MAIN LINE SPINE

Minimally Invasive Spine, Sports and Rehabilitative Medicine

Roy M. Lerman, M.D.
Board Certified
Physical Medicine and Rehabilitation
Board Certified American Board of Independent Medical Examiners

Denis P. Rogers, M.D.
Board Certified
Physical Medicine and Rehabilitation

Andrew A. Badulak, D.O.
Board Certified
American Board of Family Practice

Jeffery J. Rowe, M.D.
Board Certified
Physical Medicine and Rehabilitation

Marc S. Effron, M.D.
Board Certified
Physical Medicine and Rehabilitation

Scott J. Davidoff, M.D.
Board Certified
Physical Medicine and Rehabilitation

Shivani Dua, M.D.
Board Certified
Physical Medicine and Rehabilitation

L. Matthew Schwartz, M.D.
Board Certified
Physical Medicine and Rehabilitation
Pain Medicine
Integrated Holistic Medicine

Samuel R. Grodofsky, M.D.
Board Certified
Pain Medicine and Anesthesiology

Farzad H. Karkvandeian, D.O.
Board Certified
Physical Medicine and Rehabilitation

Andrea E. Feldman, PA-C

Sharon A. Folger, PA-C

Lauren M. Ziegler, PA-C

*All correspondence please to our King of Prussia address:
The Merion Building
700 South Henderson Road
Suite 308C
King of Prussia, PA 19406

Westtown Business Center
1589 McDaniel Drive
West Chester, PA 19380

2 Bala Plaza, Suite IL-52
333 East City Avenue
Bala Cynwyd, PA 19004

3855 West Chester Pike
Suite 250
Newtown Square, PA 19073

599 Arcola Road, Suite 105
Collegeville, PA 19426

(610) 337-3111
Fax (610) 337-3506

ATTENTION

IN ORDER TO KEEP A TIMELY SCHEDULE, WE ASK THAT YOU PLEASE COMPLETE THIS QUESTIONNAIRE PRIOR TO YOUR APPOINTMENT.

ALSO, PLEASE ARRIVE **15 MINUTES PRIOR TO YOUR APPOINTMENT TIME** TO HAVE YOUR INFORMATION ENTERED/UPDATED.

THANK YOU ☺

MAIN LINE SPINE

Minimally Invasive Spine, Sports and Rehabilitative Medicine

Roy M. Lerman, M.D.
Board Certified
Physical Medicine and Rehabilitation
Board Certified American Board of Independent Medical Examiners

Denis P. Rogers, M.D.
Board Certified
Physical Medicine and Rehabilitation

Andrew A. Badulak, D.O.
Board Certified
American Board of Family Practice

Jeffery J. Rowe, M.D.
Board Certified
Physical Medicine and Rehabilitation

Marc S. Effron, M.D.
Board Certified
Physical Medicine and Rehabilitation

Scott J. Davidoff, M.D.
Board Certified
Physical Medicine and Rehabilitation

Shivani Dua, M.D.
Board Certified
Physical Medicine and Rehabilitation

L. Matthew Schwartz, M.D.
Board Certified
Physical Medicine and Rehabilitation
Pain Medicine
Integrated Holistic Medicine

Samuel R. Grodofsky, M.D.
Board Certified
Pain Medicine and Anesthesiology

Farzad H. Karkvandeian, D.O.
Board Certified
Physical Medicine and Rehabilitation

Andrea E. Feldman, PA-C

Sharon A. Folger, PA-C

Lauren M. Ziegler, PA-C

*All correspondence please to our King of Prussia address:
The Merion Building
700 South Henderson Road
Suite 308C
King of Prussia, PA 19406

Westtown Business Center
1589 McDaniel Drive
West Chester, PA 19380

2 Bala Plaza, Suite IL-52
333 East City Avenue
Bala Cynwyd, PA 19004

3855 West Chester Pike
Suite 250
Newtown Square, PA 19073

599 Arcola Road, Suite 105
Collegeville, PA 19426

(610) 337-3111
Fax (610) 337-3506

Dear:

Your initial office visit with Dr. ______________________________ is scheduled for __________________ at ____________________ in the ____ office. Enclosed please find all of the necessary paperwork that we need you to fill out for us. In order to see the doctor, please fill out **ALL** of the paperwork, and bring it with you to the appointment. **PLEASE, DO NOT MAIL BACK**. Please make certain that all the pertinent insurance information is completed. **PHOTO I.D. & INSURANCE CARD ARE REQUIRED UPON REGISTRATION**. If you have an insurance that requires a referral, we ask that you obtain the referral or referral number prior to your appointment. This is an **INSURANCE REFERRAL** from your **PRIMARY CARE PHYSICIAN**.

