STAR
SPINE TECHNOLOGY AND REHABILITATION

O NEW O CHANGE Effective date: ____/_____/_____

PATIENT DEMOGRAPHIC INFORMATION

Personal Information:

Last Name First Name Middle Initial

O Male O Female DOB (mm/dd/yyyy): _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home# _____ O Preferred Work# _____ O Preferred

Mobile# _____ O Preferred E-mail: _____

Employer: _____ Address: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact (not in the same household): _____ Phone# _____

Referral Information:

Referring Doctor: _____ Phone# _____

Family Doctor: _____ Phone# _____

I agree to provide to my physician accurate and complete information, including, but not limited to, insurance information, cause of injury, medical history, etc. I understand that not providing accurate and complete information will result in the physician not receiving correct reimbursement from the appropriate insurance company and I agree to be responsible for all charges for services rendered.

_____ _____

Signature Date

In accordance with HIPAA regulations, I authorize STAR to disclose my protected health information (PHI) to other healthcare providers as well as to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

O NEW O CHANGE Effective date: ____/_____/_____

_____ _____

Patient's Signature Date

PATIENT INSURANCE INFORMATION

We will need to make a copy of your insurance card(s)

Patient Name:

_____

Last Name First Name Middle Initial

Is this injury: O Work-Related? O Auto-injury? If so, please complete the information in this section:

Company Name: _____ Claim # _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone # _____

Date of Injury (mm/dd/yyyy): _____ I have contacted an attorney: O Yes O No

Primary Insurance Information:

Insurance Company: _____ Phone #_____

Address: _____

Contract# _____ Group# _____ Effective Dates: _____

Subscriber's Legal Name: _____ DOB (mm/dd/yyyy): _____

SSN: _____ Subscriber's Relationship to patient: _____

Subscriber's Employer: _____ Phone# _____

Secondary Insurance Information:

Insurance Company: _____ Phone# _____

Address: _____

Contract# _____ Group# _____ Effective Dates: _____

Subscriber's Legal Name: _____ DOB (mm/dd/yyyy): _____

SSN: _____ Subscriber's Relationship to patient: _____

Subscriber's Employer: _____ Phone# _____

O NEW O CHANGE Effective date: ____/_____/_____

Prescription Insurance Information:

Do you have Prescription Coverage? O Yes O No

Name of Provider: _____ Phone# _____

Contract# _____ Group# _____ Effective Dates: _____

PATIENT HISTORY ASSESSMENT

Patient Name:

Last Name First Name Middle Initial

Section A:

What is your primary complaint? _____

Category of pain (choose one): O A gradual onset without trauma, injury, or change in activity.
O An abrupt onset without trauma, injury or change in activity.
Date of onset (mm/dd/yyyy): _____

This injury is a… O Personal Injury (Continue to Section B)
O Worker's Compensation Injury (Continue to Section C)
O Automobile Injury (Continue to Section D)
O None of the Above (Continue to Section E)

Section B: Personal Injury

Date of Injury (mm/dd/yyyy): _____ Location (Ex. home, parking lot, etc.): _____

What happened? (Ex. fell of ladder, etc.): _____

Where have you been treated for your injury? _____

Has any legal action been taken? O Yes O No If yes, is the litigation still pending? O Yes O No

If yes, who is your attorney? _____

PLEASE CONTINUE TO **SECTION E.**

SECTION C: Workman's Compensation (WC)

Date of Injury (mm/dd/yyyy): _____

Has your employer filled the claim? O Yes O No State where claim was filled: _____

Briefly explain the cause of your injury: _____

Is the WC claim still open? O Yes O No If no, date closed (mm/dd/yyyy): _____

O NEW O CHANGE Effective date: ____/_____/_____

If yes, do you have an attorney? O Yes O No If yes, who is your attorney? _____

PLEASE CONTINUE TO **SECTION E.**

SECTION D: Automobile Injury (AA)

Date of accident (mm/dd/yyyy): _____ Do you have an open auto claim? O Yes O No

If yes, do you have an attorney? O Yes O No If yes, who is your attorney? _____

Any open litigation? O Yes O No If yes, please explain: _____

Mark all that apply: O Driver O Passenger O Pedestrian O Wearing Seat Belt O Not Wearing Seat Belt

O Rear-ended O Head-On O Side-swiped O T-boned O Single Auto-accident PLEASE CONTINUE TO **SECTION E.**

