Tower Orthopaedics and Sports Medicine and Tower Orthopaedics Neurosurgical ̇O Institute

Today's Date: ______________________

❑ Dr. Bakshian ❑ Dr. Ganjianpour
❑ Dr. Patel

Patient Information

Your Name: ______________________ Social Security Number: ______________________

Street Address: ______________________ Date of Birth: ______________________

City/State/Zip: ______________________ Height: __________ Weight: __________ lbs

Email: ______________________ Gender: ❑ Male ❑ Female

Marital Status

Preferred Phone: ______________________ ❑ Home ❑ Mobile ❑ Work ❑ M ❑ S

Secondary Phone: ______________________ ❑ Home ❑ Mobile ❑ Work ❑ D ❑ W

Employer: ______________________ Occupation: ______________________

Occupational Status: ❑ Employed ❑ Retired ❑ Unemployed ❑ Disabled

Emergency Contact

Contact Name: ______________________ Phone: ______________________

Referral and Physician Information

Were you referred to Tower Orthopaedic and Sports Medicine by another physician? ❑ Yes/ ❑ No

If so, whom? ______________________

If not, how did you hear about us? ❑ Internet ❑ Patient ❑ Family

Who is your primary care physician? ______________________

Who is your surgeon? ______________________

Preferred Pharmacy - *Per CMS guidelines we are required to use Electronic Prescription*

Pharmacy Name: ______________________ Phone: ______________________

Street Address: ______________________ City/State/Zip: ______________________

Demographic Data

Race: ❑ American Indian ❑ Asian ❑ African American ❑ Pacific Islander ❑ Caucasian ❑ Other Race ❑ Unknown

Language: ❑ Arabic ❑ ˚ ❑ Chinese ❑ ¨English ❑ 7 ...... ❑ ˙French ❑ German ❑ Haitian ❑ Hebrew
❑ Hindi ❑ Italian ❑ Japanese ❑ Korean ❑ Polish ❑ Portuguese ❑ Russian ❑ Spanish ˙˙˙ ❑ ˙\

Ethnicity: ❑ Hispanic ❑ Not Hispanic

Healthcare Coverage

Mark the following sources of medical coverage that apply to you for this current pain complaint(s)

- ❑ Private Insurance
- ❑ Medicare
- ❑ State Medicaid
- ❑ Worker's Compensation
- ❑ Self-Pay
- ❑ Automobile Insurance

Primary Insurance Plan

Payer (e.g. BC/BS): ______________________ Plan: ______________________

Group Number: ______________________ Policy/I.D. Number: ______________________

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other

Complete this box if you are *not* the policy holder for your primary insurance

Policy Holder Name: ______________________ Policy Holder Gender: ❑ Female ❑ Male

Street Address: ______________________ Date of Birth: ______________________

City/State/Zip: ______________________ Social Security Number: ______________________

Primary telephone number: ______________________ Employer: ______________________

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): ______________________ Plan: ______________________

Group Number: ______________________ Policy/I.D. Number: ______________________

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other

Complete this box if you are *not* the policy holder for your secondary insurance

Policy Holder Name: ______________________ Policy Holder Gender: ❑ Female ❑ Male

Street Address: ______________________ Date of Birth: ______________________

City/State/Zip: ______________________ Social Security Number: ______________________

Primary telephone number: ______________________ Employer: ______________________

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: ______________________ Agent Name: ______________________

Phone number: ______________________ Fax number: ______________________

Claim Number: ______________________ Date of initial injury: ______________________