PLEASE BE SURE TO BRING THE FOLLOWING:

1. Any X-Rays, MRIs, CT Scans, or bone scans you had done pertaining to this appointment, and we ask that you obtain the **films/disc(s)** and **radiology report(s)**. Please bring a list of **ANY** medications you are taking even over the counter such as Aspirin.
2. Please have your referring physician fax us a copy of your last office visit report to: **#610-337-3506**.

Sincerely,

Main Line Spine ☺

PATIENT REGISTRATION FORM

NAME:________________________ D.O.B__________ AGE:__________ SEX:____
STREET:____________________ CITY:______________ STATE:______ ZIP:__________
SS #:______________________ ETHNICITY:________________ RACE:___________
LANGUAGE:_____________ PHONE # TO LEAVE A PERSONAL MESSAGE:_____________
HOME PHONE #:_____________ WORK #:______________ CELL #:______________
E-MAIL ADDRESS:____
EMERGENCY CONTACT:______________ RELATION:__________ PHONE #:__________
EMPLOYER NAME:______________________ ADDRESS:_________________________
DATE OF INJURY:________________ REASON FOR VISIT:_____________________
REFERRED BY DOCTOR:________________ PRIMARY DOCTOR:____________________
ADDRESS:___________________________ ADDRESS:___________________________
___________________________________ ___________________________________
PHONE #:___________________________ PHONE #:___________________________
BILLING INFO: (CIRCLE ONE) WORKER'S COMP AUTO PRIVATE HEALTH INSURANCE
PRIMARY INSURANCE:_________________ SECONDARY INSURANCE:_______________
ADDRESS:___________________________ ADDRESS:___________________________
___________________________________ ___________________________________
CL/I.D #:__________________________ I.D.#______________ GRP#___________
ADJUSTER'S NAME:___________________ SUBSCRIBER'S NAME:_________________
PHONE #:___________________________ SUBSCRIBER'S DOB/RELATION:_________
EFFECTIVE DATE:____________________ EFFECTIVE DATE:____________________

PLEASE LET US SCAN YOUR HEALTH INSURANCE CARD AND PHOTO ID, EVEN IF THIS IS THROUGH WORKMEN'S COMP OR AUTO. THANK-YOU.

IF APPLICABLE, NAME AND ADDRESS OF ATTORNEY:___________________________
____
PHONE #:___________________________ FAX #:_____________________________

WE DO NOT BILL ATTORNEY'S FOR SERVICES RENDERED, NOR DO WE ACCEPT LETTERS OF PROTECTION.

I AUTHORIZE INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN AND UNDERSTAND I AM RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE PROCESSING OF THE CLAIMS.

