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
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Andrew A. Badulak, D.O.
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Pain Medicine
Integrative Holistic Medicine

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Sharon A. Folger, PA-C

Lauren M. Ziegler, PA-C

Renée DiGuiseppe, PA-C

Jordyn Wallace, CRNP

*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

3855 West Chester Pike
Suite 250
Newtown Square, PA 19073

599 Arcola Road, Suite 105
Collegeville, PA 19426

PHONE (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**. 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,

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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 ☺

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 AN ATTORNEY 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:_____

(Revised 1/13/2021)

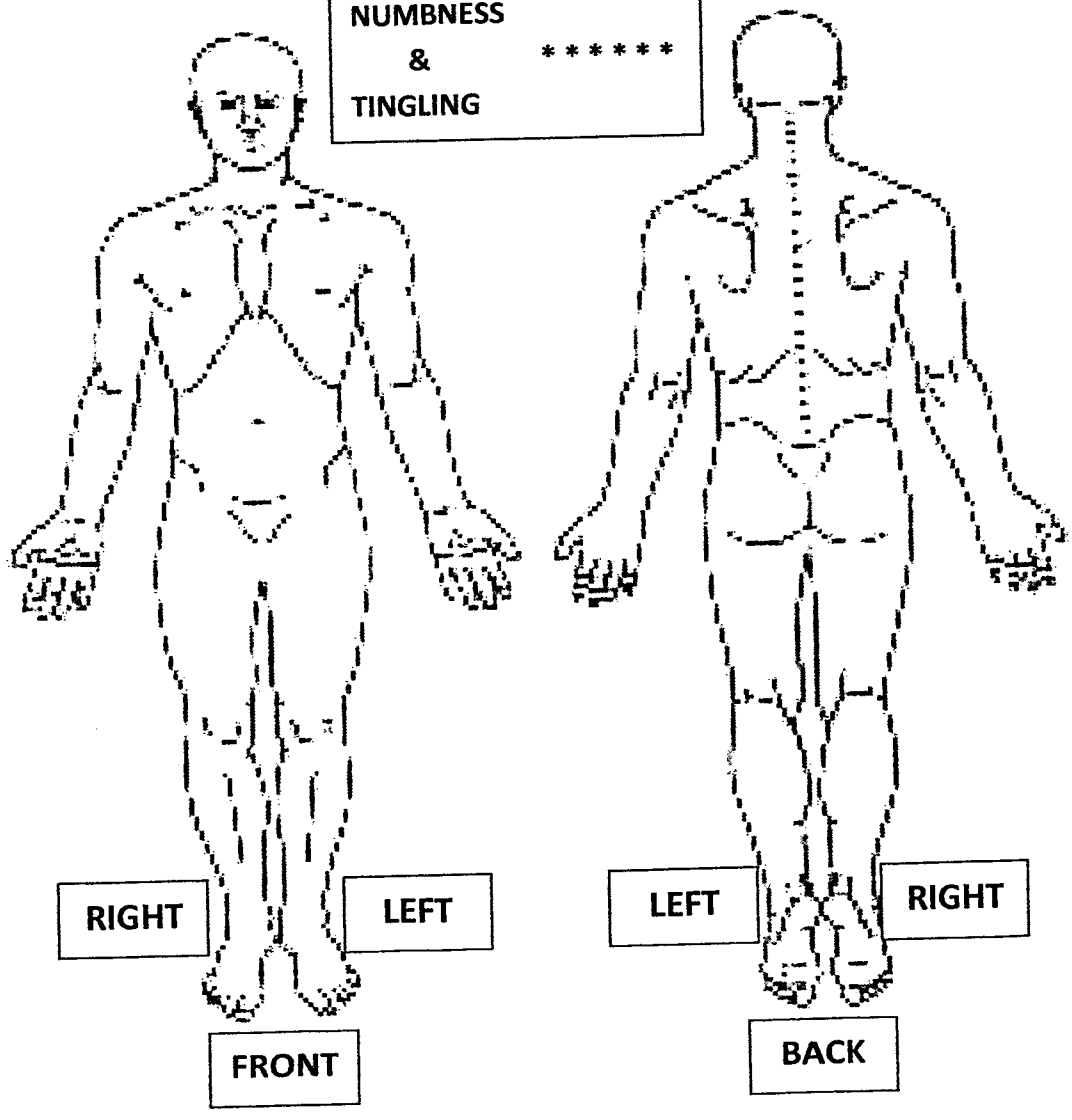
MAIN LINE SPINE: PAIN DIAGRAM

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	XXXXX
ACHE	OOOOO
STABBING	//////
NUMBNESS & TINGLING	******



(Revised 5/5/22)

