LOTUS
Spine & Pain

Patient's Name_____ D.O.B_____

Phone Number _____ Alternate number _____

S.S #_____

Address: _____

Appointment:

Date_____ Time_____ Reason for visit _____

Primary Insurance

Name of insurance_____ Phone #_____

Policy holder name_____ S.S # _____

Insurance Id #_____ Group #_____

Secondary Insurance

Name of insurance_____ Phone #_____

Policy holder name_____ S.S # _____

Insurance Id #_____ Group #_____

Authorization #_____ Copay$_____ Deductible $_____ Met$_____

Out of pocket$_____ Met $_____

Assignment of Benefit: I hereby authorize payment directly to physician of benefits due to me for his/her services, I understanding I am financially obligated for charges not covered by this authorization. I authorize the release of any medical or other information necessary to process this claim.

Signature: _____ Date_____

Printed Name: _____

LOTUS
Spine & Pain

PATIENT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number | Male/Female

Marital Status | Race (optional) | Language other than English

Home Address | Apt # | City | State | Zip

Home phone | Work Phone | Alternative phone

Email Address | Employer | Occupation

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | Referring Physician

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient (If self, skip to Emergency Contact)

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Home Address | Apt# | City | State | Zip

Home Phone | Work Phone | Other Phone

EMERGENCY CONACT INFORMATION/AUTHORIZED HIPPA CONTACT

Last Name | First Name | Relationship to Patient

Home Address | Apt # | City | State | Zip

Check the treatments you have had for pain: (circle all that apply)

Acupuncture Physical Therapy Trigger Points Massage Exercise Tens Unit
Chiropractor Brace Surgery Facet Blocks Radiofrequency Neurotomy
Epidural Nerve Blocks Biofeedback Other: _____

Imaging Studies/Test Done: (Circle all that apply)

MRI CT Scan X-rays EMG/NCV Results of Test: _____

PAST MEDICAL HISTORY (circle all that apply)

Constitutional
Obesity Weight Loss Weight Gain Cancer

Musculoskeletal
Arthritis Fibromyalgia Muscle Spasms

Neurological
Headache Seizures Migraines Stroke

Psychiatric
Depression Substance Abuse Anxiety
Bipolar Schizophrenia

Cardiovascular
Angina Heart Attack Heart Stent
Pacemaker High Blood Pressure (hypertension)

Respiratory
Asthma Emphysema Chronic Bronchitis
Lung Cancer Obstructive sleep Apnea COPD

Gastrointestinal
Reflux Hepatitis Ulcer
Irritable Bowel Syndrome Heartburn
Cirrhosis Diverticulitis Colon Cancer

Genitourinary
Impotence Kidney Stones Incontinence

Endocrine Hematologic Allergy/Immunologic
Diabetes Hypothyroidism Hyperthyroidism
HIV Hyperlipidemia (Elevated Cholesterol)

Rheumatologic
Lupus Sjogrens Scleroderma
Polymyalgia Rheumatica Rheumatoid Arthritis

REVIEW OF SYSTEMS (circle all that apply)

