ORION
SPINE AND PAIN

New Patient Registration

Demographic Information

Patient Name:_____

DOB: _____ Sex:_____

Mailing address:_____

City: _____State:_____Zip Code:_____

Email:_____

Cell number: _____Home number:_____

Employer Name:_____

Employer phone:_____

Primary care physician:_____

PCP practice name: _____

Referring physician:_____

Pharmacy name:_____

Pharmacy address:_____

City: _____State: _____ Zip Code:_____

Pharmacy phone number:_____

Marital Status:_____

Ethnicity:_____

Emergency Contact Information

Emergency contact name:_____

Relationship to patient:_____Phone number:_____

Additional information

Do you have an Advanced Directive:_____

Can you provide us with a copy:_____

Power of Attorney for medical decisions:_____

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Insurance Information

Primary Insurance company:_____

Insurance phone number:_____

Insurance address:_____

City: _____State: _____ Zip Code:_____

Insurance ID number:_____Group number:_____

If applicable:

Secondary Insurance company:_____

Insurance phone number:_____

Insurance address:_____

City: _____State: _____ Zip Code:_____

Insurance ID number:_____Group number:_____

Responsible party/Insured's information

Name:_____

DOB: _____ Sex:_____

Address:_____

City: _____State:_____Zip Code:_____

Email:_____

Phone number: _____SSN:_____

Relationship to patient:_____

Employer Name:_____

Employer phone:_____

Employer Address: _____

Open Workman's Comp or MVA claims

_____

_____

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Pain Questionnaire

Location of primary area of pain:_____

When did it start (year+/-month): _____

What happened and when?(fall/accident)_____

Does the pain stay in one area or radiate?_____

Is your pain constant or intermittent: _____

On a scale of 0 to 10, how bad is your pain today? (0=no pain and 10= severe pain) :_____

On a scale of 0 to 10, how bad is your average pain score in the last 30 days ? :_____

How would you describe your pain ? (sharp/burning/aching)_____

Is the pain associated with tingling/numbness or both?_____

What makes your pain worse?_____

What makes your pain better?_____

Have you tried PT for this pain? When and for how long? What was the response?

_____

Have you tried NSAIDS for this pain? When and for how long? What was the response?

_____

Have you tried any other medication or treatment (Chiropractor/massage/TENS/acupuncture/ brace/injections/lifestyle modification/ointments/heat or ice/psychosocial support)for this pain? Which one helped?How long did you try it?_____

_____

_____

How does this pain affect your sleep, mood,work,social activities and relationships?_____

_____

How does this pain affect your function? Name at least 2 activity of daily living which are affected:

_____

If x-ray/CT/MRI was done of that body part, then where can we get the report?_____

_____

Have you seen another pain management doctor in the past? Please tell us who and when? Why did you leave?_____

_____

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Health History

Age:_____Height:_____Weight:_____

Past Medical history:

☐Diabetes ☐Abnormal kidney function ☐Abnormal liver function ☐Acid reflux ☐Stomach ulcers

☐Bleeding disorder ☐Osteoporosis ☐Cancer ☐Arthritis ☐Sleep apnea ☐COPD ☐HIV/Hepatitis HIV

☐Anxiety ☐Depression ☐any other?

_____

Past Surgical history-specify details and write down the year if you had surgery on your:

☐Neck ☐ Back ☐ Knees ☐ Hips ☐ Shoulder ☐ Heart ☐ Bones/nerves

_____

_____

_____

Are you taking any blood thinners?(including Goody's powder,aspirin,herbal supplements)?Name and dose_____

Are you taking any medication (prescribed/OTC/Vitamins/Herbal supplements): Name and dose

_____

_____

_____

Are you allergic to:

☐Latex ☐ Adhesive ☐ Contrast Dye ☐ Lidocaine/Marcaine ☐Betadine/Chloroprep ☐Antibiotics

any other?_____

Have you had any falls since you last saw your PCP?

Social history:

☐ Alcohol use ☐ Tobacco use ☐ Recreational Drug Use ☐ Marijuana use

☐ History of alcohol abuse ☐ History of prescription or illicit drug abuse