FRONT RANGE SPINE & NEUROSURGERY

HISTORY OF PRESENT ILLNESS

Today's Date: _____/_____/_____

Patient name: _____DOB: _____/____/_____Age: _____

Referring physician: Primary care physician:

Reason for today's visit:

Date current injury or symptoms began: ____/_____/_____ I'm: ❑ Right handed ❑ Left handed

Injury type: ❑ work injury ❑ auto accident ❑ sports injury ❑ other injury ❑ no injury

Please give a brief description of how the injury occurred: _____

_____

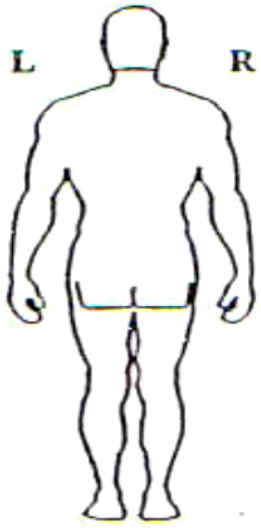
_____

Did you have similar symptoms prior to this injury? _____

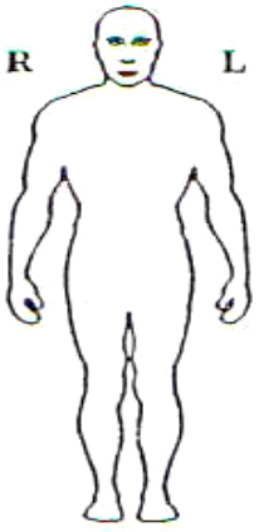
Please describe your current symptoms:

Using the appropriate symbols below, please mark the affected areas

Numbness = NNN Weakness=WWW Burning=BBB Shooting Pain=SSS Aches=AAA Tingling=TTT



BACK



FRONT

USING THE SCALE BELOW, PLEASE RATE YOUR PAIN LEVEL:

0 1 2 3 4 5 6 7 8 9 10

no pain mild moderate severe very severe worst possible

Type of pain: ❑ Ache ❑ Stabbing ❑Throbbing ❑Shooting ❑ Burning ❑ Click/Pop

Pain aggravated by: ❑ Standing ❑Sitting ❑ Driving ❑ Stairs

❑ Sleeping ❑ Walking ❑ Lying ❑ Cough/Sneeze

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Cervical evaluation

What % of your pain is neck pain and what % is arm pain?	What is the distribution of your arm pain?	Where is your arm pain? Right arm	Left arm	Raising the arm:	Moving the neck:
❑ Neck 0%, Arm 100%	Right 0%, Left 100%	❑No pain	No pain	❑Improves the pain	Improves the pain
❑ Neck 10%, Arm 100%	Right 10%,Left 90%	❑Upper back	Upper back	❑Worsens the pain	Worsens the pain
❑ Neck 25%, Arm 75%	Right 25%,Left 75%	❑Shoulder	Shouder	Does not affect the pain	Does not affect the pain
❑ Neck 50%, Arm 50%	Right 50%, Left 50%	❑Upper arm	Upper arm		
❑ Neck 75%, Arm 25%	Right 75%,Left 25%	❑Forearm	Forearm		
❑ Neck 90%, Arm 10%	Right 90%, Left 10%	Hand/finger	❑Hand/finger		
❑ Neck 100%, Arm 0%	Right 100%,Left 0%				

Do you have any weakness in your arms?		Do you have any numbness or tingling in your arms and hands?		Do you have difficulty picking up small objects like coins or buttoning buttons?	
❑ No weakness in the arms and hands		Right:	Left:	❑ Yes ❑No	
Right:	Left:	❑ No numbness	❑ No numbness	**Do you have problems with balance or tripping frequently?**	
❑No weakness	❑ No weakness	❑ Upper arm	❑ Upper arm		
❑ Shoulder	❑ Shoulder	❑ Forearm	❑ Forearm		
❑ Upper arm	❑ Upper arm	❑ Thumb	❑ Thumb	❑ Yes ❑No	
❑ Forearm	❑ Forearm	❑ Index Finger	❑ Index Finger	**Do you have any headaches in the back of the head?**	
❑ Hand/Finger	❑ Hand/Finger	❑ Middle Finger	❑ Middel Finger		
		❑ Ring Finger	❑ Ring Finger	❑ Frequent	❑ Occasional
		❑ Small Finger	❑ Small Finger	❑ No	

