SPINE & EXTREMITIES CENTER

Today's Date: ______________________ Referred by: ______________________

Patient Name: ____________________________________________

Address: ____________________________________________

City: ______________________ State: ______________ Zip: __________

Phone Number: ______________________ Email: ______________________

Date of Birth: ______________ Age: ______________ Occupation: ______________

Emergency Contact: ______________ Phone: ______________ Relationship: __________

Primary Care Provider: ______________________ Phone: ______________________

***The following is very important in our evaluation process. Please answer these questions as specifically as possible to provide us with a clear picture of your present pain and functional status.***

**Do you have any allergies or sensitivities?** □ Yes □ No If yes, please list: ______________________

____________________________________________

**Are you currently taking any medications?** □ Yes □ No If yes, please list: ______________________

____________________________________________

____________________________________________

**Are you currently taking any aspirin, ibuprofen, minerals, herbs or nutritional supplements?** □ Yes □ No

If yes, please list: ____________________________________________

**Lifestyle**: Do you smoke, vape, or chew tobacco? □ Yes □ No Recreational drug use? □ Yes □ No

**Women only**: Are you pregnant, nursing, or planning a pregnancy? □ Yes □ No

**Have you experienced any of the following?**

High or Low Blood Pressure □ Yes □ No
Seizures/Epilepsy □ Yes □ No
Stroke □ Yes □ No
Hepatitis □ Yes □ No
Hemophilia/bleeding disorder □ Yes □ No
Rheumatoid arthritis □ Yes □ No
Osteoporosis □ Yes □ No
Aneurysm □ Yes □ No
Complex regional pain syndrome □ Yes □ No
Diabetes □ Yes □ No
Hormone Replacement Therapy □ Yes □ No

Circulatory problems □ Yes □ No
Fainting or dizzy spells □ Yes □ No
DVT/Blood clots □ Yes □ No
Autoimmune disease □ Yes □ No
Migraine headaches □ Yes □ No
Cancer □ Yes □ No
Scleroderma □ Yes □ No
Hyper or Hypopigmentation □ Yes □ No
Keloid scars □ Yes □ No
Treatment with Accutane □ Yes □ No
Other: ______________________

**What is the primary issue or problem that brings you in today?** (check all that apply)

- □ Lower back pain
- □ Thoracic/mid back
- □ Neck pain
- □ Shoulder pain
- □ Elbow pain
- □ Headaches
- □ Knee pain
- □ Hip pain
- □ Plantar fasciitis
- □ Foot/ankle pain
- □ Skincare
- □ Fatigue
- □ Lack of energy
- □ IV Drip Therapy
- □ NAD Therapy

Does the pain or symptoms radiate into your hips or legs? □ Yes □ No

Does the pain or symptoms radiate into your arms? □ Yes □ No

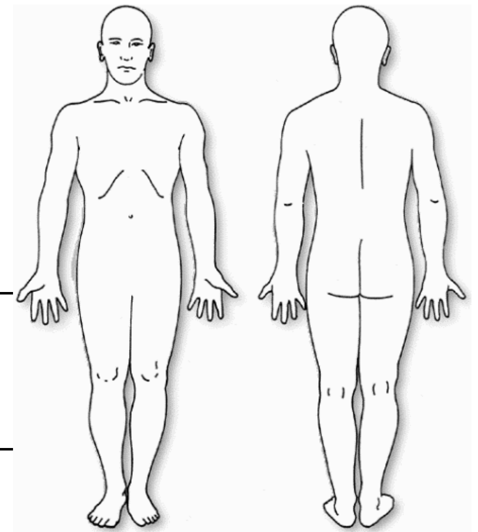
Have you had imaging (MRI, X-ray, etc.) for this condition? □ Yes □ No

Have you had previous interventional pain management (such as epidural steroids or steroid/cortisone shots) for this condition? □ Yes □ No ______________________________

**Please describe your pain:**

- □ Burning
- □ Electric Shock
- □ Crawling
- □ Spontaneous
- □ Relieved by posture or movement pattern
- □ Dull
- □ Sharp
- □ Ache
- □ Intermittent