PATIENT'S SIGNATURE:______________________________ DATE:______________

06/19/2019 Revised

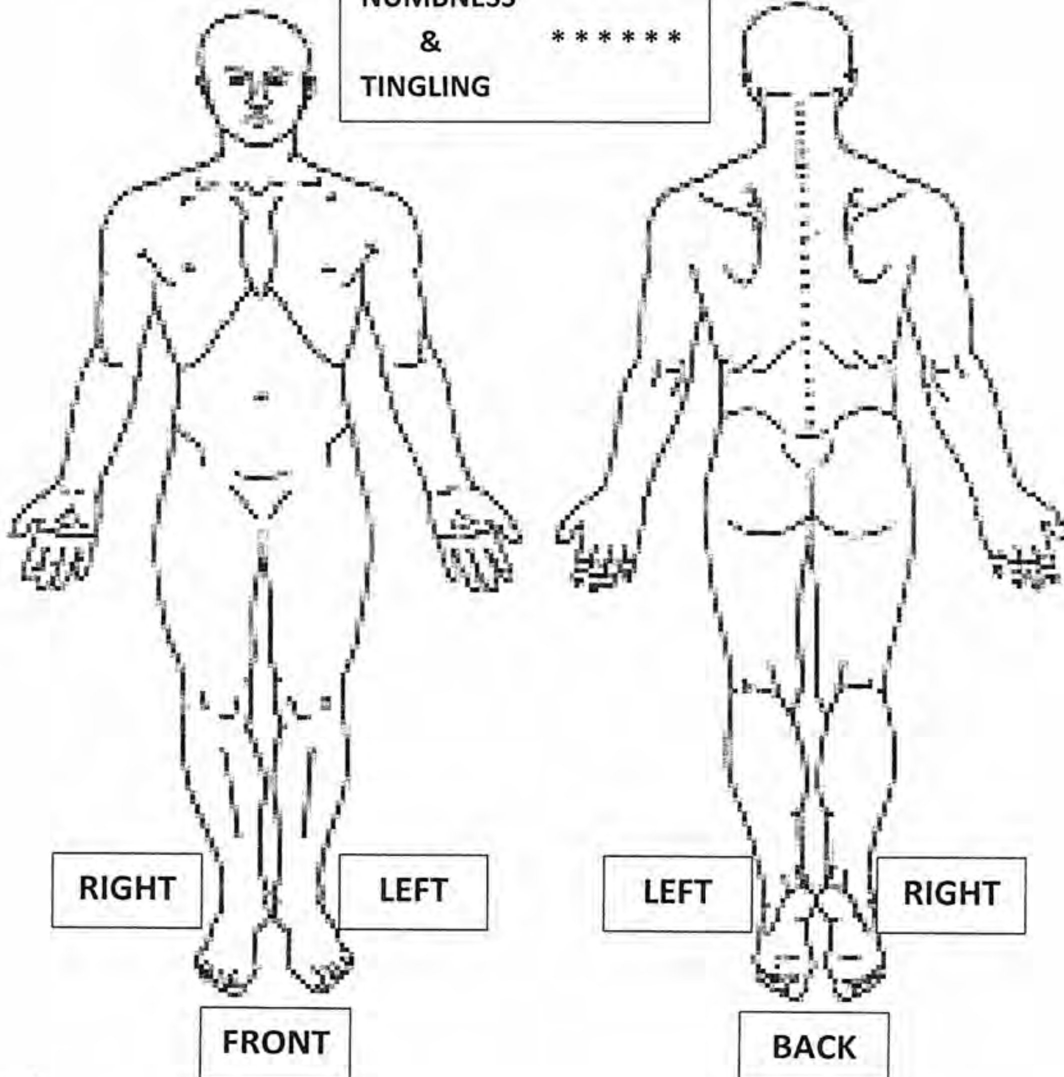
MAIN LINE SPINE: PAIN DIAGRAM

NAME________________________________ DOB______________

DATE OF APPOINTMENT________________________

Please mark the diagram according to the symptoms you are currently experiencing. Indicate the location of your symptoms and the nature of your symptoms by using the markers shown here.

BURNING	**X X X X X**
ACHE	**O O O O O**
STABBING	**/ / / / / /**
NUMBNESS & TINGLING	*** * * * * ***



06/19/2019 Revised

1. Is this related to a:

Work injury – date of Injury: ______________________________

Auto accident – date of accident: __________________________

2. Do you have (please circle all that apply):

Neck Pain   Arm Pain   Mid-Back Pain   Low Back Pain   Leg Pain   Other:____________________

3. When did your pain begin? ________________________________

4. Did your pain result from (please circle one):

a work related injury   an auto accident   a lifting event   a fall without any precipitating event or trauma

Other________________________________

5. Since your symptoms began your pain has (please circle one): worsened   improved   remained the same

6. Describe your pain (please circle all that apply):

aching   burning   cramping   dull   fiery   hot   numbing   pinching   pressure-like   pulsing

sharp   shock-like   shooting   spasms   squeezing   stabbing   stinging   tenderness   tingling

