SOS
Spine, Pain
& Wellness Institute

Today's Date: _____

Name: (Last, First, Middle) _____ **Preferred Name:** _____

SSN: _____ **Date of Birth:** ____/____/____ **Age:** _____ **Sex:** ☐ **M** ☐ **F**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: (**)** _____ **Cell: (** **)** _____ **Marital Status:** ☐ **S** ☐ **M** ☐ **D** ☐ **W**

Employer: _____ **Employment Status:** ☐ **FT** ☐ **PT** ☐ **Retired** ☐ **Unemployed**

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Email: _____ **Primary Care Physician:** _____

Referred by: ☐ **Physician** _____ ☐ **Hospital** ☐ **Family/Friend** ☐ **Ad** _____

Where did your injury occur? ☐ **Home** ☐ **Auto** ☐ **School** ☐ **Work** ☐ **Other** _____ ☐ **No Known Injury**

****Auto related injury?** ☐ **Yes** ☐ **No** **Date of Injury:** _____

Insurance Company: _____ **Phone:** _____

Claim Number: _____ **Adjuster:** _____

**** Work Related Injury?** ☐ **Yes** ☐ **No** **Date of Injury:** _____

Insurance Company: _____ **Phone:** _____

Claim Number: _____ **Adjuster:** _____

Employer: _____

Are you represented by an Attorney? ☐ **Yes** ☐ **No**

Attorney Name: _____ **Phone:** _____

Health Insurance Information

Primary Insurance: _____ **Policy Holder:** _____

Relationship to Patient: _____ **SSN:** _____ **DOB:** _____

ID Number: _____ **Group Number:** _____ **Employer:** _____

Secondary Insurance: _____ **Policy Holder:** _____

Relationship to Patient: _____ **SSN:** _____ **DOB:** _____

ID Number: _____ **Group Number:** _____ **Employer:** _____

Person Responsible for Bill: (If the patient is a minor)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Employer: _____

_____ **By initialing, I understand that I will be treated by one or more SOS physicians who may refer me for further procedures, imaging, surgery and/or other related services to OCOM hospital (Oklahoma Center for Orthopaedic and Multi-Specialty Surgery). I further understand that the following physicians have an ownership interest in the OCOM hospital: Bradley Reddick, DO, Derek West, DO, Kristopher Avant, DO, Brian Levings, DO, RJ Langerman, DO, Mehdi Adham, MD, & Steven Sands, DO.**

I attest that the information stated on this document is true and correct to the best of my knowledge and agree to inform SOS of any changes to the information stated herein.

_____ _____

Signature of Patient or Guardian Date

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New Patient Medical History **Date:**

Patient Name: **DOB:**

What problem(s)/issue(s) brings you here today?	
How and when did it start?	
What makes it worse?	
What Makes it better?	

What diagnostic testing have you had for this problem? (Circle one)	**X-Ray**	**MRI**	**CT-Scan**	**EMG**	**Bone scan**
What treatments have you tried for this problem? (Circle one)	**Massage**	**Injections**	**Chiropractor**	**Physical Therapy**	**Psych evaluation**

Pain Score

0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like (circle any that apply):

Dull Achy Burning Stabbing Numbness Tingling Pulling Cramping Tightness

Please describe the time course of your pain (circle any that apply):

Constant Comes and Goes Worse in the morning Worse at night

Please list medications you are currently taking with doses: (Include over-the-counter medications)

Please list other Medical Problems, Drug Allergies, and past Surgeries:

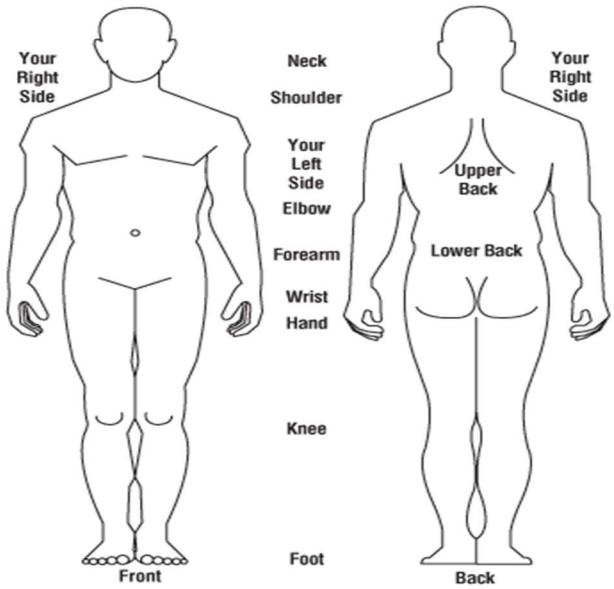
What exercise do you do?