Patient Information

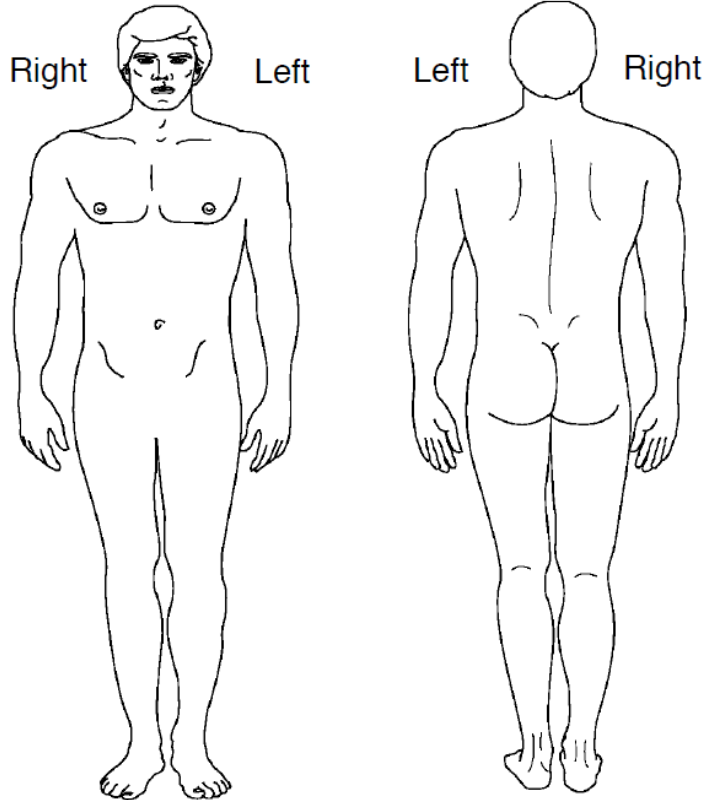
Your Name: ________________________________ Date of Birth: ______________________

Age: ________ Dominant Hand: ❑ R ❑ L Height: ___'___" Weight: ______lbs

Pain Diagram

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching



Chief Complaint: Why are you here today?

____

____

____

Where is your worst area of pain located? ______________________________________

Does this pain radiate? If so, where? ______________________________________

Please list any additional areas of pain: ______________________________________

Pain Description

Check all of the following that describe of your pain

❑ Aching	❑ Hot/Burning	❑ Shooting	❑ Stabbing/Sharp
❑ Cramping	❑ Numbness	❑ Spasming	❑ Throbbing
❑ Dull	❑ Shock-like	❑ Squeezing	❑ Pain
❑ Tiring/Exhausting	❑ Weakness	❑ Swelling	❑ Instability
❑ Stiffness/Motion Loss	❑ Locking	❑ Grinding	❑ Clicking
❑ Catching	❑ Numbness/TIngling	❑ Tingling/Pins and Needles	

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ During the day ❑ Evenings ❑ Middle of the night ❑ Mornings

Onset of Symptoms

Did your problem result from a specific injury? ❑ No ❑ Yes, Date of Injury: ______________________________

Can you describe your current injury? ____

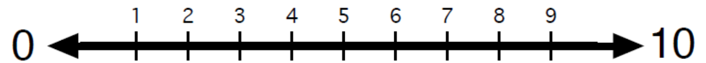
Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

If no injury, how did the problem start? ____

Pain Scale

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out



_______ What number on the pain scale (0-10) best describes your pain **right now**?

_______ What number on the pain scale (0-10) best describes your **worst pain**?

_______ What number on the pain scale (0-10) best describes your **least pain**?

_______ What number on the pain scale (0-10) best describes your **average pain over the last month**?

Mark all of the following activities that are adversely/negatively affected by your pain

❑ Enjoyment of Life ❑ Normal Work ❑ Sleep

❑ General Activity ❑ Recreational Activities ❑ Walking

❑ Mood ❑ Relationships With People ❑ Other: ____________________

Mark the effect of each of the following on your pain

What makes your pain better?

____

____

What makes your pain worse?

____

____

\ )

Mark the following physicians or specialists you have consulted for treatment of your current pain problem(s).

(ONLY FOR PAIN RELIEF; NOT FOR OTHER PROBLEMS) ❑ None (Please skip this section if this box is checked)

❑ Acupuncturis ❑ General Physician ❑ Pain Physician

❑ Chiropractor ❑ Internist ❑ Physical Therapist

❑ Neurologist ❑ Rheumatologist ❑ Neurosurgeon

❑ Orthopedic Surgeon ❑ Podiatrist

❑ Other (Please list other MD names): ______________________________

____

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

❑ I HAVE NOT HAD ANY INTERVENTIONAL PROCEDURES PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

❑ MRI of the ______________________________ Date: ______________

❑ X-ray of the ______________________________ Date: ______________

❑ CT scan of the ______________________________ Date: ______________

❑ EMG/NCV study of the ______________________________ Date: ______________

❑ Other diagnostic testing: ______________________________ Date: ______________

Interventional Pain Treatment History

Mark all of the following interventional pain treatments you have undergone prior to today's visit:

❑ I HAVE NOT HAD ANY INTERVENTIONAL PROCEDURES PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

❑ Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar Date: ______________

❑ Joint Injection – Joint(s) Date: ______________

❑ Trigger Point Injection – Area ______________________________ Date: ______________