Lumbar evaluation

What % of your pain is back and what % is leg pain?	What is the distribution of your leg pain?	Where is your leg pain? Right leg:	Left leg:	How many minutes can you stand in one place without pain?	Do you have weakness in your legs?	
❑ Back 0%, Leg 100%	❑ Right 0%, Left 100%	❑ No pain	❑ No pain	❑ 0-10	❑ No weakness of the legs	
❑ Back 10%, Leg 90%	❑ Right 10%, Left 90%	❑ Buttock	❑ Buttock	❑ 15-30	Right:	Left:
❑ Back 25%, Leg 75%	❑ Right 25%, Left 75%	❑ Thigh-front	❑ Thigh-front	❑ 30-60	❑ No weakness	❑ No weakness
❑ Back 50%, Leg 50%	❑ Right 50%, Left 50%	❑ Thigh-back	❑ Thigh-back	❑ 60+	❑ Thigh	❑ Thigh
❑ Back 75%, Leg 25%	❑ Right 75%, Left 25%	❑ Calf	❑ Calf	**How many minutes can you walk?**	❑ Calf	❑ Calf
❑ Back 90%, Leg 10%	❑ Right 90%, Left 10%	❑ Foot	❑ Foot		❑ Ankle	❑ Ankle
❑ Back 100%, Leg 0%	❑ Right 100%, Left 0%			❑ 0-10	❑ Foot	❑ Foot
	❑ No leg			❑ 15-30		
				❑ 30-60		
				❑ 60+		

Do you have numbness or tingling in your legs and feet?	Right:	Left:	
	❑ No numbness	❑ No numbness	
	❑ Thigh	❑ Thigh	
	❑ Calf	❑ Calf	
	❑ Foot	❑ Foot	❑ No numbness or pins and needles of the legs and feet

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Treatments to date

Patient's name_____

I have had NO treatment for my neck/ back problems to date ❑

I have had these treatments for my neck/ back problems to date

Neck or back brace ❑ Yes ❑ No
❑ No relief ❑ Mild relief
❑Temporary relief ❑ Great relief

Chiropractic care ❑yes ❑no
❑ No relief ❑ Mild relief
❑Temporary relief ❑ Great relief

Physical therapy❑ Yes ❑ No How many sessions____
❑ No relief ❑ Mild relief
❑Temporary relief ❑ Great relief

Anti-inflammatory medications ❑ Yes ❑ No
How long:____ days _____ weeks ____ month___year

Injections: ❑yes ❑no Results: ❑worse ❑same ❑mild ❑temporary ❑great

Injection type	Date of the last inj.	Levels	# of inj.	% of improvement after inj.
Epidural				
Facet				
Rhizotomy				
Selective nerve block				
Trigger point				
Sacro-illiac joint				
Other				

Diagnostic testing

❑ none to date

❑EMG	❑Upper extrem.	❑Lower extrem.		Done by Dr._____	Date:_____
❑ x-ray	❑neck	❑middle back	❑lower back		Date: _____
❑ CT	❑head	❑neck	❑middle back	❑lower back	Date: _____
❑ MRI	❑brain	❑neck	❑middle back	❑lower back	Date: _____
❑Discogram	Levels			Done by Dr. _____	Date: _____
❑ Other tests					

Previous spine surgery

❑I have never had surgery on my ❑Neck ❑ Back

Surgery #1 _____ Date: _____ Surgeon name: _____ Hospital: _____
Reason for surgery: _____
Results ❑pain free now ❑ temporary pain relief ❑some help but still problems ❑no relief at all

Surgery #2 _____ Date: _____ Surgeon name: _____ Hospital: _____
Reason for surgery: : _____
Results ❑pain free now ❑ temporary pain relief ❑some help but still problems ❑no relief at all