Do you use Tobacco? If so, what kind and how long?

Illicit drug use? (Example: cocaine,heroin,meth)

Opioid use? (Example: Oxycodone, hydrocodone, tramadol)

What is your Occupation?
Number of hours worked per week?



Draw on the diagram where you have pain.

Review of systems:

GENERAL	**Night pain**	**Headaches**	**Fevers**	**Unintentional weight loss**		
VISION/RESP	**Vision Change**	**Double vision**	**Shortness of Breath**	**Wheezing**	**Coughing**	
CARDIAC/NEURO	**Chest pain**	**Palpitation**	**Dizziness**	**Weakness**	**Numbness**	**Tingling**
MUSC/SKEL	**Low Back Pain**	**Joint pain**	**Joint swelling**	**Muscle Pain**		
PSYCH	**Depressed mood**	**Suicidal thoughts**	**Sleep problems**	**Anxiety**		
DERM/URO	**New rash**	**Psoriasis**	**Urinary frequency/urgency**	**Loss of control of urine**		
GASTO/INTESTINAL	**Nausea**	**Vomiting**	**Black stool**	**Loss of control of stool**		

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The Roland-Morris Disability Questionnaire

Today's Date: _____

Name: _____ Date of Birth: _____

With your pain, you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have pain. When you read them, you may find that some stand out because they describe you ***today.***

As you read the list, think of yourself ***today***. When you read a sentence that describes you ***today***, circle the number of the sentence. If the sentence does not describe you, then leave it and go on to the next one.

Remember, only mark the sentence if you are sure that it describes you *today*.

1. I stay at home most of the time because of my pain.
2. I change position frequently to try and make myself comfortable.
3. I walk more slowly than usual because of my pain.
4. Because of my pain, I am not doing any of the jobs that I usually do around the house.
5. Because of my pain, I use a handrail to get upstairs.
6. Because of my pain, I lie down to rest more often.
7. Because of my pain, I have to hold on to something to get out of a chair.
8. Because of my pain, I ask other people to do things for me.
9. I get dressed more slowly than usual because of my pain.
10. I only stand up for short periods of time because of my pain.
11. Because of my pain, I try not to bend or kneel down.
12. I find it difficult to get out of a chair because of my pain.
13. My pain hurts most of the time.
14. I find it difficult to turn over in bed because of my pain.
15. My appetite is not very good because of my pain.
16. I have trouble putting on my socks (or stockings) because of my pain.
17. I only walk short distances because of my pain.
18. I sleep less because of my pain.
19. Because of my pain, I get dressed with the help of others.
20. I sit down for most of the day because of my pain.
21. I avoid heavy jobs around the house because of my pain.
22. Because of my pain, I am more irritable and bad tempered with people.
23. Because of my pain, I go upstairs more slowly than usual.
24. I stay in bed most of the time because of my pain.

TOTAL: ☐

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Mental Health and Substance Abuse History **Date:**

Patient Name: **DOB:**

For the following table, circle the number in all boxes that apply to you. For instance, regarding **"Family History of Alcohol Abuse,"** if you are Female and you have this in your family, you should circle the **"1"** in the corresponding box. If you are Male, you should circle the **"3"** in the corresponding box. Next, add the total of the numbers that you circled at the bottom.

	Female	Male	
FAMILY HISTORY OF SUBSTANCE ABUSE			
Alcohol	1	3	
Illegal Drugs	2	3	
Prescription Drugs	4	4	
PERSONAL HISTORY OF SUBSTANCE ABUSE			
Alcohol	3	3	
Illegal Drugs	4	4	
Prescription Drugs	5	5	
MENTAL HEALTH HISTORY			
ADD, OCD, Bipolar, Schizophrenia	2	2	
Depression/Anxiety	1	1	
Your age is between 16 and 45 years	1	1	
History of Preadolescent Sexual Abuse	3	0	

Add columns: _____ + _____

TOTAL:

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9) **Date:** _____

Name: _____ DOB: _____

Over the last two weeks, how often have you been bothered by any of the following problems?
(Circle your answer for each question)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure doing things.	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as, reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed - Or the opposite - being fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or thoughts of hurting yourself.	0	1	2	3

Office use only: Add columns _____ + _____ + _____

Total: _____

If you checked any problems, how difficult have these problems made it for you to do your work, take care of things at home or have a good relationship with other people? (Circle one of the following)

