Las Sendas Spine Institute

3654 N Power Rd # 143, Mesa, Arizona 85215 ~ Ph: 480.396.8665

Patient Information

Date:_____

Patient Name: _____ _____ _____
Last First M.I.

Local Address: _____ _____ _____ _____
Street City State Zip

Phone: _____ _____ _____
Home Work Cell

Age ☐ ☐Male ☐Female _____ _____ _____
Birthdate Social Security # Email

_____ _____ _____
Patient Employer Occupation Employers Address

☐Married ☐Widowed ☐Single Spouse's Name: _____

_____ _____
Spouse's Employer Spouse's Phone#

_____ _____ _____ _____
Emergency Contact Relationship Home Phone Cell/Work

IF YOU ARE A WINTER VISITOR, COMPLETE THE INFORMATION BELOW

Summer Address _____ Apt/Space#_____
City _____State ____Zip _____Phone#_____

Have you ever had a Bone Mineral Density Scan for Osteoporosis? _____YES _____NO If you answered YES:
(1) Was the test taken within the last 12 months?
(2) What were you told the results were?
(3) Where was the last test performed:

Will verify insurance at time of appointment

Signature of Fact, Receipt of Notice Privacy Policies, Acknowledgement of Insurance Assignment and Release

I understand that my care in this office may involve the making of judgments that are based upon the facts known by the doctor. Therefore, the above information is true & complete to the best of my knowledge. *I acknowledge that I have received, reviewed understand and agree to the Notice of Privacy Practices of Las Sendas Spine Institute which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice*. I certify that I have insurance coverage and assign directly to Las Sendas Spine Institute all insurance benefits. 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 of all insurance submissions.

_____ _____
Patient's/Parent's/Legal Guardian's Signature Date

_____ _____
Dr. Signature Date

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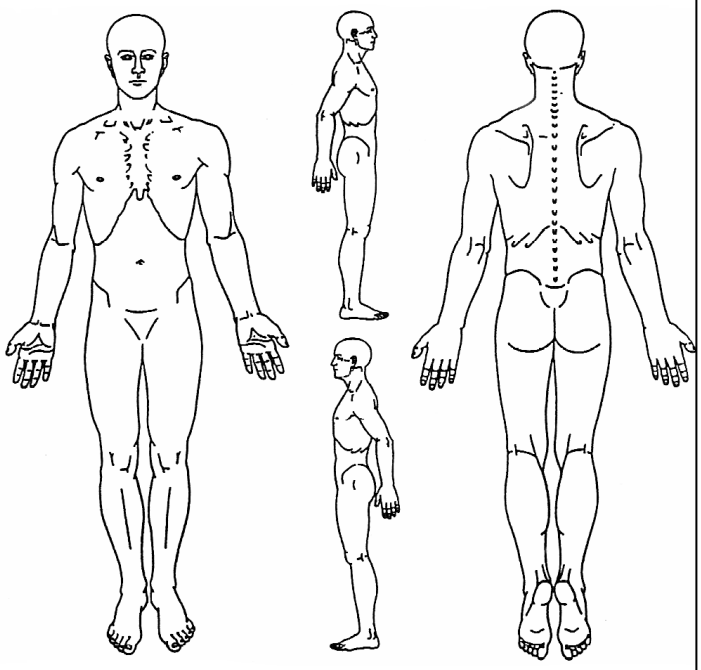
Date: _____ ***Patient Condition***

Mark an **X** on the picture where you continue to have pain, numbness, or tingling .



What is your **main** complaint?

_____

When did your symptoms appear?

_____

Is this condition getting progressively worse? □Yes □No □ Unknown

Type of pain: □Sharp □Aching □Throbbing □Dull □Shooting □Numbness □Burning □Tingling □Cramps □Stiffness □Swelling □Other

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain?

_____

Is it constant or does it come and go?

_____

What makes it feel better?

_____

What makes it feel worse?