❑ Other: ______________________________ Date: ______________

Please mark all of the following treatments you have used for pain relie O " V

	Helped pain	Worsened pain	No change
Acupuncture	❑	❑	❑
Brace Support	❑	❑	❑
Chiropractic Treatment	❑	❑	❑
Hot/Cold Packs	❑	❑	❑
Injection Therapy	❑	❑	❑
Medications	❑	❑	❑
Physical Therapy	❑	❑	❑

Past Medical History – Diagnosed Problems Only

Mark the following conditions/diseases that you have been diagnosed with: ❑ None (Leave this section blank)

General Medical

- ❑ Cancer – Type ____________
- ❑ Diabetes – Type ___________

Head/Eyes/Ears/Nose/Throat

- ❑ Headaches
- ❑ Migraines
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Glaucoma

Cardiovascular

- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Stroke
- ❑ Coronary Artery Disease

Respiratory

- ❑Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia
- ❑ Tuberculosis

Gastrointestinal

- ❑ Bowel Incontinence
- ❑ GERD (Acid Reflux)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

Musculoskeletal

- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
- ❑ Chronic Joint Pain
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Rheumatoid arthritis
- ❑ Vertebral Compression Fracture

Genitourinary/Nephrology

- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Infection(s)
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Infection

- ❑ Hepatitis A (active / inactive / unsure)
- ❑ Hepatitis B (active / inactive / unsure)
- ❑ Hepatitis C (active / inactive / unsure)
- ❑ HIV

Neuropsychological

- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Reflex Sympathetic Dystrophy/CRPS

Other Diagnosed Conditions:____

____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

❑ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE. (Leave this section blank if this box is checked)

Abdominal Surgery

❑ Gallbladder removal ______________________

❑ Appendectomy ______________________

❑ Other ______________________

Female Surgeries

❑ Caesarean section ______________________

❑ Hysterectomy ______________________

❑ Laparoscopy ______________________

❑ Ovarian ______________________

❑ Other ______________________

Heart Surgery

❑ Valve replacement ______________________

❑ Aneurysm repair ______________________

❑ Stent placement ______________________

❑ Other ______________________

Joint Surgery

❑ Shoulder ______________________

❑ Hip ______________________

❑ Knee ______________________

Spine / Back Surgery

❑ Discectomy (levels)______________________

❑ Laminectomy ______________________

❑ Spinal fusion (levels) ______________________

Other Common Surgeries

❑ Hemorrhoid surgery ______________________

❑ Hernia repair ______________________

❑ Thyroidectomy ______________________

❑ Tonsillectomy ______________________

❑ Vascular surgery ______________________

Please list any other surgeries and dates (attach an additional sheet if necessary)

____ ______________

____ ______________

____ ______________

Anesthesia History

Mark the following statement that describes your history with anesthesia:

❑ I have had anesthesia previously WITHOUT adverse reaction.

❑ I have never had anesthesia (no surgery requiring sedation).

❑ I have had anesthesia previously WITH AN ADVERSE REACTION FROM:

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ Medication IV

Please explain: ____

❑ I have a family history of adverse reaction to anesthesia from:

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ Medication IV

Current Medications

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Are you currently taking any blood-thinners or anticoagulants? ❑ Yes ❑ No

Allergies

Please list all medications you are allergic to.

Medication Name	Allergic Reacion Type	Medication Name	Allergic Reacion Type

Topical Allergies: ❑ Iodine ❑ Latex ❑ Tape

Are you allergic to shellfish? ❑ Yes ❑ No

Accident / Injury Information

Complete this section only if your pain is a result of an accident or injury

My pain is caused by ❑ A work-related injury ❑ An automobile accident ❑ Other accident

1) Following the accident I
   - ❑ was taken to the hospital by ambulance
   - ❑ was taken to the hospital by CareFlight
   - ❑ went for treatment the same day
   - ❑ first went for treatment on or about ____________________

2) LEGAL ACTION : Complete the following that apply to your accident/injury:
   - ❑ I have hired an attorney for this case. Name of attorney: ____________________
   - ❑ My case is currently in litigation.
   - ❑ My case is closed and no longer in litigation.

For motor vehicle accidents, please complete questions 3 – 6 .

