



CEDARS-SINAI MEDICAL CENTER.
Institute for Spinal Disorders

Demographic Intake Sheet for Consultation

Preferred MD: _____ Reason for Consult: _____

Patient Information

Last Name: _____		First Name: _____	
Address: _____		City: _____	
State: _____	ZIP: _____	Home Phone: () _____	
Work Phone: () _____		Cell Phone: () _____	
Date of Birth: ____ / ____ / ____	SS#: ____ - ____ - ____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Employer Information

Name: _____	Address: _____
City: _____	State: _____ ZIP: _____

Insurance Information

Primary Insurance: _____	<input type="checkbox"/> HMO	<input type="checkbox"/> PPO	<input type="checkbox"/> POS
Address: _____	City: _____		
State: _____	ZIP: _____	Group#: _____	ID#: _____
Medicare#: _____	Effective Date: ____ / ____ / ____	<input type="checkbox"/> A	<input type="checkbox"/> B <input type="checkbox"/> A&B
If patient is not subscriber, provide subscriber's...			
Date of Birth: ____ / ____ / ____	SS#: ____ - ____ - ____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Workers Compensation (If Applicable)

Company Name: _____	Address: _____
City: _____	State: _____ ZIP: _____
Date of Injury: ____ / ____ / ____	Claim#: _____
Name of Adjuster: _____	
Adjuster Phone: () _____	Fax: () _____
Employer Name at Time of Injury: _____	
Employer Address: _____	City: _____
State: _____ ZIP: _____	Phone: () _____

Referred By

Physician: _____	Specialty: _____
Address: _____	City: _____
State: _____ ZIP: _____	Phone: () _____
License#: _____	UPIN#: _____

Internist/Primary Care Physician

Physician: _____	Specialty: _____
Address: _____	City: _____
State: _____ ZIP: _____	Phone: () _____
License#: _____	UPIN#: _____

Other Physicians Involved in Your Care

Physician: _____	Specialty: _____
Address: _____	City: _____
State: _____ ZIP: _____	Phone: () _____
License#: _____	UPIN#: _____

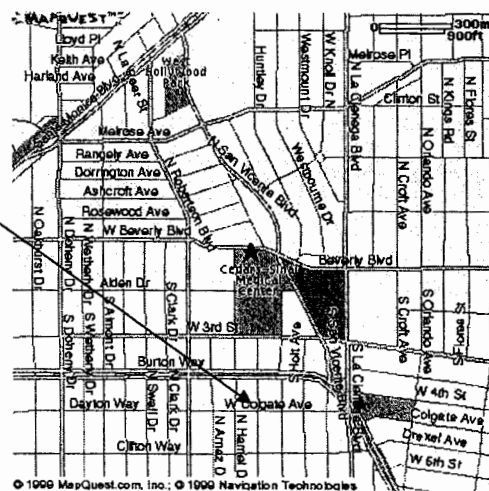
Office Location and Directions

Cedars-Sinai Institute for Spinal Disorders
 Mark Goodson Building
 444 S. San Vicente Blvd., Suite 800
 Los Angeles, CA 90048
 Phone: (310) 423-9900
 Fax: (310) 423-9991

From the Santa Monica Freeway:

- 10 to La Cienega Boulevard and exit
- North on La Cienega Boulevard
- Right on Wilshire Boulevard
- Left on San Vicente Boulevard
- Right on Colgate Avenue

Parking is immediately on the right.



© 1999 MapQuest.com, Inc.; © 1999 Navigation Technologies

Personal Information

Last Name: _____	First Name: _____	MI: _____
Age: _____	Occupation: _____	<input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed

Current Problem

Symptoms:	Duration:

Past Medical History

Previous Operations:	Dates:

Other Past and Current Medical Problems (e.g., hypertension, stroke, diabetes, cancer, etc.)

Family Medical History (if deceased, list cause)

Current Medications (including over-the-counter medicines)

Allergies (medication and others)

Other Information

Smoke _____ /day	Alcohol Usage: _____
Recent X-Rays, CTs, MRIs (including dates): _____	
Regarding MRIs, are you claustrophobic? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have metal implants? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Cedars-Sinai Institute for Spinal Disorders
 Preliminary Patient Appointment/History/Registration Sheet

BACK PAIN DRAWING

Patient Name: _____

Date: _____

Age: _____

WHERE IS YOUR PAIN NOW:

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

Back Pain _____ %
 Leg Pain _____ %
 Total 100%

PLEASE MARK ON THE LINE:

How bad is your back pain now?