_____

Does it interfere with your: □Work □Sleep □Daily Routine □Recreation

Activities or movements that are painful to perform:
□Sitting □Standing □Walking
□Bending □Lying Down

Please Mark each that applies to your Daily activities:

□ Stay at home most of the time due to the problem.
□ Changes position frequently to try and get comfortable.
□ Walks more slowly than usual because of the problem.
□ Does not do jobs around the house because of the problem.
□ Has to use handrails to get up stairs, etc.
□ Has to lay down and rest frequently due to the problem.
□ Has to hold on to something to sit or stand from a chair.
□ Have to get other people to do things for you.
□ Has difficulty getting dressed due to the problem.
□ Has a loss of appetite due to the problem.
□ Can only walk short distances due to the problem.
□ Have difficulty sleeping because of the problem.
□ Has to sit most of the day because of the problem.
□ Are more irritable because of the problem.
□ Stays in bed most of the day because of the problem.

Dr. Signature _____

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Date: _____ ***Health History***

What treatment have you already received for your condition? □Physical Therapy □Surgery □ Medications
□Chiropractic Services □Bed Rest □Epidural Injections □None □Other
Name of other doctor(s) who have treated you for your condition: _____
Doctor's Address:_____Date Last seen :_____
Date of Last: Physical Exam _____ Spinal X Ray _____ Blood Test _____
Spinal Exam _____ MRI, CT-Scan, Bone Scan_____

Relevant Medical History: (Please check the condition that you have now or have had previously)

Current / Past		Current / Past		Current / Past	
□	□ Abdominal Pain	□	□ Frequent Urination	□	□ Numbness
□	□ Anemia	□	□ Hand or wrist pain	□	□ Pacemaker
□	□ Appendicitis	□	□ Headaches	□	□ Parkinson's Disease
□	□ Arthritis	□	□ Heartburn	□	□ Painful Urination
□	□ Asthma	□	□ Heart Disease	□	□ Polio
□	□ Back Pain	□	□ Hepatitis	□	□ Prostate Problem
□	□ Bleeding Disorders	□	□ Hernia	□	□ Prosthesis
□	□ Breast Lumps	□	□ Herniated Disk	□	□ Psychiatric Care
□	□ Cancer	□	□ High Blood Pressure	□	□ Rheumatic Fever
□	□ Cataracts	□	□ High Cholesterol	□	□ Seizures
□	□ Cold Hands/Feet	□	□ HIV	□	□ Sciatica
□	□ Concussion	□	□ Hot Flashes	□	□ Sinus Trouble
□	□ Convulsion	□	□ Kidney Stones	□	□ Stroke
□	□ Circulatory Problems	□	□ Measles	□	□ Thyroid Problems
□	□ Depression	□	□ Menstrual Cramps	□	□ Tuberculosis
□	□ Diabetes	□	□ Menstrual Irregularity	□	□ Tumors, Growths
□	□ Difficulty Urinating	□	□ Multiple Sclerosis	□	□ Ulcers
□	□ Digestion Problems	□	□ Mumps	□	□ Varicose Veins
□	□ Dizziness	□	□ Osteoporosis	□	□ Venereal Disease
□	□ Epilepsy	□	□ Muscular Dystrophy	□	□ Whiplash
□	□ Excessive Thirst	□	□ Neck Pain/Spasm	□	□ Other_____
□	□ Fibromyalgia	□	□ Neuritis		_____

EXERCISE	□None □Moderate □Daily □Heavy
WORK ACTIVITY	□Sitting □Standing □Light Labor □Heavy Labor
HABITS	□Smoking Packs/Day _____ □Alcohol Drinks/Week_____ □Coffee/Caffeine Drinks Cups/Day_____ □High Stress Level Reason
Previous Hospitalizations: □Yes □No If yes, why?	(Women) Are you Pregnant? □Yes □No

Injuries/Surgeries you have had

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Dr. Signature _____