Constitutional
Chills Fever Fatigue

Musculoskeletal
Numbness Weakness

Neurological
Confusion Dizziness Light Sensitivity

Psychiatric
Suicidal Thoughts Difficulty Sleeping

Cardiovascular
Chest Pain Palpitations

Respiratory
Cough Shortness of Breath

Gastrointestinal
Diarrhea Constipation Abdominal Pain Bloating
Nausea Vomiting

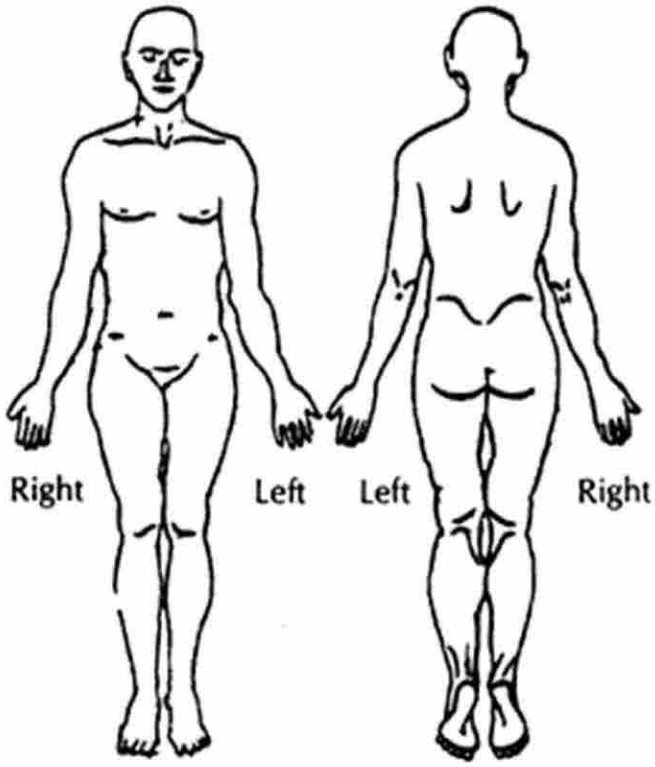
Genitourinary
Decreased Libido Urinary Frequency

Endocrine Hematologic Allergy/Immunologic
Easy Bruising Ringing In Ears

Surgical History (circle all that apply)

Appendectomy Tonsillectomy/Adenoids Gallbladder Surgery Coronary Bypass Hernia Repair Tubal Ligation
Mastectomy Hysterectomy Breast Biopsy Prostate Vasectomy Knee Replacement Hip Replacement Knee
Surgery Shoulder Surgery Cataracts Colon Liver Surgery
Lumbar Spinal Surgery/Back Surgery: _____
Cervical Spinal Surgery/Neck Surgery: _____
Other: _____

MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN. ALSO INDICATE ANY NUMBNESS, TINGLING, BURING, AND SPASMS.



Notes: _____

Pain:

When did the pain begin? _____

How did the pain start? _____

Duration of pain: (Circle) 1-4 weeks 1-3 months 3-6 months Less than 1 year Many Years

How often does pain occur? (Circle) Constantly Frequently Occasionally Intermittently Less than Daily Monthly

Describe your pain: (Circle) Throbbing Shooting Sharp Cramping Hot/Burning Aching Stabbing Tingling

Numbing Dull-Ache Other: _____

How do the following factors affect your pain? (Choose 0-10, 0 being no pain and 10 being the worst pain.)

Standing _____ Walking _____ Sitting _____ Rising from the Seated Position _____ Rising from the Lying Position _____

Lifting _____ Carrying _____ Stairs_____ Sneezing _____ Coughing _____ Weather _____

What is your current pain level? (Use the same 0-10 pain scale.) _____

Best pain level? _____

Worst pain level? _____

Women: Are you pregnant? Yes_____ No_____ Not Sure_____ Patient's Initials: _____

Social History:

Do you smoke? Yes_____ No_____ If yes, how much per day? _____ How long? _____

Do you drink? Yes_____ No_____ If yes, how often? _____

Do you use illicit drugs? Yes_____ No_____ If yes, how often? _____

Family History:

Please circle: Mother Father Siblings
Diabetes Heart Kidney Cancer Depression Back

Other (Please explain): _____

Allergies:

Please circle: Latex IV Contrast Betadine/Iodine Shellfish/Seafood
Other: _____

Drug Allergies:

Please list all known drug allergies: _____
_____

Current Medications:

Please list all current medications:

Medication	Dose	Prescriber	Medication	Dose	Prescriber

Are you currently taking any blood thinners? _____

Past pain medications tried: _____

_____

_____

I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE

_____ _____
Patient or Legal Guardian Signature Date