7. Is the pain (please circle one): continuous   intermittent

8. Is the pain worse (please circle one): in the morning   in the evening   no difference

9. Use the following guidelines to describe your pain:

1 – No pain
2 - 3 – Mild pain
4 - 5 – Moderate pain
6 - 7 – Pain limits ability to perform daily activities
8 - 9 – Severe pain limits all activities
10 – The worst pain you can imagine – Must go to the hospital

Based on the guidelines above, your pain on a scale of 1-10 is graded as:

at best:	**(least)**	1	2	3	4	5	6	7	8	9	10	**(severe)**
on average:	**(least)**	1	2	3	4	5	6	7	8	9	10	**(severe)**
at its worst:	**(least)**	1	2	3	4	5	6	7	8	9	10	**(severe)**

10. Pain scale of 1-10 is graded as (PLEASE CIRCLE) IN THE PAST WEEK

best describes your pain on average: 1 2 3 4 5 6 7 8 9 10

best describes your pain that has interfered with your enjoyment of life: 1 2 3 4 5 6 7 8 9 10

best describes your pain that has interfered with your general activity: 1 2 3 4 5 6 7 8 9 10

11. Describe your pain ratio:

Please circle one:	**Please circle one:**
Neck Pain/Arm Pain %	**Low back Pain/ Leg Pain %**
100% Neck/0% Arm	100% Back/0% Leg
90% Neck/10% Arm	90% Back/10% Leg
80% Neck/20% Arm	80% Back /20% Leg
70% Neck/30% Arm	70% Back /30% Leg
60% Neck/40% Arm	60% Back /40% Leg
50% Neck/50% Arm	50% Back /50% Leg
40% Neck/60% Arm	40% Back /60% Leg
30% Neck/70% Arm	30% Back /70% Leg
20% Neck/80% Arm	20% Back /80% Leg
10% Neck/90% Arm	10% Back /90% Leg
0% Neck/100%Arm	0% Back /100% Leg

12. Do you have any numbness? (please circle one): yes no **If yes, where?**____________________

13. Do you have any weakness? (please circle one): yes no **If yes, where?**____________________

14. Do you have any stiffness: (please circle one): yes no If yes, where?____________________

15. Your pain is aggravated by (please circle all that apply):

activity sitting standing walking driving coughing sneezing

looking to the same side as the pain looking away from the side of the pain looking up

looking down lifting everything nothing in particular lying down movement

physical therapy position change work turning over steroid injections other__________

16 . Your pain is improved by (please circle all that apply):

rest medications sitting standing walking lying down position change

physical therapy massage ice heat nothing in particular acupuncture activity

chiropractics steroid injections TENS unit use other____________________________

17. I no longer have pain in (name of body part)____________________________________

18. What is your tolerance (in minutes) for : (example 30minute , 1 hour)

- **a) Sitting:________________ Standing:________________ Walking:________________**
- **b) Are you functionally limited? YES / NO What is hard to do?________________**
- **c) Falls? YES / NO If so, when?________________ Injury?________________**
- **d) Equipment used to help myself:________________________________**

19. What imaging studies related to this condition have been performed? (please circle all that apply):

*****PLEASE GIVE ALL FILMS/DISCS/REPORTS TO THE RECEPTIONIST*****

MRI X-Ray CT Scan Bone Scan Ultra Sound None

Please list body part:____

20. What medications have you used for this condition? (please circle all that apply):

non-steroidal anti-inflammatories muscle relaxants nerve stabilization agents

narcotics oral Prednisone taper patches/gel/pain cream other________________

21. What amount of relief do you receive from the medications? (please circle one):

10-20% 20-30% 30-40% 40-50% 50-60% 60-70% 70-80%

80-90% greater than 90% 100% no relief at all

22. What treatments have you received for this condition? (please circle all that apply):

no specific treatment home exercise program physical therapy chiropractic therapy

acupuncture epidural steroid injections trigger point injection shoulder injections knee joint injections

hip joint injections facet injections Botox nerve condition/ electro diagnostic studies medications

radiofrequency ablation sympathetic blocks spinal cord stimulator other________________

