may terminate this Agreement at any time.

______________________________ ____________

Patient Signature Date

____

Patient Name Printed

______________________________ ____________

Provider Signature Date

____

Provider Name Printed

Financial Responsibility

For Non-Workers Compensation Patients:

I, ____________________, understand that I am personally, financially responsible for any and all treatment through Spine & Nerve Diagnostic Center. This includes but is not limited to: Co-pays, co-insurance and deductibles. Co-pays are due on the date of my visit prior to seeing a Provider. I also understand that in the event that my insurance changes or terminates, it is my sole responsibility to notify Spine & Nerve Diagnostic Center prior to the date of my appointment. I understand that if my insurance changes and I have failed to notify SNDC and an authorization is required for an appointment, my appointment will be cancelled and I will be charged a no-show fee.

For Workers Compensation Patients:

I, ______________________, understand that if my workers compensation case settles or closes in any manner, and I fail to notify Spine & Nerve Diagnostic Center of the settlement or closure and I seek treatment after said settlement or closure, I am personally, financially responsible for any and all treatment through Spine & Nerve Diagnostic Center.

Please note that the Spine & Nerve Diagnostic Center Billing Department sends out monthly patient statements for non-workers compensation patients. You may at any time contact the billing department if you have any questions or concerns regarding your insurance, bill or balance. The phone number to reach our billing department is (916) 772 - 5325.

Thank you,

Spine & Nerve Diagnostic Center

______________________________ ____________________

Patient Signature Date

Spine&Nerve
DIAGNOSTIC CENTER

Acknowledgment of Receipt of Notice of Privacy Practices, Policies and Procedures

I hereby acknowledge that I reviewed this medical practice's Notice of Privacy Practices in the office or on-line at www.spinenerve.com. I further acknowledge that a copy of the current notice is available to me at the front desk, and I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ______________________ Date: ____________________

Print Name: ______________________

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: ______________________

____

____

I authorize Spine and Nerve Diagnostic Center to share/discuss my personal health information with the following family member or friend:

- ☐ I decline sharing my personal health information with anyone, Or
- ☐ I authorize the following person:

Name: ______________________ Relationship: ______________________

Patient Signature: ______________________ Date: ______________

Please let us know if who we can share your personal health information changes at any point

CANCELLATION AND NO SHOW POLICY

Office appointments require a minimum of 1 business day cancellation and procedure appointments require 2 business day cancellation notice. Without proper notification you will be subject to a no show fee. Patients who No-Show three (3) or more times in a year, may be dismissed from the practice and will be denied any future appointments.

Office Appointments – Minimum 1 business day cancellation

Procedures (injections and nerve studies) – Minimum 2 business days cancellation

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read understand and agree to this Cancellation and No show Policy.

____________________________ ____________________________

Print Name and DOB Patient signature

Financial Interest Statement

Business and Professions Code Section 2426 requires all physicians to report any financial interest in specified health-related facilities held by them or members of their immediate families. The information will be available to other governmental agencies and public and private third-party payers.

Dr. Vinay M. Reddy and Dr. Brian C. Joves are owners of Spine and Nerve Diagnostic Center which is a California Medical Corporation that provides health care services, clinical laboratory services, physical therapy, diagnostic imaging and testing, pharmacy services, clinical studies, and spinal injection procedures.

Dr. Vinay M. Reddy and Dr. Brian C. Joves also have ownership interest at Fort Sutter Surgery Center, located at 2801 K St #525, Sacramento, CA 95816.

Dr. Brian C. Joves has ownership interest at Roseville Surgery Center, located at 1420 E Roseville Pkwy Suite 100, Roseville, CA 95661.

Patient Acknowledgement:

I, the name patient or legal representative of such patient, hereby acknowledge reading and receipt of a copy of the foregoing Physician Disclosure of Financial Interest.

____________________________ ____________

Printed Name: Date:

____

Signature:

Electronic Communication Authorization Form

Electronic communication is fast becoming the preferred method of communication for many of our patients. If you would like us to communicate with you via electronic mail or text message regarding recent health updates, changes to policy, advances in medicine, etc., please list your name and e-mail address below. Your privacy is important to us and your electronic address will not be shared with anyone.

Name: ______________________________

Signature: ______________________________

E-Mail Address: ______________

Cell Phone #: ______________

New Patient Acknowledgement

We are delighted that you have been referred to Spine & Nerve Diagnostic Center for a new patient consult. Our mission is to help our patients improve the quality of their lives through an active and independent lifestyle.

The first visit to our practice is designed to review your medical condition, pinpoint the source of your pain, and collaborate with you on your treatment choices. A key element of our review revolves around your diagnostic studies, such as an MRI and nerve mapping provided by an EMG-Nerve Conduction Study. If these diagnostic studies are either unavailable or over two-years old, we will likely need to help you obtain them.

We will also need to gain a clear understanding of the treatment options you have either tried or are currently using to relieve your pain. It is often as important to know about treatments that have been ineffective as those that have worked well, so please be prepared to discuss these.

Since medications are often used as a central element of treating chronic pain, we will need to evaluate the type and dosage of your current medications, which may include opioids, such as Norco, Vicodin, or Oxycodone. If you are taking an opioid dosage above the levels recommended by the Centers for Disease Control and Prevention, we will counsel you on your alternatives, which may include a referral outside of our practice.

______________________________ ____________

Patient Signature Date:

____

Patient Name

1 A full report can be found at www.cdc.gov/HomeandRecreationalSafety/Poisoning/brief.htm

Opioid Risk Tool

Patient Form

Patient Name: ______________________ **Date:** ______________

Please Circle One: **Female** **Male**

		Please Mark all That Apply Yes	Please Mark all That Apply NO
1. Family history of substance abuse	▪ Alcohol ▪ Illegal drugs ▪ Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
2. Personal history of substance abuse	▪ Alcohol ▪ Illegal drugs ▪ Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
3. Age (mark if 16-45 years)		[ ]	[ ]
4. History of preadolescent sexual abuse		[ ]	[ ]
5. Psychological disease	▪ Attention-deficit/ hyperactivity disorder, obsessive compulsive disorder, bipolar disorder, schizophrenia ▪ Depression	[ ] [ ]	[ ] [ ]

Name:______________________________ Date:______________________________

DOB:______________________________ Provider:______________________________

GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

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NAME:________________

DATE:________________ DOB:____________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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Name: ____________________ **Todays' Date:** _____________

DOB: _________

Initial Opioid Questionnaire

1. Are you on opioid (narcotic) pain medications:

   YES NO

2. If you answered YES to question 1, what medications and what doses and frequency are you currently on? If you answered NO, skip to question 5.

3. Who currently prescribes your opiate medications? Are they going to continue prescribing?

4. What other pain medications have you tried?

5. Do you believe that you may be requiring some opioid (narcotic) pain medication on this visit?

   YES NO