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

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

Farzad H. Karkvandeian, DO, FAAPMR
Board Certified
Physical Medicine and Rehabilitation

Eric A. Liu, D.O.
Board Certified
Physical Medicine and Rehabilitation

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

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

Sharon A. Folger, PA-C

Lauren M. Ziegler, PA-C

Renée DiGuiseppe, PA-C

Lindsay Lahoda, 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

2870 Audubon Village Drive
Suite M
Audubon, PA 19403

Phone (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 **30 MINUTES PRIOR TO YOUR APPOINTMENT TIME** TO HAVE YOUR INFORMATION ENTERED OR 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

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

Farzad H. Karkvandeian, DO, FAAPMR
Board Certified
Physical Medicine and Rehabilitation

Eric A. Liu, D.O.
Board Certified
Physical Medicine and Rehabilitation

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

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

Sharon A. Folger, PA-C

Lauren M. Ziegler, PA-C

Renée DiGuiseppe, PA-C

Lindsay Lahoda, 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

3853 West Chester Pike
Suite 340
Newtown Square, PA 19073

2870 Audubon Village Drive
Suite M
Audubon, PA 19403

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

Attached, please find all the necessary paperwork that we need you to fill out for us. In order to see the doctor, please fill out **ALL** the paperwork, and bring it to your appointment. **PLEASE, DO NOT MAIL BACK**. Make certain that all the pertinent insurance information is completed. **PHOTO I.D. & INSURANCE CARDS 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 XRAYS, MRIs, CT scans, or bone scans you had done pertaining to this appointment. We ask that you obtain the **disc(s)** and **radiology report(s)**. We may not have access to the facilities system.
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: _____ PHONE# _____

EMPLOYER NAME: _____ ADDRESS: _____

DATE OF INJURY: _____ REASON FOR VISIT: _____

REFERRED BY DOCTOR: _____ PRIMARY DOCTOR: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

PHONE #: _____ PHONE #: _____

BILLING INFO: 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 WORKER'S COMP OR AUTO. THANK YOU.

IF APPLICABLE, NAME AND ADDRESS OF ATTORNEY: _____

_____

PHONE #: _____ FAX #: _____

PHARMACY NAME: _____CITY: _____PHONE#_____

WE DO NOT BILL ATTORNEYS 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: _____