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
 NO PAIN INTERMEDIATE PAIN WORST PAIN

I can tolerate my back pain at a pain score of: _____

How bad is your leg pain now?

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
 NO PAIN INTERMEDIATE PAIN WORST PAIN

I can tolerate my leg pain at a pain score of: _____

PLEASE CIRCLE THE DURATION OF PAIN:

CONTINUOUS POSITIONAL INTERMITTENT (ON/OFF) UNABLE TO RATE

General Review of Systems (check all that apply)

Allergies

- Asthma
- Hay fever
- Skin eruptions

Cardiovascular

- Chest pain
- Irregular heartbeat
- High/low blood pressure
- Poor circulation
- Rapid heart rate
- Swelling of ankles
- Varicose veins

Constitutional

- Chills/sweats/fever
- Fainting
- Forgetfulness
- Headache
- Loss of sleep
- Nervousness
- Weight loss

Ears, Nose, Mouth, Throat

- Bleeding gums
- Difficulty swallowing
- Earache
- Ear discharge
- Hearing loss
- Hoarseness
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems

Endocrine

- Rapid weight loss/gain
- Intolerance to warm room
- Multiple broken bones
- Menstrual period cessation
- Excessive hunger/thirst
- Loss of libido
- Spontaneous nipple discharge

Eyes

- Blurred vision
- Crossed eyes
- Double vision
- Vision flashes or halos

Genitourinary

- Blood in urine
- Lack of bladder control
- Painful urination

Gastrointestinal

- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Poor appetite
- Rectal bleeding
- Stomach pain

Hematologic

- Swollen lymph nodes
- Easy skin bruising
- Prolonged bleeding from cuts, tooth extractions

Integumentary

- Skin rashes or eruptions
- Chronic skin itching

Men

- Breast lump
- Lump in testicle
- Penis discharge
- Sore on penis

Musculoskeletal

- Pain, weakness, numbness or swelling in hands, wrists, hips, knees or joints
- Pain in arms or legs

Neurologic

- Fainting
- Headaches
- Numbness of arms or legs
- Seizures
- Tingling of hands, feet, arms or legs

Psychiatric

- Anxiety
- Depression
- Pain attacks
- Restlessness

Respiratory

- Blood
- Cough
- Dizziness
- Shortness of breath

Women

- Abnormal Pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse

Please give date of last:

Period _____

Pap smear _____

Mammogram _____

Are you currently pregnant?

Yes No

of Children: _____

FUNCTIONAL QUESTIONNAIRE

NAME: _____

DATE: _____

How long have you had back/neck pain? _____ Years _____ Months _____ Weeks

How long have you had leg/arm pain? _____ Years _____ Months _____ Weeks

Please read:

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one box** which applies to you.

SECTION 1- PAIN INTENSITY

- I can tolerate the pain I have without having to use pain killers
- The pain is bad but I can manage without taking pain killers
- Pain killers give complete relief from pain
- Pain killers give very little relief from pain
- Pain killers give have no effect on the pain and I do not use them

SECTION 2- PERSONAL CARE (Washing, Dressing, etc)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help everyday in most aspects of self care
- I do not get dressed, wash with difficulty and stay in bed

SECTION 3- LIFTING

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, ie on the table
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can lift only very light weights
- I cannot lift or carry anything at all

SECTION 4- WALKING

- Pain does not prevent me from walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than ½ mile
- Pain prevents me from walking more than ¼ mile
- Pain prevents me from walking more than 10 mins
- Pain prevents me from walking at all

SECTION 5- SITTING

- I can sit in my chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than ½ hour
- Pain prevents me from sitting more than 10 mins
- Pain prevents me from sitting at all

SECTION 6- STANDING

- I can stand as long as I want without extra pain
- I can stand as I want but it give me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 mins
- Pain prevents me from standing for more than 10 mins
- Pain prevents me from standing at all

SECTION 7- SLEEPING

- Pain does not prevent me from sleeping well
- I can sleep well only by using tablets
- Even when I take tablets I have less than six hours sleep
- Even when I take tablets I have less than four hours sleep
- Even when I take tablets I have less than two hours sleep
- Pain prevents me from sleeping at all