**Please shade in areas of pain/concern:**



**When did your symptoms begin?** ______________________________

**Did anything cause or start the pain?** (accident, illness, or injury?)

______________________________

**Are you currently experiencing any of the following?**

| | | |
|---|---|---|
| Fever | □ Yes | □ No |
| Unintentional weight loss/gain | □ Yes | □ No |
| Night sweats | □ Yes | □ No |
| Difficulty walking | □ Yes | □ No |
| Severe neck pain | □ Yes | □ No |
| Swelling in your arms or legs | □ Yes | □ No |
| Bladder or bowel incontinence | □ Yes | □ No |
| Numbness/anesthesia in your groin | □ Yes | □ No |
| Severe headache | □ Yes | □ No |
| Dizziness or visual disturbances | □ Yes | □ No |

*** Do you currently have any of the following?**

| | | |
|---|---|---|
| Pacemaker | □ Yes | □ No |
| Implanted spinal stimulator | □ Yes | □ No |
| Cochlear implant | □ Yes | □ No |

Other: ______________________________

*** Please list your previous surgical history**: ______________________________

______________________________

**Please rate your pain in the last 24-72 hours using the "0-10" scales where 0 is no pain and 10 is worst:**

At its worst: ________ At its best: ________ At present: ________ When sleeping: ________

At what time of the day are your symptoms the worst? ____________________

At what time of day are your symptoms the best? ____________________

What activities increase your pain? ____________________

What activities decrease your pain? ____________________

Do you have discomfort, shortness of breath, or pain with exercise? □ Yes □ No

If yes, please has this been evaluated by a physician? □ Yes □ No

***For regenerative aesthetic patients only:***

What type of skin do you have?

□ Normal □ Dry □ Oily □ Combination

What areas of concern do you have regarding your skin?

□ Breakouts/Acne □ Blackheads/Whiteheads □ Sun Damage
□ Uneven skin tone □ Wrinkles/Fine lines □ Dull/Dry skin
□ Hyperpigmentation □ Broken Capillaries □ Rosacea

Other: ____________________

Do you currently or have you used in the last 3 months: Retin-A, AHA's or Retinol/Vitamin A derivate products? □ Yes □ No If yes, please list: ____________________

Please describe your goals and expectations: ____________________

To the best of my knowledge, the information on the form is accurate. I understand that providing false information can be dangerous to my health. It is my responsibility to inform Spine & Extremities Center of ***any*** changes to my medical history.

**Printed Name**: ________________________ **Signature**: ____________________________ **Date**: _______________
**(**patient, parent, or representative)

*Staff Signature:*_________________________________ *Date:* _______________

**Cancellation/ Late Arrival Policy**: 24-hour notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. Failure to do so will result in the service being charged in full. If you arrive late, your session will be shortened to accommodate appointments that follow yours. Regardless of the length of the treatment, the session will be charged in full.

**Printed Name**: ________________________ **Signature**: ____________________________ **Date**: _______________
**(**patient, parent, or representative)

**Liability Policy**: Spine & Extremities Center is not responsible for any items that you may leave unattended. We strongly recommend leaving expensive, personal items at home, or locked in your care. If you do bring them with you, be sure to gather all items from the treatment room prior to leaving.

**Printed Name**: ________________________ **Signature**: ____________________________ **Date**: _______________
**(**patient, parent, or representative)

**Imaging Policy:** If imaging is ordered by one of our providers you may have the imaging performed at the facility of your choice. If you obtain your imaging at Clarion Hospital or a Butler Health System (BHS) facility Dr. Barrett will be able to view your images directly as he is on staff and is credentialed and contracts to provide professional interpretation services at these facilities. If you go to a facility other than Clarion Hospital or a Butler Health System (BHS) site please ask the staff to provide you with a CD copy of your images and bring to your follow up appointment. If your imaging results show anything that needs more urgent attention, we will contact you sooner, otherwise they will be discussed at your follow-up visit. Most facilities also have patient portals to access these reports. If you have any questions about your imaging results prior to a follow-up visit, please call our office.

**Printed Name**: ________________________ **Signature**: ____________________________ **Date**: _______________
**(**patient, parent, or representative)

**Notice of Privacy Practices/HIPAA**: In general, any information that is about your health, the health care you receive, or payment for that care is considered confidential under HIPAA compliance statutes and protected by our Company. We may need to use your Protected Health Information to carry out treatment, payment, healthcare operations and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures. The form is found on our website (www.spineandextremitiescenter.com) and is available at our center for you to read and take home with you. By signing below, I acknowledge the receipt of the Notice of Privacy Practices at Spine & Extremities Center, PC.

**Printed Name**: ________________________ **Signature**: ____________________________ **Date**: _______________
**(**patient, parent, or representative)