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 or an auto accident: **If so, did you have any similar pain prior to this injury: YES OR NO**

a lifting event or a fall or without any precipitating event or trauma or 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 numbing pinching pressure-like

sharp shock-like shooting spasms stabbing tingling

7. Is the pain (please circle one): continuous OR 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. Does your pain interfere with your quality of life and Activities of daily living. YES OR NO

11. Describe your pain ratio:

Please circle one: **Neck Pain/Arm Pain %**	**Please circle one:** **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

chiropractic steroid injections TENS unit use other_____

17. 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:**_____

18. 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: _____

19. 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_____

20. 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

21. 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_____

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

23. Do you have a structured home exercise program? Yes NO

24. Sleep: **Excellent Good Fair Poor**

 # hours per night_____

 # hours awoken per night_____ **why awoken?**_____

Work History

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

modified duty sedentary level

26. What is your occupation:_____

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

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

sitting_____% standing_____% walking_____% driving_____% lifting_____%

28. At work you are expected to lift _____ **pounds.**

Past Medical History

29. LIST ALL MEDICATIONS YOU ARE TAKING CURRENTLY (PRESCRIPTION AND OVER THE COUNTER). IF YOU HAVE A MEDICATION LIST PLEASE SUBMIT TO REGISTRATION:

_____

_____

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

Atrial Fibrillation Pacemaker Defibrillator 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

31. Are you allergic to any medications? Yes No

If yes, please list : include reaction:_____

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

If yes, please describe your reaction: _____

32. Please list all surgeries you have had_____

_____

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

If yes, please describe:_____

_____

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

Lower back pain Neck pain Osteoarthritis Rheumatoid arthritis Mental Illness

Relationship:_____ **Status: Alive/ Deceased**

Social History

35. Are you a smoker? Yes No: **If so, are you?** Ready to quit Thinking about quitting Not ready to quit

36. Do you consume alcohol? Yes No

37. 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

38. What is your approximate: Height:_____ **Weight:**_____

39. CIRCLE: YES OR NO IF YOU HAD A PNEUMONIA VACCINE: IF SO DATE:_____

40. CIRCLE: YES OR NO IF YOU HAD A FLU VACCINE: IF SO DATE:_____

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

MOTOR VEHICLE PATIENTS ONLY

42. Date of accident:_____

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

44. Were you wearing your seatbelt? Yes No

45. 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

46. Did the airbags deploy? Yes No

47. Did you have loss of consciousness? Yes No

48. 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

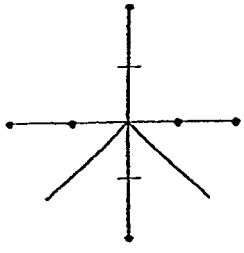
did not seek medical attention

Patient's Signature _____ Date:_____

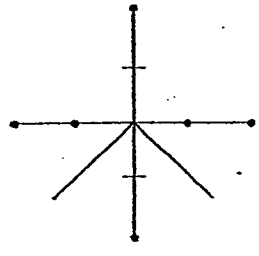
OFFICE USE ONLY:

PHYSICAL EXAM

CERVICAL



LUMBAR



NEURO NL ABNL

SHOULDER ABD FLEX IR ER

R: FULL LIMITED ___ ___ ___ ___

L: FULL LIMITED ___ ___ ___ ___

TENDER + – R L ANT SUB POST

RESISTIVE MAN + – R L SUP INF SUB DEL

SLR R_____B L

L_____B L

KNEE TO CHEST R + – L + – B + –

PRESS UP + – B L

INTERSPACE C1 2 3 4 5 6 7 T1 2 3 4 L1 2 3 4 5 S1

FACETS R C1 2 3 4 5 6 7 T1 2 3 4 L1 2 3 4 5 S1

L C1 2 3 4 5 6 7 T1 2 3 4 L1 2 3 4 5 S1

R L TRAP RHOMBOID INTERSCAPULAR

R L SI GLUT

SENSORY_____ MOTOR_____ DTR_____

(Revised 5/5/22)