O NEW O CHANGE Effective date: ____/_____/_____

SECTION E: Disability

Are you on Social Security Disability? O Yes O No If yes, do you have Medicare Part D? O Yes O No

Are you on Short Term (Sick Leave) Disability through your employer? O Yes O No

If yes, state the last day you worked: _____ Doctor that authorized it: _____

Are you on Long Term (Sick Leave) Disability through your employer? O Yes O No

If yes, state the last day you worked: _____ Doctor that authorized it: _____

A Functional Capacity Evaluation (FCE) is an assessment tool utilized for those who have suffered an injury that may affect employment. It is a standardized way to collect information regarding physical abilities to determine whether or not you can return to your previous job duties. You may be asked to have an FCE if off work for an extended period of time.

Have you had an FCE? O Yes O No If yes, state the date and place: _____

SECTION F: Education and Employment Status

What is the highest grade you have completed in education? _____

Employment Status: O Employed O Unemployed O Disability O Sick Leave O Retired

If employed, what is your occupation? _____ For how many years? _____

If retired, what was your occupation? _____ For how many years? _____

If you are currently unemployed, on disability or on sick leave, please describe briefly why you are unable to work:

_____

SECTION G: Social History

Marital Status: _____ # of children: _____ Household Occupancy: _____

SECTION H: Family History

Please list any condition that your family members have or have been treated for:

Family Member	Condition
_____	_____
_____	_____
_____	_____

Is there any family history of osteoporosis (brittle bone)? O Yes O No

SECTION I: Past Medical History I (check yes or no)

SKIN	YES	NO	EYES, EARS, NOSE AND THROAT	YES	NO

Skin Infections	___	___	Foreign object in eyes	___	___
Decubitus Ulcer	___	___	Visual Disturbances	___	___
Skin Ulcers	___	___	Ringing in ears	___	___
Scars	___	___	Mouth Sores	___	___
Incisions	___	___	Nose Drainage	___	___
Rashes	___	___	Hearing Loss	___	___
			Double Vision	___	___

SECTION J: Past Medical History II (mark all that apply)

CARDIO
O Coronary Artery Disease
O Congestive Heart Failure
O High Blood Pressure
O Peripheral Vascular Disease
O Heart Murmur
O History of Heart Attack

RENAL
O Kidney Disease
O Kidney Failure
O Kidney Transplant
O History of Kidney Cancer

ENDOCRINOLOGY
O Diabetes (w/insulin)
O Diabetes (w/o insulin)
O Hypothyroidism
O Low Testosterone
O Addison's Disease

HEMATOLOGY
O Anemia
O Leukemia
O Lymphoma
O Bleeding Disorder

DERMATOLOGY
O Skin Lupus
O Eczema
O Psoriasis
O History of Skin Cancer

INFECTIOUS DISEASES
O Shingles
O Lyme Disease
O HIV/Aids

URO/GYN
O Kidney Stones
O Kidney Cysts
O Pelvic Inflammatory Disease
O History of Testicular Cancer
O Endometriosis
O Tubal Pregnancy
O Erectile Dysfunction

PSYCHIATRIC
O Depression
O Bipolar Disease
O Anxiety
O Social Phobia
O History of Suicide Attempt
O History of Blood Clotting

RHEUMATOLOGY/ORTHO
O Crohn's Disease
O Rheumatoid Arthritis
O Systemic Lupus
O Psoriatic Arthritis
O Osteoporosis
O Osteopenia
O Osteoarthritis
O Myasthenia Gravis
O Polymyositis
O Carpal Tunnel Syndrome
O Fibromyalgia

PULMONARY
O COPD/Emphysema
O Asthma
O Sleep Apnea
O History of Ovarian Cancer
O History of Pulmonary Embolism

NEUROLOGY
O Multiple Sclerosis
O Neuropathy

GASTROENTEROLOGY
O Heartburn/Reflux
O Systemic Lupus
O Colitis
O Chronic Diarrhea
O Chronic Constipation
O Irritable Bowel Syndrome
O Psychosis
O Celiac Disease- Gluten Sensitive
O Ulcers
O Bleeding Ulcers
O History of Colon Cancer
O Barrett's Esophagus

OTHER CONDITIONS
O Recurrent Pneumonia

SECTION K: Previous Medication (mark all that apply)

