GEORGIA
BRAIN & SPINE
CENTER

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PERSONAL INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____
SSN #: _____Gender: M or F E-mail _____
Address: _____
Street City State Zip Code
Spouse's name and phone # _____

Home Phone: _____ Cell Phone: _____ OK to receive text messages ☐NO ☐YES

Occupation: _____ Employer _____ Work Phone # _____
Emergency Contact and Phone #:_____

How did you hear about us? (Circle one) Physician Internet Patient Friend Other_____(**Explain**)

Family Physician/Internist _____ Phone#: (_____)_____
Referring Physician _____ Phone#: (_____)_____
Pharmacy: _____ Phone: _____ Address: _____
Ethnicity_____ Preferred Language_____ Race _____

Height _____ Weight _____ Are you Claustrophobic? ☐NO ☐YES

Is there a family member or friend living with or near you who would be available to assist you once you've been discharged from the hospital, should the need arise? ☐NO ☐YES

INSURANCE INFORMATION

Primary Insurance_____ ID#_____ Group#_____
Address _____
Insured Name _____ Relationship to Insured _____

Is this a Medicare replacement plan? ☐NO ☐YES

Secondary Insurance_____ ID#: _____
Address_____
Group#: _____ Insured Name _____Relationship _____
If Medicare supplemental, what plan? _____

Auto/Workers Comp Insurance_____Claim#_____
Address _____
Date of Injury/Accident _____ Type of Injury Auto Workers Compensation
Adjusters Name _____Phone# (_____) _____

Attorney Information

Attorney Name_____ Contact Name_____ Phone _____

Were you injured in an accident? ☐NO ☐YES

If yes check one: ☐ Motor Vehicle Accident ☐Worker's Comp Accident ☐other _____

MEDICAL INFORMATION

What is the reason for your visit today?

_____

When did this problem begin?

_____

Did anything cause or contribute to the onset?

_____

Has the problem been constant, or does it come and go?

_____

Has the problem been getting better, worse, or staying the same?

_____

Have you found anything that makes it better?

Have you found anything that makes it worse?

_____

Have you experienced any changes in bodily functions? (urination, defecation, breathing, vision, sexual, etc)

_____

MEDICAL AND SURGICAL HISTORY

Please list any medical problems you have been diagnosed with:

_____
_____
_____
_____
_____
_____

Specifically, have you ever been treated for:

	No	Yes		No	Yes			
Bleeding disorder	☐	☐	Epilepsy	☐	☐	Hepatitis C	☐	☐
Cancer	☐	☐	Heart attack	☐	☐	HIV/AIDS	☐	☐
Diabetes	☐	☐	Heart disease	☐	☐			

PREVIOUS SURGERY: ☐ check here if you have not had any surgery

Please list **ALL** operations you have had.

Month/year	type of surgery	Surgeon	City
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____ _____ _____
_____ _____ _____ _____

Are there any medical implants in your body? (Pacemaker, aneurysm clips, rods, screws, pins shrapnel etc.)

☐NO ☐YES
If yes, explain: _____

Please list any prior hospitalizations: _____
_____

CURRENT MEDICATIONS:

Please list **ALL** of the medications you currently take, including aspirin, vitamins and other supplements. You may attach a medication list if needed.

Name of medication	Dosage	How often	Taken for:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you on any blood thinners? (For example, Aspirin, Plavix, Coumadin, Xarelto, etc.)

_____

_____

ALLERGIES:

Are you allergic to latex? ☐NO ☐YES, Reaction: _____

Are you currently working? If so, what is your job? _____

Who do you live with? _____

Do you smoke? ☐NO ☐YES, How many packs per day? _____

Do you drink alcohol? ☐NO ☐YES, How many drinks in an average week? _____

Do you use any recreational drugs ☐NO ☐YES, Please specify: _____

FAMILY HISTORY	Cancer	Heart disease	Stroke	Diabetes	Aneurysm	Brain tumor	Other muscular/neurologic disease
Father							
Mother							
Brother							
Sister							
Child							
Paternal Grandfather							
Paternal Grandmother							

Maternal Grandmother							
Maternal Grandfather							
Aunt							
Uncle							

Review of Systems:

Musculoskeletal

Broken Bones ☐NO ☐YES
Neck Pain ☐NO ☐YES
Arm Pain ☐NO ☐YES
Arm Weakness ☐NO ☐YES
Leg Pain ☐NO ☐YES
Leg Weakness ☐NO ☐YES
Joint Pain ☐NO ☐YES
Leg Numbness ☐NO ☐YES
Arm Numbness ☐NO ☐YES
Back Pain ☐NO ☐YES

Constitutional

Fatigue ☐NO ☐YES
Fever ☐NO ☐YES
Night Sweats ☐NO ☐YES
Weight Loss ☐NO ☐YES

Ophthalmic

Corrective Lens ☐NO ☐YES
Infections ☐NO ☐YES
Glaucoma ☐NO ☐YES
Cataracts ☐NO ☐YES