3) I was ❑ not wearing my seatbelt ❑ wearing my seatbelt

4) I was the ❑ back seat passenger ❑ front seat passenger ❑ driver

5) The vehicle was struck ❑ from behind ❑ from the front ❑ from the left side ❑ from the right side

6) The airbags ❑ deployed ❑ did not deploy

Social History

Marital status: ❑ Divorced ❑ Domestic Partner ❑ Married ❑ Single ❑ Widowed

Highest level of education obtained: ❑ Grammar school ❑ High School ❑ College ❑ Post-graduate

Alcohol Use: ❑ Daily Limited Use ❑ History of Alcoholism ❑ Current Alcoholism
❑ Never Drinks Alcohol ❑ Drinks Alcohol Socially

Tobacco Use: ❑ Current Tobacco User ❑ Former Tobacco User ❑ Has Never Used Tobacco

Have you ever abused narcotic or prescription medications? ❑ YES ❑ NO

Current Employment: ___________________________________

Family History - Mark all diagnoses as they pertain to your biological MOTHER AND FATHER only.

	Mother	Father
Arthritis	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Headaches	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Kidney Problems	❑	❑
Liver Problems	❑	❑
Osteoporosis	❑	❑
Rheumatoid Arthritis	❑	❑
Seizures	❑	❑
Stroke	❑	❑

Other medical problems: ____

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY.
❑ I AM ADOPTED (NO MEDICAL HISTORY AVAILABLE).

Review of Symptoms

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History (page)*

❑ None (Please skip this section if this box is checked)

Constitutional:
- ❑ Chills
- ❑ Difficulty Sleeping
- ❑ Easy Bruising
- ❑ Excessive Sweating
- ❑ Excessive Thirst
- ❑ Fatigue
- ❑ Fevers
- ❑ Insomnia
- ❑ Low Sex Drive
- ❑ Night Sweats
- ❑ Tremors
- ❑ Unexplained Weight Gain
- ❑ Unexplained Weight Loss
- ❑ Weakness

Eyes:
- ❑ Recent Visual Changes

Ears/Nose/Throat/Neck:
- ❑ Dental Problems
- ❑ Earaches
- ❑ Hearing Problems
- ❑ Nosebleeds
- ❑ Recurrent Sore Throats
- ❑ Ringing in the Ears
- ❑ Sinus Problems

Cardiovascular:
- ❑ Bleeding Disorder
- ❑ Chest Pain
- ❑ Deep Vein Thrombosis
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Lightheadedness
- ❑ Shortness of Breath During Sleep
- ❑ Swelling in the Feet

Respiratory:
- ❑ Cough
- ❑ Wheezing
- ❑ Pulmonary Embolism
- ❑ Shortness of Breath on Exertion/Effort
- ❑ Shortness of Breath at Rest

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

Musculoskeletal:
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Joint Stiffness
- ❑ Joint Swelling
- ❑ Muscle Spasms
- ❑ Neck Pain

Genitourinary/Nephrology:
- ❑ Blood in Urine
- ❑ Decreased Urine Flow/Frequency/Volume
- ❑ Flank Pain
- ❑ Painful Urination

Neurological:
- ❑ Carpal Tunnel Syndrome
- ❑ Dizziness
- ❑ Headaches
- ❑ Numbness/Tingling
- ❑ Instability When Walking
- ❑ Tremors
- ❑ Seizures

Psychiatric:
- ❑ Depressed Mood
- ❑ Feeling Anxious
- ❑ Stress Problems
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning

Doctor's Signature: ______________________________

Consent for Treatment

I authorize Tower Orthopaedics and anyassociates, assistants and other health care providers it may deem necessary to treat my condition. I understand that no warrant or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

Signed:____ Date: ________________________

Medication History Consent

A medication history is a list of medicines that Tower Orthopaedics and other doctors have recently prescribed for a patient. It is collected from a variety of sources, including a patient's pharmacy, health plans, and other healthcare providers.

I give my consent for Tower Orthopaedics to retrieve and review my medication history. I understandthat this will become part of my medical record.

Signed:____ Date: ________________________

Privacy Practices and Consent to Release Protected Health Information

The Notice of Privacy Practices for Tower Orthopaedics is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I acknowledge I have had the opportunity to review the Notice of Privacy Practices.

I authorize Tower Orthopaedics to release my Protected Health Information (medical records) to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Tower Orthopaedics that Tower Orthopaedics will not release my Protected Health Information to any other party without expressed consent.

Signed: ____ Date: ________________________

Medicare Release

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT:

I request that payment under the medical insurance program be made on my behalf to Tower Orthopaedics for any services furnished me by its physician (s) and/or practitioners. I authorize any holder of medical information about me to release to my healthcare insurance (Medicare) and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed:____ Date: ________________________