O Amerge	O Frova	O Norgesic Forte	O Soma
O Amrix	O Gabitril	O Neurontin	O Talwin
O Arthrotec	O Ibuprofen	O Opana ER	O Topamax
O Avinza	O Imitrex	O Oxycodone	O Trazadone
O Axert	O Indocin	O OxyContin	O Treximet
O Celebrex	O Kadian	O Pamelor	O Tylenol
O Celexa	O Keppra	O Panlor SS	O Tylox
O Cymbalta	O Klonopin	O Parafon	O Ultracet
O Darvocet	O Lexapro	O Paxel	O Ultram ER

O Darvon	O Lodine	O Pennsaid	O Valium
O Daypro	O Lortab	O Percocet	O Vicodin
O Depakote	O Luvox	O Prestiq	O Voltaren
O Dilaudid	O Lyrica	O Prozac	O Wellbutrin
O Duragesic	O Maxalt	O Relafen	O Zanaflex
O Effexor	O Methadone	O Relpax	O Zoloft
O Elavil	O Mirapex	O Remeron	O Zomig
O Embeda	O MS-Contin	O Requip	O Zonegran
O Exalgo	O MSIR (morphine)	O Robaxin	O _____
O Fentora	O Naprosyn	O Ryzolt	O _____
O Flexeril	O Norflex	O Senokot	O _____

SECTION L: Current Medication

MEDICATION	DOSE	FREQUENCY	EFFECTIVENESS (high, medium, low)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SECTION M: Allergies (mark all that apply)

O No Known Drug Allergies O Dye/Contrast Allergy O Iodine Allergy O Seafood/Shell Fish Allergy

ALLERGEN REACTION

_____ _____

_____ _____

_____ _____

SECTION N: Nature of Symptoms: RATE the affective areas according to severity (1st being highest priority)

____ Neck	____ Right Elbow	____ Right Ankle
____ Mid-Back	____ Left Elbow	____ Left Ankle
____ Low Back	____ Right Wrist	____ Right Foot
____ Buttock	____ Left Wrist	____ Left Foot
____ Right Arm	____ Right Hand	____ Chest Wall
____ Left Arm	____ Left Hand	____ Abdominal
____ Right Leg	____ Right Hip	____ Pelvic
____ Left Leg	____ Left Hip	____ Headaches
____ Right Shoulder	____ Right Knee	____ Tail Bone
____ Left Shoulder	____ Left Knee	____ Other: _____

SECTION O: Review of Symptoms (choose all that apply)

O Weakness Where? _____ O Numbness Where? _____

O Tingling Where? _____ O Burning Pain Where? _____

O Shooting Pain Where? _____ O Stabbing Pain Where? _____

O Achy Pain Where? _____ O Muscle Spasms Where? _____

O Loss of Bladder O Loss of Bowels O Pain disrupts sleep O Pain disrupts housework

O Pain disrupts my job O Pain disrupts my ability to care for myself/family

Pertaining to Headaches (choose all that apply)

O Left-Sided O Head and Eyes O Double vision O Worse when lying down

O Right-Sided O Nausea O Runny Nose O Better when lying down
O Behind the head O Vomiting O Eyes Watering O Awaken by headache
O Forehead O Sensitive to light O Ear Drainage O History of TMJ
O Facial Pain O Sensitive to sound O Nasal Congestion O Grinding Teeth
O Sides of head O Dizziness O Metallic taste in mouth O Other: _____
O Top of head O Blurred vision O Worse when standing/sitting

SECTION P: Review of Symptoms II

ACTION	PAIN LEVEL		
When I first get out of bed	O Worsens Pain	O Relieves Pain	O No change
Sitting	O Worsens Pain	O Relieves Pain	O No change
Leaning forward	O Worsens Pain	O Relieves Pain	O No change
Lying on side	O Worsens Pain	O Relieves Pain	O No change
Lying on back	O Worsens Pain	O Relieves Pain	O No change
Lying on stomach	O Worsens Pain	O Relieves Pain	O No change
Lifting	O Worsens Pain	O Relieves Pain	O No change
Bending backwards	O Worsens Pain	O Relieves Pain	O No change
Getting up	O Worsens Pain	O Relieves Pain	O No change
Standing	O Worsens Pain	O Relieves Pain	O No change
Walking	O Worsens Pain	O Relieves Pain	O No change
Driving	O Worsens Pain	O Relieves Pain	O No change
Coughing	O Worsens Pain	O Relieves Pain	O No change
Stooping	O Worsens Pain	O Relieves Pain	O No change
Twisting	O Worsens Pain	O Relieves Pain	O No change
Other: _____	O Worsens Pain	O Relieves Pain	O No change

SECTION Q: Diagnostic Testing (choose all that apply)