ENT

Hearing Loss ☐NO ☐YES
Loss of Smell ☐NO ☐YES
Nosebleeds ☐NO ☐YES
Ringing in Ears ☐NO ☐YES
Sinus Pain ☐NO ☐YES
Sore Throat ☐NO ☐YES

Endocrine

Diabetes ☐NO ☐YES
Excess Sweating ☐NO ☐YES
Excess Thirst ☐NO ☐YES
Freq. Urinating ☐NO ☐YES
Thyroid Disorder ☐NO ☐YES

Respiratory

Asthma ☐NO ☐YES
Cough ☐NO ☐YES
Pneumonia ☐NO ☐YES
Short of Breath ☐NO ☐YES

Cardiovascular

Chest Pain ☐NO ☐YES
Heart Murmur ☐NO ☐YES
Heart Problems ☐NO ☐YES
Hypertension ☐NO ☐YES
Swelling hands/feet ☐NO ☐YES

Gastrointestinal

Abdominal Pain ☐NO ☐YES
Blood in stool ☐NO ☐YES
Change in bowel ☐NO ☐YES
Heartburn ☐NO ☐YES
Nausea ☐NO ☐YES
Vomiting ☐NO ☐YES

Genitourinary

Incontinence ☐NO ☐YES
Blood in urine ☐NO ☐YES
Kidney problems ☐NO ☐YES
Painful Urination ☐NO ☐YES

Neurologic

Coordination loss ☐NO ☐YES
Diff. Speaking ☐NO ☐YES
Fainting ☐NO ☐YES
Headache ☐NO ☐YES
Memory loss ☐NO ☐YES

Seizures ☐NO ☐YES

Psychiatric

Anxiety ☐NO ☐YES

Depression ☐NO ☐YES

Any other psychiatric conditions

☐NO ☐YES

Georgia Brain and Spine Center – Spine Supplement:

Describe the severity your pain a scale from 0 to 10. Zero being no pain, 10 being the worst pain ever.

	Pain Scale
Neck	0 1 2 3 4 5 6 7 8 9 10
Right Arm	0 1 2 3 4 5 6 7 8 9 10
Left Arm	0 1 2 3 4 5 6 7 8 9 10
Back	0 1 2 3 4 5 6 7 8 9 10
Right Leg	0 1 2 3 4 5 6 7 8 9 10
Left Leg	0 1 2 3 4 5 6 7 8 9 10

Please draw in diagram below where you feel your pain, if applicable.

Do you have any of the following? If so, where?

Numbness ___No ___Yes, Where: _____

Weakness ___No ___Yes, Where: _____

Tingling ___No ___Yes, Where: _____

Describe any injury that may have resulted in the symptoms that brought you in, if applicable.

_____

_____

Do your symptoms improve with rest? If so, to what extent?

Have you noticed any changes posture or gait? If so describe. _____

Have you had any falls? _____

Have you had any loss of bowel or bladder control? _____

How long can you tolerate walking?
__ Indefinitely**,** __ 5 minutes or less**,** __ 15 minutes or less**,** __ 30 minutes or less**,** __ 1 hour or less
Have you noticed any of the things happening?
___ Dropping objects more frequently, ___ Difficulty with handwriting, ___ Difficulty walking
Do any of these positions make the pain worse?
__ Standing, __ Laying, __ sitting, __ bending forward, __ bending backwards, ___ walking, __other
Do any of these positions improve the pain?
__ Standing, __ Laying, __ sitting, __ bending forward, __ bending backwards, ___ walking, __other

Have you had any of the below treatment/ medications to aid with your current symptoms?

☐ Physical therapy

☐ Chiropractic manipulation

☐ Trigger injections

☐ Epidural injections

☐ Nerve blocks

☐ Muscle relaxants (Flexeril, Robaxin, Valium, Soma etc.)

☐ Anti-inflammatory (Naproxen, Aleve, ibuprofen, goody powders, meloxicam etc.)

☐ Narcotic pain medications (Norco, Percocet, Dilaudid etc.)
If so who provides them?_____

Have you had any type of brain or spine surgery? If so when and what type of surgery?

_____

New Patient Information

To better assist us in your care, please answer the following questions:

1) Have you been in any accident, including any work-related accident, which may have caused or is in any way related to the condition for which you are seeking treatment with us?
   Yes_____ No_____
   If Yes, please describe:
   _____
   _____
2) Is the condition you are seeking treatment with us a Worker's Compensation case?
   Yes_____ No_____
3) Are you in the process of or intend to file for any form of disability, including social security disability, due to the current condition for which you are seeking treatment with us?
   Yes_____ No_____

If Yes, please describe:

_____

_____

_____

By signing below, I testify that the above statements are true and complete.

_____	_____	_____
(Signature)	(Print Name)	(Date)

Witness

I have confirmed the above information with the patient.

_____	_____	_____