PHONE/FAX 702.779.3994
SUSPINEANDSPORTS.COM English / Espanol / Chinese

2585 Montessouri Street, Suite 100
Las Vegas, NV 89117

2995 South Jones Blvd.
Las Vegas, NV 89146
(Personal Injury Only)

NEW PATIENT FORM

NEW PATIENT INFORMATION

Name: ____________________ Gender: [ ] Male [ ] Female

DOB: ____________________ SSN ____________________

Address: ____________________

Home Phone: ____________ Cell Phone: ____________ Email: ____________

MAIN SYMPTOMS

What is the most important reason for your visit today? ____________________

Where is it the most painful? ____________________

If the pain radiates, where does it radiate to? ____________________

Any other additional areas of pain? ____________________

When did this pain start? ____________________

What might cause this pain? ____________________

How did this pain happen? [ ] Gradually [ ] Suddenly

How has your pain changed since first happened? [ ] Increased [ ] Decreased [ ] The same

QUALITY OF PAIN:

[ ] Tiring / Exhausting [ ] Aching [ ] Cramping [ ] Dull [ ] Hot / Burning [ ] Numbness [ ] Shock-like

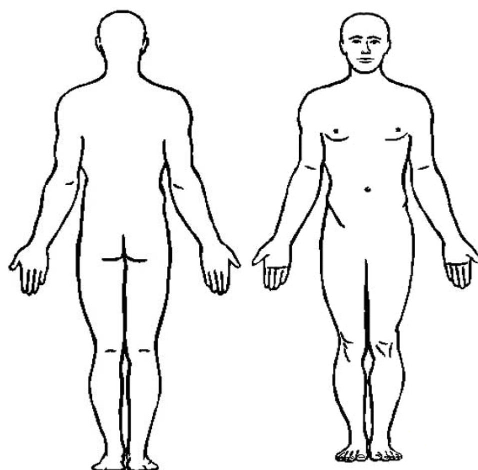
[ ] Shooting [ ] Spasming [ ] Squeezing [ ] Stabbing / Sharp [ ] Throbbing [ ] Tingling / Pins & Needles

TIMING OF PAIN

What is the frequency of your pain? [ ] Constant [ ] Intermittent

When is the most painful? [ ] Morning [ ] Day time [ ] Evenings [ ] Midnight

MARK THE LOCATION OF YOUR PAIN ON THE PICTURE



PAIN HISTORY:

Indicate your pain level with number, from 0 to 10.

Describe Your Pain:
0 = No Pain; 10 = Extreme Pain

My **current** pain is **[ ]**
The **best** of the pain in the past week is **[ ]**
The **worst** of the pain in the past week is **[ ]**
The **average** of the pain in the past week is **[ ]**
The **average** of the pain in the past 3 months is **[ ]**

How Much Does Pain Affect Your Daily Life:
0 = Strongly Disagree; 10 = Strongly Agree

I have trouble sleeping **[ ]**
I have trouble feeling comfortable **[ ]**
I am less independent **[ ]**
I am unable to work **[ ]**
I need to take more medication **[ ]**

Describe Your Feelings:
0 = Strongly Disagree; 10 = Strongly Agree

Afraid **[ ]**
Depressed **[ ]**
Tired **[ ]**
Anxious **[ ]**
Stressed **[ ]**

Activities Negatively Affected By Pain:
0 = Strongly Disagree; 10 = Strongly Agree

Go to the store **[ ]**
Do housework **[ ]**
Enjoy with my family and friends **[ ]**
Exercise **[ ]**
Participate in my hobby **[ ]**

HAVE YOU DEVELOPED ANY NEW SYMPTOMS RECENTLY?

[ ] Balance problem **[ ] Bladder incontinenc** **[ ] Bowel Incontinence** **[ ] Chills** **[ ] Difficulty Walking**
[ ] Fevers **[ ] Nausea** **[ ] Vomiting**

[ ] Numbness or Tingling? Please list the location: ______________________________

[ ] Weakness? Please list the location: ______________________________

[ ] I have NOT recently developed any of the above conditions.

DIAGNOSTIC IMAGING HISTORY

What tests have you had for your pain complaint?

[ ] MRI of the ______________ **Date** ______________ **Facility** ______________

[ ] X-ray of the ______________ **Date** ______________ **Facility** ______________

[ ] CT of the ______________ **Date** ______________ **Facility** ______________

[ ] EMG/NCV study of the ______________ **Date** ______________ **Facility** ______________

[ ] Ultrasound of the ______________ **Date** ______________ **Facility** ______________

[ ] Other diagnostic testing

[ ] I have NOT had any diagnostic tests for this pain complaints.

