SANTA MONICA
2811 WILSHIRE BLVD, #850
SANTA MONICA, CA 90403

TEL: (310) 828-7757
FAX: (310) 828-6687
WWW.LASPINE.COM

THE SPINE INSTITUTE

CENTER FOR SPINAL RESTORATION

PATIENT REGISTRATION

Patient Name (First, Middle, Last)				
Home Address		City	State	Zip
Home Tel	Cell		Work	
Email		Driver's License #		
Social Security #	Date of Birth (MM/DD/YYYY)	Sex (M/F)	Age	Marital Status
Employer	Occupation		Are you currently working?	YES NO

EMERGENCY CONTACT INFORMATION

Name	Phone	Relationship

REFERRING PHYSICIAN

Name (First, Last)		
Specialty		
Address		
City	State	Zip
Phone	Fax	

Do you want a copy sent to this Physician? No Yes

PRIMARY CARE PHYSICIAN

Name (First, Last)		
Specialty		
Address		
City	State	Zip
Phone	Fax	

Do you want a copy sent to this Physician? No Yes

WORK RELATED INJURIES

Claim Number	Date of Injury		
Carrier Name	Phone	Fax	
Address	City	State	Zip
Subscriber's Name	Subscribers Date of Birth	Subscriber's SSN	Relationship
Adjuster Name	Phone	Fax	
Claim / Nurse Manager	Phone	Fax	
Employer			

OPTIONAL

Attorney's Name	Phone	Fax

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How did you hear about us? (check all that apply)

☐ Physician ☐ Friend/Family ☐ Internet ☐ Social Media ☐ TV ☐ Radio ☐ Print Ad Other

This information allows us to evaluate your spinal needs and tailor a customized treatment plan that best meets those.
Thank you in advance for understanding that every question is important.

1 How did your pain or problem happen?

2 What is your main complaint?

3 Is this a second opinion consultation? No Yes If yes, Physician's contact information:

Physician	Address, City, State	Phone

4 Please describe past treatments for this condition.

5 Have you had prior spine surgery? No Yes If yes, please provide details below.

Type	Date
Surgeon	Location
Type	Date
Surgeon	Location

PHYSICAL THERAPY:

Therapist	Date

INJECTIONS:

Type	Date
Type	Location

6 Please provide any previous surgical history not for this condition.

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YOUR MEDICAL HISTORY

7 Mark any of the following you are currently being treated for or have been treated for in the past.

☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Hepatitis ☐ AIDS/HIV

☐ Heart Disease ☐ Diabetes ☐ Tuberculosis ☐ Bleeding Disorder Other:

8 Do you see a cardiologist? No Yes If yes, Physician's contact information:

Physician	Address, City, State	Phone

9 Do you currently smoke? No Yes If yes, how much?

10 Do you drink alcohol? No Yes If yes, how much?

11 Do you use recreational drugs? No Yes If yes, what drug(s) and how frequently?

12 Who lives with you? (Mark all that apply).

☐ Self ☐ Spouse ☐ Children ☐ Roommate ☐ Significant Other ☐ Partner ☐ Friend ☐ Caregiver ☐ Group Home Other:

SPINE IMAGE HISTORY

Please indicate whether you have had any of the following studies:

	Study	When (MM/YYYY)	Where
☐	Regular X-Ray of Spine		
☐	CT Scan		
☐	EMG/NCV (Nerve Test)		
☐	Bone Scan		
☐	Myelogram		
☐	Discogram		
☐	MRI of Spine		
☐	Other		

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YOUR MEDICAL HISTORY

Are you currently taking any medications? No Yes If yes, please provide details below.

List all medication you are currently taking for ALL health issues:
Prescription and over-the-counter medication (examples: aspirin, antacids)
Dietary supplements (example: vitamins) and herbals (example ginseng, gingko).
Include medications taken as needed (example: inhalers, nitroglycerin).

Name	Dose	# Per Day

(may attach a list)

ALLERGIES

Do you have any known allergies? No Yes If yes, please provide details below.

Please list any allergies and adverse reactions to medications, contrast dyes used in diagnostic tests, latex and what type of reaction you had to these medications (may attach a list):

Substance	Reaction

PRESCRIPTION / PHARMACY INFORMATION

Where would you like us to send your prescriptions (electronic submission)?

Pharmacy Name		Phone	
Address	City	State	Zip

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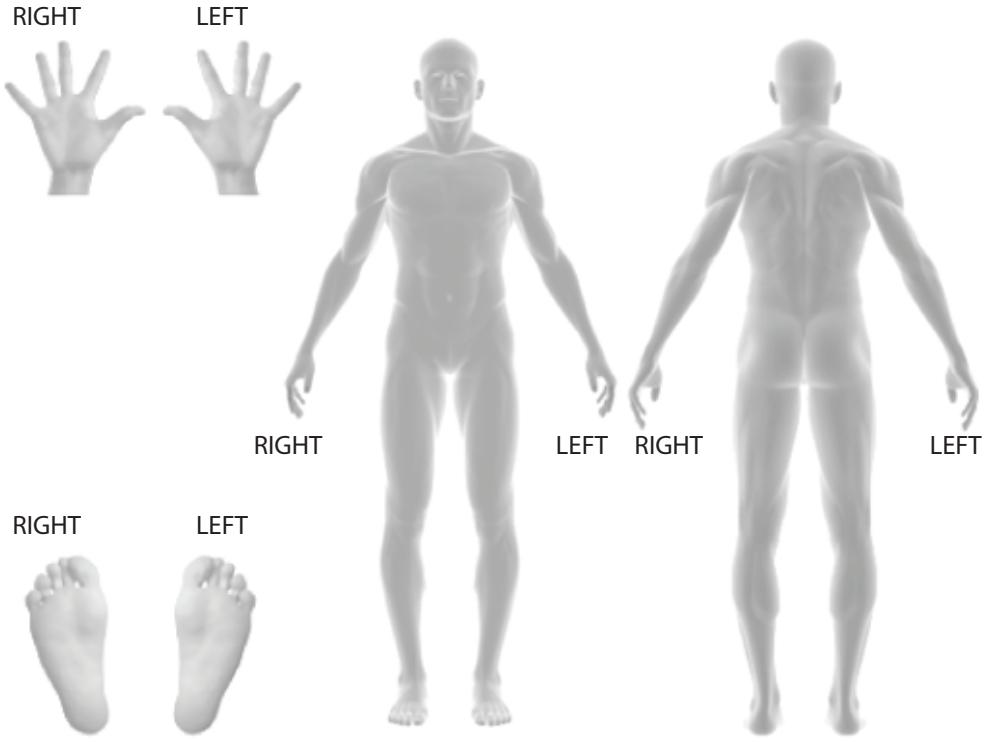
ADDITIONAL QUESTIONS

Do you have any recent changes in controlling your bladder or bowel?	YES	NO
Do you have weakness in your arms?	YES	NO
Do you have weakness in your legs?	YES	NO

ORTHOPEDIC PAIN CHART



Mark the areas on your body where you feel the described sensation using the appropriate symbol from the chart below.

Please include all affected areas.

SYMBOL CHART	
Numbness	= = =
Pins & Needles	O O O
Burning / Aching	X X X
Stabbing	/ / /

Please indicate your daily pain by drawing a perpendicular line across the line or by clicking the appropriate segment.
"0" = no pain / "10"= worst pain imaginable

PAIN MANAGEMENT

What makes your pain better?	What makes your pain worse?