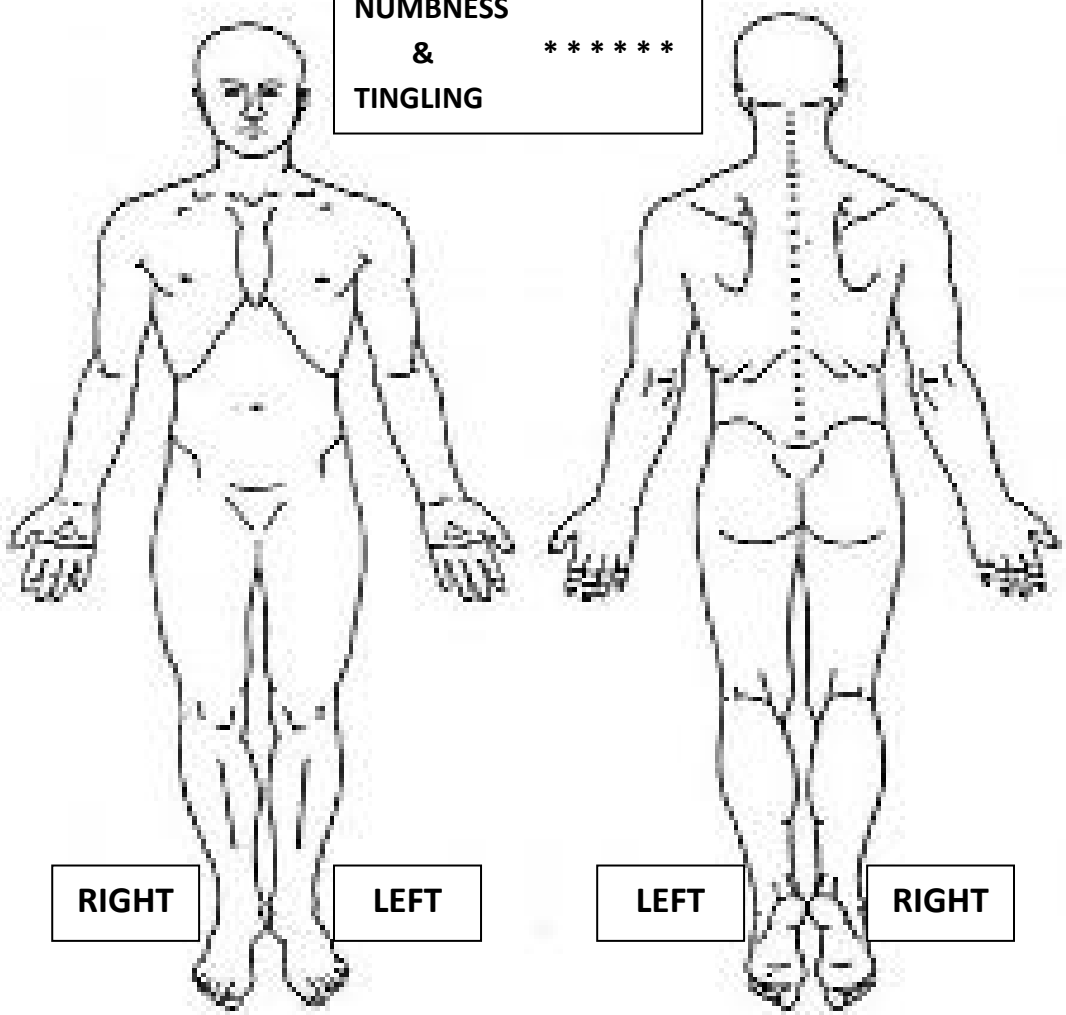
MAIN LINE SPINE: PAIN DIAGRAM

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 (please check one if applicable): Work injury____ Date of Injury:_____Auto accident____ Date of accident: _____

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

Neck Pain____ Arm Pain____ Mid-back Pain____ Lower back Pain____ Leg Pain____ Hip Pain____ Other:_____

3. When did your pain begin?_____

4. Did your pain result from (please check one): A work-related injury____ A fall____ Without any precipitating event or a trauma____ Other:_____

5. Since your symptoms began your pain has (please check one): Worsened____ Improved____ Remained the same____

6. Describe your pain (please check 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 check one): Continuous____ Intermittent____

8. Is the pain worse (please check 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 its 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____ NO____

11. Describe your pain ration: (Please check one): **(Please check 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 check one): YES____ NO____ If yes, where?_____

13. Do you have any weakness? (please check one): YES____ NO____ If yes, where?_____

14. Do you have any stiffness? (please check one): YES____ NO____ If yes, where?_____

15. Your pain is aggravated by (Please check all that apply):

Activity____ Coughing____ Driving____ Everything____ Lifting____ Looking up____ Looking down____

Looking to the same side as the pain____ Looking away from the side of the pain____ Lying down____

Movement____ Nothing in particular____ Position change____ Physical therapy____ Sitting____

Sneezing____ Standing____ Steroid injections____ Turning over____ Walking____ Working____

Does anything improve your pain?_____

16. What is your tolerance (IN MINUTES) for: (EXAMPLE 30 MINUTES, 1HOUR, Etc.)

a) Sitting:_____Standing:_____Walking:_____
b) Are you functionally limited: YES____ NO____ What is hard to do?_____
c) Have you had any falls: YES____ NO____ If so, when?_____ Injury?_____
d) Have you felt: Unsteady or worried about falling: YES____ NO____

17. Do you have any devices: Wheelchair____ Walker____ Cane____ Other:_____

18. What imaging studies have been done related to this condition? (please check all that apply):

MRI____ X-Ray____ CT Scan____ Bone Scan____ Ultrasound____ None____
Please list body part: _____

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

Muscle relaxants____ Narcotics____ Nerve stabilization agents____ Non-steroidal Anti-inflammatories____

Oral Prednisone taper____ Patches/gel/pain cream____ Other_____

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

0-40%____40-70%____70-100%____Greater than 90%___100%____No relief____

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

No specific treatment___ Acupuncture____ Chiropractic therapy____ Epidural steroid injections____
Facet injections____ Hip injections____ Home exercise____ Knee joint injections____ Medications____
Electrodiagnostic study (EMG)____Physical therapy____ Radiofrequency ablation____
Shoulder injections____ Spinal cord stimulator____ Trigger point injections____ Other:_____

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

23. Are you in a structured home exercise program YES____ 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 workday 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

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

28. Check any of the following medical problems you have had:

Atrial fibrillation____ Asthma Acid reflux ____ Aneurysm____ Cancer_____ COPD____
Defibrillator____ Deep vein thrombosis (blood clot)____ Diabetes____ Heart attack____ Heart murmur____
Heart disease____ Hepatitis B or C____ High blood pressure____ High cholesterol____
Irregular heartbeat____ Kidney stones____ Kidney failure-dialysis____ HIV/AIDS_____ Mini stroke____
Pacemaker____ Pulmonary Embolism____ Seizures____ Sleep apnea____ Stent____ Stroke____ Thyroid
Disease____ Tuberculosis____ Required daily use of: Oxygen inhalers____ C-pap machine____ Other_____

29. Please list any medication ALLERGIES: _____
Please list any reaction:_____

30. Do you have any allergies to seafood, shellfish, or X-ray/IV dye? YES____ NO____
If yes, please describe reaction_____

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.*WITH IN THE LAST 3 TO 6 MONTHS HAVE YOU HAD ANY HOSPITALIZATION FOR TREATMENT FOR ANY CARDIAC ISSUES:** YES____NO____ *******IF YES PLEASE DESCRIBE THE HOSPITALIZATION PROCEDURES:**_____
_____

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

Lower back pain____ Neck pain____ Osteoarthritis____ Rheumatoid arthritis____ Mental illness____

Relationship:_____ Status**:** Alive____ Deceased____

SOCIAL HISTORY

35. Do you smoke, vape or use any other form of tobacco? YES____ NO____
If so, how often: Everyday____ Somedays____
Are you interested in: Quitting____ Thinking about quitting____ Not ready to quit____

36. Do you consume alcohol? YES____NO____
If yes:

a) How often did you have a drink containing alcohol in the past year?_____
b) How many drinks did you have on a typical day when you were drinking in the past year?_____
c) How often did you have six or more drinks on occasion in the past year?_____

37. Check any of the following symptoms that you regularly experience:

Painful joints____ Swollen joints____ Headaches____ 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____

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

MOTOR VEHICLE PATIENTS ONLY!!!