Past medical history

❑ No medical problems	❑ Bronchitis	❑ Stroke	❑ Bleeding disorders	❑ Anorexia/Bulimia
❑ High blood pressure	❑ Emphysema	❑ Seizures	❑ Anemia	❑ Alcoholism
❑ Heart attack	❑ Liver disease	❑ Cancer, Where?	❑ Blood clots	❑ Seen a psychiatrist
❑ Heart failure	❑ Hepatitis	❑ Kidney failure	❑ Endometriosis	❑ HIV
❑Abnormal heart rhythm	❑ Diabetes	❑ Kidney stones	❑ Ovarian cysts	
❑ Lung disease	❑ Thyroid disease	❑ Osteoporosis	❑ Anxiety	
❑ Tuberculosis	❑Stomach ulcers	❑ Osteoarthritis	❑ Depression	
❑ Asthma	❑ Irritable bowel	❑Rheumatoid arthritis	❑ Schizophrenia	

Are you under a doctor's care for any other medical condition? ❑ YES ❑ NO _____

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List any major surgeries or hospitalizations (non-spine) ❑None

Date	Surgery	Reason

List all the medications you currently take: ❑None

Drug name	Dose	Times/ a day

Allergies ❑none ❑no Known Drug Allergies ❑ **I am allergic to following medication:**

❑penicillin ❑sulfa ❑codeine ❑aspirin ❑Demerol

Reaction: _____

Other Allergies: _____ **Reaction:** _____

Check any of the following symptoms you are currently experiencing:

Eyes	❑Blurred vision	❑Double vision	❑Loss of Vision	❑Contacts/glasses/Lasik	
Ears/nose/throat	❑Hearing loss	❑Trouble swallowing	❑Loss of smell	❑Loss of taste	
Cardiovascular	❑Chest pain	❑Palpitation	❑Irregular heartbeat	❑High blood pressure	❑Swollen hands or feet
	❑History of heart attack	❑History of heart failure			
Respiratory	❑Shortness of breath	❑Asthma	❑Emphysema	❑Sleep apnea	
Hematologic	❑Bleeding problems	❑Bruise easily	❑ Anemia	❑Use of blood thinners	
Musculoskeletal	❑Joint pain	❑ Osteoporosis	❑Arthritis	❑Rheumatoid disease	
Neurologic	❑Headache	❑Dizziness	❑Unsteadiness	❑Numbness/Tingling	
Psychological	❑Depression	❑Manic-depressive disorder	❑Addiction	❑Ulcer	❑Constipation
	❑Blood in stool				
Endocrine	❑Diabetes	❑Thyroid problems	❑High blood sugar	❑low blood sugar	
Skin	❑Rashes	❑ Sores	❑Shingles	❑Psoriasis	❑Skin cancer
Gastrointestinal	❑Nausea/Vomiting	❑Heartburn	❑Non-digestion	❑Chronic diarrhea	
Genitourinary	❑Trouble with urination	❑Incontinence	❑ Prostate problems	❑Trouble with erection	
Constitutional	❑Fever/ chills	❑Unusual sweating	❑Loss of appetite	❑Weight loss	❑Fatigue
	❑History of cancer	❑History of cancer or HIV/AIDS			

Are you currently pregnant? ❑ YES ❑ NO How many weeks? _____

Social life style

Marital status:	❑Single	❑Married	❑Divorced	❑Widowed	❑Separated	❑Other: _____
Do you use any tobacco products?	❑NO, never	❑NO, I Quit When?	How much did you use?	❑pack	❑can	❑cigar How much per day? _____
❑ YES, please, specify:	❑Cigarettes	❑Snuff	❑Tobacco	❑Cigars	❑Pipe	❑Marijuana
Do you drink alcohol?	❑NO, never	❑yes	# drinks per	❑day	❑week	❑month
At this time, I am:	❑working full time	❑working part time	❑work with restrictions	❑not working	Job title: _____	
					Job description: _____	

The information I have provided is true and complete to the best of my knowledge.
Patient signature: _____ Date: _____

VITAL SIGNS					H:
Temp:	○F	SpO2:	Heart rate:	bmp	W:
BP:	Position: ❑Sitting ❑Supine ❑Standing				

Front Range Spine and Neurosurgery

Patients paper work policies:

Our office will assist you in filling up paper work RELATED to your surgery, such as FMLA, Short Term Disability or Handicapped Parking. Please fax us your forms to 303-790-1809 or e-mail it to coloradospine1@aol.com. Please remember that it takes up to 3-7 days to process all non-urgent requests.