PAST TREATMENT HISTORY

Which of the following treatments have you undergone for your pain?

[ ] Chiropractic   [ ] Physical Therapy   [ ] Spine Surgery

Trigger Point Injections   If Yes, where?

[ ] Epidural Steroid Injection: **[ ] Cervical   [ ] Thoracic   [ ] Lumbar**

[ ] Medial Branch Blocks of Facet Injections: **[ ] Cervical   [ ] Thoracic   [ ] Lumbar**

[ ] Radiofrequency Ablation: **[ ] Cervical   [ ] Thoracic   [ ] Lumbar**

[ ] Spinal Column Stimulator: **[ ] Trial Only   [ ] Permanent Implant**

[ ] Other treatments: ______________________________

[ ] I have NOT had any treatment yet.

Medication Regimen

Are you TAKING any medication for blood-thinner?   [ ] Yes   [ ] No

If yes, please mark which one you are taking: [ ] Aggrenox   [ ] Coumadin   [ ] Effient   [ ] Eliquis

[ ] Lovenox   [ ] Plavix   [ ] Pletal   [ ] Pradaxa   [ ] Ticlid   [ ] Warfarin   [ ] Xarelto   [ ] Other

List the name and phone number of the doctor who prescribed the blood medication for you.

1.

List ALL medications you are TAKING.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

ALLERGY RECORD

Are you allergic to: [ ] Iodine [ ] Tape [ ] Shellfish [ ] Peanuts [ ] Latex?

Do you require special medications or rescue measures to manage your latex allergy? ____________________

Are you allergic to or reacting to any medication? **[ ] Yes** **[ ] No**

If yes, please list ALL medications name and allergy reaction types. ____________________

PAST MEDICAL HISTORY

What Diseases or Conditions that you have been treated for?

General Medical: [ ] Cancer Type [ ] Diabetes Type [ ] HIV / AIDS

Head / Eyes / Ears / Nose / Throat: [ ] Glaucoma [ ] Headaches [ ] Head Injury [ ] Hyperthyroidism [ ] Hypothyroidism [ ] Migraines

Respiratory: [ ] Asthma [ ] Bronchitis [ ] Emphysema / COPD [ ] Pneumonia [ ] Tuberculosis [ ] Valley Fever

Cardiovascular/Hematologic: [ ] Anemia/Bleeding Disorders [ ] Heart Attack [ ] High Blood Pressure [ ] High Cholesterol [ ] Hypertension [ ] Mitral Valve Prolapse [ ] Murmur [ ] Pacemaker / Defibrillator [ ] Poor Circulation [ ] Stroke

Hepatic: [ ] Hepatitis A (active / inactive / unsure) [ ] Hepatitis B (active / inactive / unsure) [ ] Hepatitis C (active / inactive / unsure)

Gastrointestinal: [ ] Acid Reflux (GERD) [ ] Bowel Incontinence [ ] Constipation
[ ] Gastrointestinal Bleeding

Genitourinary / Nephrology: [ ] Bladder Infection [ ] Dialysis [ ] Kidney Infection [ ] Kidney Stones
[ ] Urinary Incontinence

Musculoskeletal: [ ] Amputation [ ] Bursitis [ ] Carpal Tunnel Syndrome [ ] Fibromyalgia[ ] Joint Injury
[ ] Osteoarthritis [ ] Osteoporosis [ ] Phantom Limb Pain
[ ] Rheumatoid arthritis [ ] Vertebral Compression

Neuropsychological: [ ] Alzheimer Disease [ ]Bipolar Disorder [ ] Depression [ ] Epilepsy
[ ]Multiple Sclerosis [ ] Paralysis [ ] Peripheral Neuropathy [ ] Schizophrenia
[ ] CRPS / Reflex Sympathetic Dystrophy

OTHER DIAGNOSED CONDITIONS:

Past Surgical History
Please indicate any surgery you have done before.

Surgery	Date	Type	Detail
Gallbladder Removal			
Appendectomy			
Caesarean Section			
Hysterectomy			
Laparoscopy			
Ovarian			
Valve Replacement			
Aneurysm Repair			
Stent Placement			
Shoulder			
Hip			
Knee			
Discectomy			
Laminectomy			
Spinal Fusion			
Hemorrhoid Surgery			
Hernia REPAIR			
Thyroidectomy			
Tonsillectomy			
Vascular Surgery			
Other Surgeries:			

[ ] I have NEVER had any surgery.