39. Date of accident:_____

40. Were you the driver or passenger? (please check one) Driver____ Passenger____

41. Were you wearing your seatbelt? YES____ NO____

42. Where was the point of impact? (please check one):

Front of car____ Rear of car____ Driver's side of car____ Passenger side of car____

43. Did the airbags deploy? YES____ NO____

44. Did you have loss of consciousness? YES____ NO____

45. After the accident you were (please check all that apply):

Transferred directly to the hospital (ER) via ambulance____

After being evaluated at the hospital (ER) you were: Admitted into the hospital____ Discharged home____

You sought medical attention at a later date____ You did not seek medical attention____

Patient's Signature_____ Date_____

American Heart Association.
Hard Hats with Heart™

Toolbox Talks

How Smoking and Nicotine Damages Your Body

You probably know that smoking can lead to lung cancer, but did you know smoking is also linked to heart disease, stroke and other chronic diseases? Smoking can increase your risk for cancer of the bladder, throat, mouth, kidneys, cervix and pancreas. Thinking about quitting? Look at the facts!

Why should you quit?

- Smoking is the most preventable cause of death in the United States.
- Almost one third of deaths from coronary heart disease are due to smoking and secondhand smoke.
- Smoking is linked to about 90% of lung cancer cases in the United States.
- Smoking rates overall are down, but too many adults still smoke, vape and use other forms of tobacco, especially between the ages of 21 and 34.
- On average, smokers die more than 10 years earlier than nonsmokers.
- You can be one of the millions of people who successfully quit every year.

What makes cigarettes so toxic and dangerous?

There are more than 5,000 chemical components found in cigarette smoke and hundreds of them are harmful to human health, according to the Centers for Disease Control and Prevention. Some examples are:

- **1,3-Butadiene** is a chemical used to manufacture rubber. It is considered to be a carcinogenic chemical that can cause certain blood cancers.
- **Arsenic** is used to preserve wood. Some arsenic compounds have been linked to cancer of the lung, skin, liver, and bladder.

Frequently Asked Questions:

Do you inhale carbon monoxide when smoking?
Yes, and once in your lungs, it's transferred to your bloodstream. Carbon monoxide decreases the amount of oxygen that is carried in the red blood cells. It also increases the amount of cholesterol that is deposited into the inner lining of the arteries which leads to heart disease, artery disease and possibly heart attack.

Discussion Questions:

- Have you seen an increase in smoking/vaping in the people you surround yourself with?
- Why do you think there is an increase in smoking/vaping? Stress? Accessibility?

American Heart Association.
Hard Hats with Heart™

Toolbox Talks

Is Drinking Alcohol Part of a Healthy Lifestyle?

If you enjoy sipping a glass of wine, a beer or a cocktail now and then, keep moderation in mind to protect your health. Moderate alcohol consumption means an average of one to two drinks per day for men and one drink per day for women. Different types of beer, wine and liquor have different amounts of alcohol. But in general, a drink is one 12-ounce regular beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits, such as bourbon, vodka or gin .

How does drinking alcohol affect health?

Drinking too much alcohol increases your risk for many health problems, including high blood pressure, obesity, stroke, breast cancer, liver disease, depression, suicide, accidents, alcohol abuse and alcoholism. Here's what science tells us about alcohol's effects on the body.

- Drinking too much alcohol can raise the levels of some fats in the blood known as triglycerides. A high triglyceride level has been associated with fatty buildup in the artery walls, in turn, increasing the risk of heart attack and stroke.
- Heavy drinking may also prematurely age arteries over time, particularly in men, when compared to moderate drinkers.
- All the extra calories from drinking alcohol can lead to obesity and a higher risk of developing diabetes.

Did you know?

Many think red wine is supposed to be healthy and that a glass a day can be good for the heart. BUT, no research has proved a cause-and-effect link between drinking alcohol and better heart health. Components in red wine such as flavonoids and other antioxidants can potentially reduce heart disease risk, but they can also be found in other foods like grapes or blueberries.

Frequently Asked Questions:

Is alcohol high in calories?
A beer or glass of wine is generally around 100-150 calories. A cocktail can range from 100-500 calories depending on the ingredients.

Is it okay to drink alcohol if I take aspirin?
People who take aspirin regularly are at risk for stomach problems, and alcohol can increase these risks. Consult with your doctor to see if it is safe for you.

Discussion Questions:

- What changes do you feel in your body after consuming alcohol?