- If you require FMLA papers to be filled out that are NOT related to a surgery: an appointment with Dr. Rauzzino will be necessary to review the claim.
- If you have had surgery and need FMLA forms completed for short term disability, please contact Dr. Rauzzino's Medical Assistant. Our office will only be able to fill out forms for a maximum of three months leave following your surgery.
- Dr. Rauzzino is NOT able to complete claims for Social Security permanent disability although we are able to send medical records to the Social Security Department if they request them.
- We are able to provide your attorney with copies of medical records; However, in order to remain compliant with HIPPA regulations for patient privacy, these can only be released when we receive a signed release of information form and the appropriate fee has been paid by the attorney's office.
- Dr. Rauzzino is NOT able to fill out questionnaires, statements or letters for attorneys. If statements or questions are necessary, you or your lawyer will be required to schedule an appointment or phone consultation with Dr. Rauzzino for which there will be a consultation fee.

- As of January 1, 2007, we will no longer be able to fill out forms of disability and statements for attorneys without prior arrangements to do so. If you require a form to be completed by our office you will be required to arrange a meeting appointment with Dr. Rauzzino or his Medical Assistant.

I _____ have read and understand the above information.
(Patient Name)

Signature: _____ Date: _____

Front Range Spine and Neurosurgery

Prescriptions and refills policy:

PRESCRIPTIONS ARE **ONLY** GIVEN TO PATIENTS WHO ARE ON OUR SURGERY SCHEDULE OR WHO ARE **LESS THAN THREE MONTHS** POST SURGERY.

AFTER 3 MONTHS WE WILL REFER YOU TO PAIN MANAGEMENT CLINIC WHO WILL MANAGE YOUR CHRONIC PAIN MEDICATIONS.

MEDICATIONS **WILL NOT** BE FILLED THE SAME DAY AFTER 4:30 PM

PLEASE DO NOT ASK, AS REFUSAL OFTEN DISAPPOINTS!

IT TAKES 2-3 BUSINESS DAYS NOTICE TO REFILL

DO NOT RUN OUT OF MEDICATION

BEFORE CALLING OUR OFFICE FOR REFILLS, PLEASE CALL YOUR PHARMACY **FIRST**

AND ASK THEM **TO FAX A REFILL FORM TO US AT 303 790 1809**

PERCOCET, DILAUDID, OXYCONTIN, OXYCODONE, FENTANYL

CANNOT BE CALLED OR FAXED TO A PHARMACY

YOU HAVE TO COLLECT THESE MEDICATION PRESCRIPTIONS IN PERSON OR GET THIS MAILED TO YOU

ALLOW PLENTY OF TIME FOR MAILING

WE ARE NOT RESPONSIBLE FOR THE USPS DELIVERY NETWORK!

Patient Initial: _____ Date: _____

FRONT RANGE SPINE & NEUROSURGERY

PATIENT INFORMATION:

Today's date: _____

Last name: _____ *First name:* _____ *Middle name:* _____

Street Address: _____ *Apt/Unit #:* _____

City: _____ *State:* _____ *ZIP:* _____

Home phone: _____ *Work:* _____ *Cell:* _____

Email address: _____

Ethnicity (optional): ☐ *Caucasian* ☐ *African-American* ☐ *Hispanic* ☐ *Asian* ☐ *Declined*

DOB: _____ *Age:* _____ *SSN:* _____ *Gender: M / F*

Referring physician: _____ *Phone:* _____

Primary Care physician: _____ *Phone:* _____

Other referring source: _____

Employer: _____

Primary insurance: _____ *Phone:* _____

Address: _____

Policyholder's name: _____ *DOB:* _____

ID or Claim: _____ *Group:* _____

Secondary insurance: _____ *ID #* _____

Spouse/Partner name: _____ *Phone:* _____

Emergency contact name: _____ *Phone:* _____

I authorize payment of medical benefits to the undersigned physician. X_____ Signature (Insured or Authorized person)	I authorize the release of any medical information necessary to process this claim and all future claims. X_____ Signature (Insured or Authorized person)