ALIGN INTERVENTIONAL SPINE + JOINT

Date: ______________________________

Location: ______________________________

Referring Provider: ____________________

PCP: ______________________________

Patient's Personal Information/Demographics:

(highlighted fields are MANDATORY)

Name: ____ Preferred Name: ______________________
Last First Middle

Date of Birth: ________/__________/____________ Gender: ☐ Male ☐ Female ☐ Other: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Home Address: ____

City: ____ State: _____________ Zip Code: ____________________

Home Phone: ______________________ Cell Phone: ________________________ Work Phone: _________________________

E-mail address: ____

Preferred Method of Communication? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email/Patient Portal

*** as a new up and coming practice we prefer that all patient use the patient portal for any and all communications involving: appointment scheduling, account balance inquiries, patient education, staff communication, refill requests, and to pay your bill online***

Social Security Number (SSN#): _______-_________-__________ Driver License # and State: _______________________________

Occupation: _____________________ Employer: ___________________________ Employer Phone # _____________________

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino Language Preference: _______________________________________

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander

Please list all other providers (cardiologist, neurologist, surgeons, etc): ____

Emergency Contact: ____ Relationship: ______________________________

Phone Number & Type: ______________________________ Phone Number & Type: ______________________________

Patient's Responsibilty Information (leave blank if it is the patient himself/herself):

Name: ____ Date of Birth: ______________________________

Home Address: ____

Home Phone: ______________________ Cell Phone: ________________________ Work Phone: _________________________

Social Security Number (SSN#): _______-_________-__________ Relationship: _______________________________________

E-mail address: ____

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Insurance Information (please provide insurance cards at front desk upon arrival):

Primary Insurance Name: ____

Insured Name: ______________________ DOB: ______________ SSN: ________________

Relationship to Patient: ______________ Member ID#: ______________ Group #: ______________

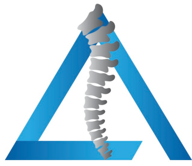
Secondary Insurance Name: ____

Insured Name: ______________________ DOB: ______________ SSN: ________________

Relationship to Patient: ______________ Member ID#: ______________ Group #: ______________

Is there an ongoing lawsuit related to your visit today? ☐ Yes ☐ No

Are you currently under worker's compensation? ☐ Yes ☐ No



MEDICAL HISTORY

Name: ____ Date of Birth: ____

PAIN EVALUATION (please fill the following information out as thoroughly so that we can form the best treatment plan for you):

Location(s) of pain: (1) __________________ (2) ___________________ (3) __________________ (4) ___________________

Onset of Pain (days, weeks, months, years): ____

Cause of Pain (accident, trauma, fall, unknown): ____

Is this work related? ☐ Yes ☐ No If so, occupation?

Have you been treated by other pain physicians? If so, who? ____

Characteristics of Pain: ☐ Constant ☐ Intermittent Duration: _______________________________________

Pain Intensity (0-10): at worst ________/10________ at least ________/10________

Your pain is: ☐ aching ☐dull ☐ burning ☐ electrical shocks
☐ numbness ☐ sharp ☐ shooting ☐ stabbing ☐ other:
____

What makes your pain WORSE? _________________________ What makes your pain BETTER? _________________________

Do you have: ☐ numbness ☐ localized weakness ☐ bowel incontinence ☐ bladder incontinence

Which of the prior treatments or tests have you had? *Please include the body part and year if possible*

☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic Treatment ☐ Massage Therapy
☐ Xrays ☐ MRI ☐ CT
☐ Injections (and which types) ☐ EMG/Nerve Testing ☐ Other:
____

Medical History (please check all that apply):
☐ High Blood Pressure/Hypertension ☐ Diabetes, if so ☐ do you take insulin
☐ Stroke ☐ Seizures

Are you currently taking any of the following medications?
☐ Eliquis/apixaban ☐ Plavix/clopidogrel
☐ Xarelto/rivaroxaban ☐ Coumadin/Warfarin
☐ Effient/prasugrel ☐ Pradaxa/dabigatran
☐ Brillinta/ticagrelor ☐ Aspirin ☐ 325mg ☐ 82mg (baby aspirin)
☐ NSAIDs (Aleve, Ibuprofen, Motrin, Naproxen, Diclofenac, Ketorlac, etc)

Current list of all medications: (1) ________________________(2) ____________________ (3) _______________________
(including over the counter) (4) ________________________(5) ____________________ (6) _______________________
(7) ________________________(8) ____________________ (9) _______________________
(10) _______________________(11) ___________________ (12) ______________________

Prior Surgeries (please list type and year):
Spine (neck, midback, low back): ____

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Shoulder: ____
Hip: ____
Knee: ____
Other: ____

Do you have any family history of illness? ____

Are you allergic to? ☐ IV Iodine ☐ Latex ☐ Topical Iodine ☐ Shellfish Your reaction: ____________________

Any other medication allergies?

Medication: ____________________ Reaction: ____________________
Medication: ____________________ Reaction: ____________________
Medication: ____________________ Reaction: ____________________
Medication: ____________________ Reaction: ____________________

Any tobacco use? ☐Yes ☐No If yes, how many per day? _______ Years? _______ Ex user, date quit _______
Any alcohol use? ☐Yes ☐No Type? _________ How much? _________ How often?_________
Do you have a history of or current drug use? ☐Yes ☐No If yes, which type of drug? ____________________
Do you have a history of?

Drug Abuse: ☐ Yes ☐ No Alcohol Abuse: ☐ Yes ☐ No Prescription Drug Abuse: ☐ Yes ☐ No

Do you have a family history of? *(Mother, Father, Grandparents, Aunts, Uncles Siblings, Children)*

Drug Abuse: ☐ Yes ☐ No Alcohol Abuse: ☐ Yes ☐ No Prescription Drug Abuse: ☐ Yes ☐ No

FEMALE PATIENTS: ☐ I am NOT pregnant ☐ I AM pregnant Name of OB/GYN: ____________________

REVIEW OF SYSTEMS (check all that apply):

- General: ☐ Fever ☐ Chills ☐ Weight Loss ☐ Fatigue
- Eyes: ☐ Blurry vision ☐ Double vision ☐ Photophobia ☐ Eye pain
- Cardiovascular: ☐ Chest pain ☐ Palpitations ☐ Swelling in arms or legs
- Respiratory: ☐ Cough ☐ Recent illness ☐ Shortness of breath ☐ Do you need O2 during the day
- Gastrointestinal: ☐ Constipation ☐ Diarrhea ☐Nausea/Vomiting ☐ Abdominal pain
- Genitourinary: ☐ Incontinence ☐ Pain with urination
- Musculoskeletal: ☐ Joint pain ☐ Joint swelling ☐ Muscle spasms ☐ Muscle cramping
- Skin: ☐ Lesions ☐ Rash
- Heme/Lymph: ☐ Bruising ☐ Bleeding
- Neurological: ☐ Weakness ☐ Numbness ☐ Tingling ☐ Syncope ☐ Dizziness ☐ Headache
- Psychiatric: ☐ Anxiety ☐ Depression ☐ Hallucinations ☐ Suicidal or Homicidal Ideations

PLEASE MARK THE AREAS ON THE BODY THAT YOU FEEL PAIN

Front Back

Additional Notes:
____
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