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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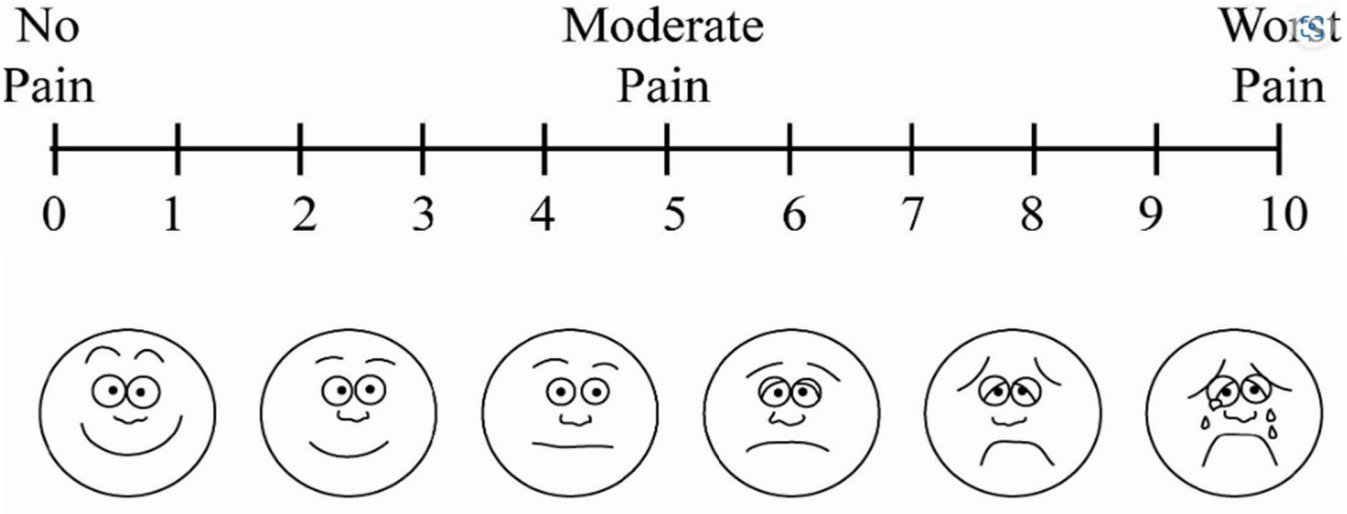
Visual Analog Pain Scale **Date:**

Name: **DOB:**

0	**Pain Free**
1	**Very minor annoyance – occasional minor twinges**
2	**Minor annoyance – occasional strong twinges**
3	**Annoying enough to be distracting**
4	**Can be ignored if you are really involved in your work, but still distracting**
5	**Can't be ignored for more than 30-minutes**
6	**Can't be ignored for any length of time, but you can still go to work and participate in social activities**
7	**Makes it difficult to concentrate, interferes with sleep. You can still function with effort.**
8	**Physical activity is severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.**
9	**Unable to speak. Crying out or moaning uncontrollably – disorientation**
10	**Unconscious. Pain makes you pass out.**



No Pain **0** | **Mild** **1– 3** | **Moderate** **4 – 6** | **Severe** | **Very Severe** **7 – 9** | **Worst Pain** **10**

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Acknowledgement & Consent to Drug Testing

Drug Testing is a critical component included in the treatment plan for all patients under the care of our SOS physician, provider, and/or medical team, especially to those who are prescribed controlled substances. As directed by the agreement between SOS and individual patients receiving care for various conditions, vital information necessary for the monitoring of these patients is obtained through regular, periodic and random drug screening. Drug testing ordered by SOS providers functions to protect patients, protect providers, protect access to therapy, protect the community and protect the health care resources.

I understand that my refusal to provide for urine, saliva and/or blood specimen, tampering with, or providing false information through the specimen's chain of custody shall be grounds for termination from the medical practice.

I understand that all information disclosed by and acquired by SOS as derived from this test shall be kept confidential and shall solely be used for the purpose of continuing medical treatment only.
I also understand that SOS reserves the right to obtain an external Rx history and randomly verify past medications through the Prescription Monitoring Database in order to be prescribed any pain medications.

I hereby release, indemnify, and hold harmless SOS, its employees, directors, and its agents from any liability, loss, or expenses, injury, damage, or claims whatsoever on or about this drug test.
By signing this form, I hereby give my consent to providing collection of drug specimen by SOS Spine, Pain & Wellness Institute or it's designated medical representative as ordered or directed.

Patient name (print): _____

Patient Signature: _____ Date: _____

Witness name (print): _____

Witness Signature: _____ Date: _____