SECTION 8 – SEX LIFE

- My sex life is normal and gives me no extra pain at all
- My sex life is normal but increases the degree of pain
- My sex life is nearly normal but is very painful
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

SECTION 9- SOCIAL LIFE

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, ie dancing, etc.
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to home
- I have no social life because of pain

SECTION 10 – TRAVELING

- I can travel anywhere without extra pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 mins
- Pain prevents me from traveling except to the doctor or hospital

COMMENTS:

We realize you may consider that two of the statements in any one section relate to you, but please just **mark the box which most closely describes your problem.**

Treatment Intensity Score*

Please answer the questions below, choosing the answer that most closely describes your situation at present. We understand that there may be one or more alternatives that may apply to you, please choose the one you feel is most descriptive of your problem.

What medication are you taking for your pain?

0. None
1. Tylenol, Aspirin, Motrin, Alleve or other non-prescription pain medication
2. Prescription Anti-inflammatories (Relafen, Celebrex, Vioxx, etc) or Muscle Relaxants (Soma, Flexuril)
3. Vicodin, Codeine,
4. Medrol Dose Pack
5. Morphine Analogs (Oxycontin, MS Contin, Percocet, etc)

How long is the pain relieved before you need medication again?

- 0 24 hours or more (rarely take them)
- 1 12 hours
- 2 8 hours
- 3 6 hours
- 4 4 hours
- 5 Less than 4 hours

How long have you taken these medications?

0. Use them occasionally only (i.e.: do not need them every day)
1. 6 weeks
2. 3 months
3. 6 months
4. 1 year
5. 2 years or more

Have you needed to seek other treatment options, specifically because of pain in your neck or back?

0. None
1. Massage Therapy, Shiatsu, Yoga, Chiropractor
2. Acupuncture, Acupressure, Alternative Medicine Therapies
3. Supervised Physiotherapy and/or Pain Management Consult
4. Injections such as Nerve Root Blocks or Epidural Steroids
5. Spinal Cord Stimulator, Morphine Pump

How often have you had to see a Doctor, Therapist or gone to the Emergency room, specifically because of unbearable pain (disregard any routine follow-up visits)?

0. Never
1. Once in 6 months or less
2. Once in three months
3. Every 6 weeks
4. Every week or 2-3 times a week
5. Needed admission to the hospital for severe pain

* Neel Anand, M.D., M.ch.Orth.

SF-36[®]

1. In general, would you say your health is:
 Excellent Very Good Good Fair Poor

2. Compared to one year ago, how would you rate your health in general now?
 Much better now than 1 year ago
 Somewhat better now than 1 year ago
 About the same
 Somewhat worse now than 1 year ago
 Much worse now than 1 year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Mark one box on each line.)

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Bending, kneeling, or stopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walking more than a mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Walking several blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Walking one block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Bathing and dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Mark one box on each line.)

	Yes	No
a. Cut down the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
b. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
c. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
d. Had difficulty performing the work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
(for example, it took extra effort)		

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (Mark one box on each line)

- | | Yes | No |
|----------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Cut down the amount of time you spent on work or other activities | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Accomplished less than you would like | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Didn't do work or other activities as carefully as usual..... | <input type="checkbox"/> | <input type="checkbox"/> |

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
 Not at all Slightly Moderately Quite a bit Extremely

7. How much bodily pain have you had during the past 4 weeks? (Mark one box.)
 None Very Mild Mild Moderate Severe Very Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Mark one box.)
 Not at all Slightly Moderately Quite a bit Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past four weeks:

- | | All
of
the
time | Most
of
the
time | A
good
bit
of
the
time | Some
of
the
time | A
little | None
of
the
time |
|--------------------------------------------------------------------------|--------------------------|---------------------------|---------------------------------------|---------------------------|--------------------------|---------------------------|
| a. Did you feel full of pep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you been a very nervous person? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Did you feel so down in the dumps that nothing could cheer you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you felt calm and peaceful? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Did you have a lot of energy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have you felt downhearted and blue? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Did you feel worn out? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Have you been a happy person? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Did you feel tired? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

11. How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I am as healthy as anybody I know ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>