FAMILY HISTORY

[ ] I do not have any significant family medical history

[ ] I do not know any family medical history (ie: I am adopted)

Indicate the diagnosed disease of your biological mother(M) & father(D) ONLY.

Arthritis: ______________________ **Cancer:** ______________________ **Diabetes:** ______________________

Headaches: ______________________ **Heart Disease:** ______________________ **High Blood Pressure:** ______________________

High Cholesterol: ______________ **Kidney Problems:** **Liver Problems:** ______________________

Osteoporosis: ______________________ **Rheumatoid Arthritis:** ____________ **Seizures:** ______________________

Stroke: ______________________ **Other medical problem:** ______________________

IMMUNIZATIONS

Have you been vaccinated of pneumonia? [ ]Yes. When? ____________________ [ ]No

ACTIVITY LEVEL

Do you exercise? [ ] Yes, and the frequency is ____________________ [ ]No

What is your frequency of exercise? ____________________

How long do you exercise each time? ____________________

What kind of exercise do you do? [ ] Bicycle [ ] Cardio [ ] Strength [ ] Swimming [ ] Walking
[ ] Other: ____________________

Have you fallen more than one time in the past 12 months? [ ] Yes [ ]No

SOCIAL HISTORY

Are you currently Pregnant? [ ] Yes [ ] No

Are you working? [ ] Yes [ ] Student [ ] Retired [ ] No

Are you on disability? [ ] Yes [ ] No

Alcohol Use: [ ] Current Alcoholism [ ] History of Alcoholism [ ] Daily Limited alcohol Use
[ ] Social Alcohol Use [ ]Never Drink Alcohol

Tobacco Use: [ ]Current User [ ] Former User [ ] Never Used Tobacco

Drug Use: [ ] **Denies Any Illegal Drug Use** ____________________

[ ] **Currently Using Illegal Drugs List:** ____________________

[ ] **Currently Using Other's Prescription Medications List:** ____________________

[ ] **Formerly Used Illegal Drugs List:** ____________________

Have you ever abused narcotic or prescription medication? [ ] NO [ ] Yes, it is

REVIEW OF SYSTEMS

Constitutional: [ ] Chills [ ] Difficulty Sleeping [ ] Easy Bruising [ ] Excessive Sweating
[ ] Excessive Thirst [ ] Fatigue [ ] Fevers [ ] Low Sex Drive [ ] Night Sweats
[ ] Unexplained Weight Gain [ ] Unexplained Weight Loss [ ] Weakness

Eyes: [ ] **Recent Visual Changes**

Ears / Nose / Throat / Neck: [ ] Difficulty Hearing [ ] Earaches [ ] Hay fever/Allergies [ ] Nosebleeds
[ ] Recurrent Sore Throats [ ] Ringing in the Ears [ ] Sinus Problems

Cardiovascular / Respiratory: [ ] Chest Pain [ ] Cough [ ] Fainting [ ] High Blood Pressure
[ ] Irregular Heartbeat [ ] Lightheadedness [ ] Swelling in the Feet
[ ] Shortness of Breath During exertion [ ] Wheezing

Gastrointestinal: [ ] Abdominal Cramps [ ] Acid Reflux [ ] Constipation [ ] Dark and Tarry Stools
[ ] Coffee Ground Appearance in Vomit [ ] Diarrhea [ ] Hernia [ ] Vomiting

Musculoskeletal: [ ] Back Pain [ ] Joint Pain [ ] Joint Swelling [ ] Muscle Spasms [ ] Neck Pain

Neurological: [ ] Dizziness [ ] Headaches [ ] Fainting [ ] Instability When Walking
[ ] Numbness/Tingling [ ] Seizures

Psychiatric: [ ] Anxiety / Stress [ ] Depressed Mood [ ] Suicidal Thoughts [ ] Suicidal Planning

PATIENT ACKNOWLEDGEMENT AND CONSENT FOR TREATMENT

I certify that the above information is accurate, complete and true.

I authorize Su Spine & Sports and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Su Spine & Sports to retrieve and review my medication history. I understand that this will become part of my medical record.

I authorize the Su Spine & Sports to release my Protected Health Information in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physicians I may be referred to. I also authorize Su Spine & Sports to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Su Spine & Sports will not release my Protected Health Information to any other party without my completing a written “Patient Authorization for Use and Disclosure of Protected Health Information” form, available at its facility and on its website.

Signed: ______________________________ **Date:** ______________________________

Print Name: ______________________________ **Date of Birth:** ______________________________

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