O X-RAY Region: _____ Date : _____
O MRI Region: _____ Date : _____
O Myelogram Region: _____ Date : _____
O Discography Region: _____ Date : _____
O Bone Scan Region: _____ Date : _____
O Spinal Tap Region: _____ Date : _____
O EMG Region: _____ Date : _____
O Arthrogram Region: _____ Date : _____
O Other: _____ Region: _____ Date : _____

SECTION R: Previous Treatments (choose all that apply)

TREATMENTS	DATES (mm/dd/yyyy-mm/dd/yyyy)	RESPONSE (+ or -)

O Massage Therapy	_____	_____	
O Medications	_____	_____	
O Chiropractic Care	_____	_____	
O Acupuncture	_____	_____	
O Traction	_____	_____	
O Tens Unit	_____	_____	
O Facet Injections	_____	_____	
O Sacroiliac Joint Injection	_____	_____	
O Joint Injections	_____	_____	# of times: _____
O Epidurals	_____	_____	Type: _____
O Home Exercise	_____	_____	# per week: _____
O Physical Therapy	_____	_____	# of sessions: _____
O Back School	_____	_____	# of sessions: _____
O Brace/Splint	_____	_____	# of sessions: _____
O Radiofrequency Ablation	_____	_____	

SECTION S: Previous Surgeries (choose all that apply)

SURGERIES	YEAR	RESPONSE	
O Spinal Cord Stimulator	_____	_____	# of times: _____
O Low Back Surgery	_____	_____	Type/Levels: _____
O Neck Surgery	_____	_____	Type/Levels: _____
O Extremity Surgery	_____	_____	Type: _____
O Vertebroplasty/Kyphoplasty	_____	_____	Type/Levels: _____
O Other: _____	_____	_____	Type: _____
O Other: _____	_____	_____	Type: _____

O NEW O CHANGE Effective date: ____/_____/_____

O Other: _____ _____ Type:

_____ _____

SECTION T: Tobacco, Alcohol and Illicit Drug Use

Tobacco Use:

O Never

O Chewing Tobacco # times a day: _____ Age you started: _____

O Cigarettes # of packs a day: _____ Age you started: _____

O Cigars How many a day? _____ Age you started: _____

O Quit How long ago? _____

Alcohol Use: O Never O Drinks per day? _____ O Drinks per week? _____

O Currently attending AA O History of rehab

Do you have any history of alcohol abuse? O Yes O No if yes, when? _____

Do you have any past or current legal issues with alcohol usage? O Yes O No

If yes, please explain: _____

Illicit/Illegal Drug Use:

	Currently Using	Past regular use	Tried it	Never
Marijuana	O	O	O	O
Cocaine	O	O	O	O
Methamphetamine	O	O	O	O
Heroin	O	O	O	O
PCP	O	O	O	O
LSD	O	O	O	O

Prescription drugs (not prescribed): _____

Other: _____

Do you have any past or current legal issues with drug usage? O Yes O No

If yes, please explain: _____

_____

As a patient at STAR, what is your goal?

_____

_____

_____

_____

○ NEW ○ CHANGE Effective date: ____/_____/_____

Please mark an **X** along the line from 0% to 100% to express the degree that your pain has affected your life:

Opioid Risk Tool:

The Opioid Risk Tool (ORT) addresses the need to predict who is at risk for opioid abuse before opioid therapy is initiated. This gives physicians a better opportunity to monitor moderate to high risk patients rather than waiting until treatment has begun to check for abuse. Dr. Lynn R. Webster designed the ORT to be used as a point of care tool for providers prescribing opioids during the initial visit for pain treatment. The ORT is a five-question, self-administered assessment that takes fewer than five minutes to complete and can accurately predict which patients are at the highest and lowest risk for displaying aberrant drug-related behaviors associated with abuse or addiction.

Mark Each Box That Applies	Female	Male
• Alcohol	○	○
Family History Of Substance Abuse □ Illegal Drugs	○	○
• Prescription Drugs	○	○
• Alcohol	○	○
Personal History Of Substance Abuse □ Illegal Drugs	○	○
• Prescription Drugs	○	○

Age (Mark Box If 16-45 Years Old)		○	○
History Of Preadolescent Sexual Abuse		○	○
Psychological Disease	☐ ADD, OCD, bipolar disorder, schizophrenia	○	○
	☐ Depression	○	○
None of the above apply to me		○	
	TOTAL		

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005; 6(6): 432-442.