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 340
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 the necessary paperwork that we need you to fill out for us. 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 CARE ARE REQUIRED UPON REGISTRATION**. If you have 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)**.
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 7/23/2021)

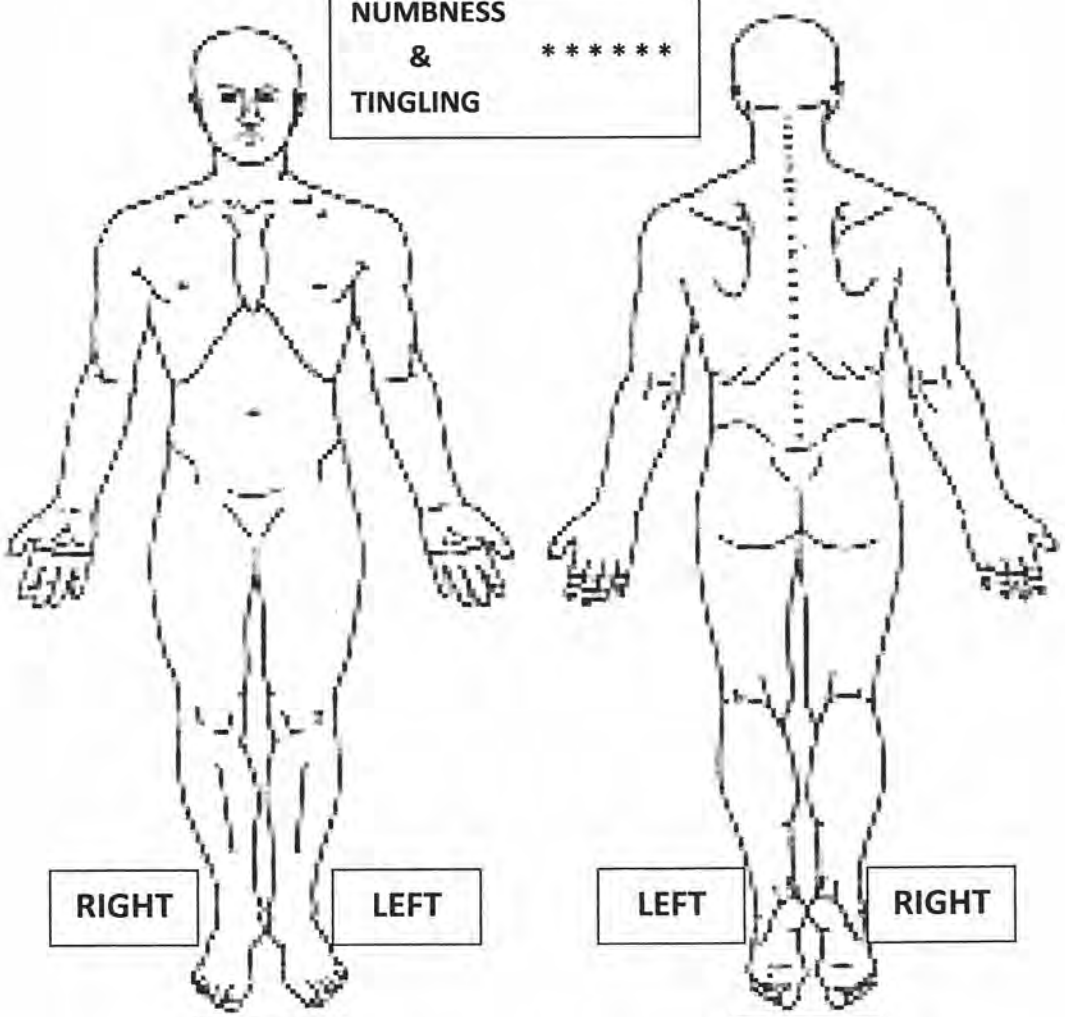
MAIN LINE SPINE: PAIN DIAGRAM

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



1. Is this a 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 pain prior to this injury: YES OR NO**

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. 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)**

11. Does your pain interfere with your quality of life and activities of daily living. YES OR NO

12. Describe your pain ratio: **Please circle one:**

Neck Pain/Arm Pain %
100% Neck/0% Arm
90% Neck/10% Arm
80% Neck/20% Arm
70% Neck/30% Arm
60% Neck/40% Arm
50% Neck/50% Arm
40% Neck/60% Arm
30% Neck/70% Arm
20% Neck/80% Arm
10% Neck/90% Arm
0% Neck/ 100% Arm

Please circle one:

Low back Pain/ Leg Pain %
100% Back/0% Leg
90% Back/10% Leg
80% Back /20% Leg
70% Back /30% Leg
60% Back /40% Leg
50% Back /50% Leg
40% Back /60% Leg
30% Back /70% Leg
20% Back /70% Leg
10% Back /90% Leg
0% Back/ 100% Leg

13. Do you have any numbness? (please circle one): YES NO **If yes, where?**_____

14. Do you have any weakness? (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):

0-40% 40-70% 70-100% Greater than 90% 100% No Relief

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

no specific treatment physical therapy home exercise program chiropractic therapy acupuncture

epidural steroid injections trigger point injection shoulder injections knee joint injections

hip joint injections facet injections nerve condition/ electro diagnostic studies medication

radiofrequency ablation 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 or No

Work History

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

modified duty sedentary level **What is your occupation:**_____

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

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

sitting_____% standing_____% walking_____% driving_____% lifting_____%

26. At work you are expected to lift _____ pounds.

Past Medical History (numbers 26-30)

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

_____

28. Circle any of the following medical problems you have had:
Atrial fibrillation Pacemaker defibrillator Irregular Heartbeat Heart murmur Stent Stroke Pulmonary embolism

Dep Vein thrombosis(Blood Clot) Mini Stroke Sleep Apnea COPD High Blood Pressure High cholesterol

Heart Disease Diabetes Thyroid Disease Seizures Hepatitis B or C Cancer_____ Asthma

Tuberculosis Acid Reflux Aneurysm Kidney Stones Kidney Failure-Dialysis HIV/AIDS MRSA

Other:_____ Required Daily use of: Oxygen Inhalers C-Pap Machines

29. Are you allergic to any medications? Yes No

If yes, please list (including reaction):_____

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

If yes, please describe_____

31. Please list all surgeries you have had:_____

_____

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

If yes, please describe:_____

33. 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

34. 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

35. Do you consume alcohol? Yes / No

36. Circle any of the following symptoms that you regularly experience

painful joints swollen joints headaches weight gain weight gain 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

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

MOTOR VEHICLE PATIENTS ONLY!!

38. Date of accident:_____

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

40. Were you wearing your seatbelt? Yes No

41. 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

42. Did the airbags deploy? Yes No

43. Did you have loss of consciousness? Yes No

44. 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

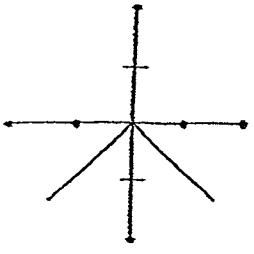
did not seek medical attention

Patient's Signature _____ Date:_____

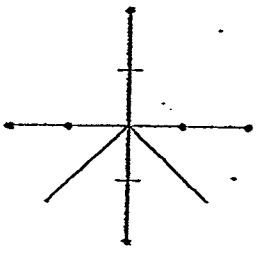
OFFICE USE ONLY:

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_____