23. If you have received physical therapy, please list name of facility and dates you attended:
Facility Name:________________________ From:______________ To:______________

24. Do you have a structured home exercise program? Yes No
(exercises given by a physical therapist or doctor)

25. Prior to this injury (WC/MVA ONLY), have you had a history of similar neck or back pain? Yes / No

26. Sleep: Excellent Good Fair Poor
 # hours per night______________
 # hours awoken per night____________ why awoken?_______________

Work History

27. Are you currently working? full-time part-time not working retired no restrictions

modified duty sedentary level

28. What is your occupation:____

Date last worked:______________ **Are you on disability?** Yes No **Date disability began:**__________

29. What percentage of your typical work day do you spend (total number should equal 100%):

sitting_____% standing_____% walking_____% driving_____% lifting_____%

30. At work you are expected to lift _______________ pounds.

Past Medical History

31. List ALL medications you are currently using including prescription, over the counter, herbal, and any others:____

____

32. Circle any of the following medical problems you have had:

Atrial Fibrillation Irregular Heartbeat Heart Murmur Stents Stroke Pulmonary Embolism

Deep Vein Thrombosis (Blood Clot) Mini Stroke Sleep Apnea COPD Shortness of Breath

High Blood Pressure High Cholesterol Heart Disease Diabetes Hypothyroidism Hyperthyroidism

Seizures Hepatitis **B** or **C** Cancer ________________ Asthma Tuberculosis Acid Reflux – G.E.R.D.

Stomach Ulcers Kidney Stones / Kidney Infections Kidney Failure – Dialysis HIV/AIDS MRSA
Other____________________________________

* Required Daily use of: Oxygen Inhalers C-Pap Machine

33. Are you allergic to any medications? Yes No

If yes, please list (including reaction):____

____

34. Do you have any allergies to seafood, shellfish, or X-ray/IV dye? Yes No

If yes, please describe____

35. Please list all surgeries you have had:______________________________________

____

____

36. Have you been hospitalized for anything other than surgery? Yes No

If yes, please describe:____

____

____

37. Please list which family member(s) have/had the following (please circle all that apply)?

Lower back pain: **relation:**__________ **Status: (alive/deceased)** __________

Neck pain: **relation:**__________ **Status: (alive/deceased)** __________

Osteoarthritis **relation:**__________ **Status: (alive/deceased)**__________

Rheumatoid arthritis: **relation:**__________ **Status: (alive/deceased)**__________

Mental Illness: **relation:**__________ **Status: (alive/deceased)**__________

Social History

38. Are you a smoker? Yes No

If so, how often? Everyday Some days

If so, are you? Ready to quit Thinking about quitting Not ready to quit

39. Do you consume alcohol? Yes No

40. Circle any of the following symptoms that you regularly experience:

painful joints swollen joints headaches weight gain weight loss

congestion rash blurred vision dizziness shortness of breath chest pain

abdominal pain   constipation   easy bruising   prolonged bleeding   urinary incontinence

balance difficulty   gait abnormality   seizures   anxiety   depressed mood

41. What is your approximate: Height:____________ Weight:______________

42. CIRCLE: YES OR NO IF YOU HAD A PNEUMONIA VACCINE: IF SO DATE:__________

43. CIRCLE: YES OR NO IF YOU HAD A FLU VACCINE: IF SO DATE:____________

44. Do you have an Advanced Directive: (circle one): YES / NO

<u>MOTOR VEHICLE PATIENTS ONLY</u>!!

45. Date of accident:____________________________________

46. Were you the driver or passenger? (please circle one)   driver   passenger

47. Were you wearing your seatbelt?   Yes   No

48. Where was the point of impact? (please circle one):

front of car   rear of car   driver's side of car   passenger's side of car

49. Did the airbags deploy?   Yes   No

50. Did you have loss of consciousness?   Yes   No

51. After the accident you were (please circle all that apply):

transferred directly to the hospital (ER) via ambulance

after being evaluated at the hospital (ER): admitted into the hospital **OR** discharged home

sought medical attention at a later date

did not seek medical attention

Patient's Signature ____________________________________ Date:__________________