Spine and Brain
Institute of San Diego

A Message from our Doctors

Welcome to the Spine and Brain Institute of San Diego! Thank you for choosing us for your spinal care needs. Our team is committed to providing you with the highest level of care and compassion. Our team consists of many staff members striving to make your experience the best possible.

Our mission is to be readily available to answer any questions or address any concerns you may have. Also, our administrator, Josephine Turner, is always available to help in any way possible. Email is the preferred method of communication; however, you can contact us by phone should that be your preferred method.

Ramin Raiszadeh, MD
ramin@sbiosd.com

New Patient Scheduler: dalila@sbiosd.com P:619.229.5345
Front Desk/Follow Up Appointments: marisol@sbiosd.com P: 619.229.5354
Physician Assistant: sophea@sbiosd.com P: 619.229.5393
Physician Assistant: stephanie@sbiosd.com P: 619.229.5393
Referral Coordinator: kimberly@sbiosd.com P: 619.255.2198 (Last Name A-I)
Referral Coordinator: melanie@sbiosd.com P: 619.794.2468 (Last Name J-Q)
Referral Coordinator: chelsea@sbiosd.com P: 619.269.7907 (Last Name R-Z)
Surgery Scheduler: cj@sbiosd.com P: 619.229.5396
Medical Assistant: arul@sbiosd.com P. 619.610.9626

Paul D. Kim, MD
paul@sbiosd.com

New Patient Scheduler: janeth@sbiosd.com P: 619.269.4628
Front Desk/Follow Up Appointments: natalia@sbiosd.com P: 619.610.9624
Physician Assistant: amelia@sbiosd.com P:619.955.8994
Referral Coordinator/Surgery Scheduler: breanna@sbiosd.com P: 619.310.5591
Medical Assistant: beatrice@sbiosd.com P:619.955.5400

Evan Nigh, MD
evan@sbiosd.com

New Patient Scheduler: dalila@sbiosd.com P:619.229.5345
Front Desk/Follow Up Appointments: andrew@sbiosd.com P: 619.955.8750
Referral Coordinator/Surgery Scheduler: alli@sbiosd.com P: 619.255.2336
Medical Assistant: kayleigh@sbiosd.com P: 619.949.3237

Sunil Jeswani, MD
sunil@sbiosd.com

All Inquiries:
yami@sbiosd.com P: 619.241.2225

Sabareesh Natarajan, MD
sabareesh@sbiosd.com

All Inquiries:
admin@bsvneuro.com P: 619.984.6969

Administrator:
jo@sbiosd.com

Spine and Brain Institute of San Diego

To Our Valued Patients:

Thank you for choosing the Spine and Brain Institute of San Diego for your spinal care needs. In our efforts to provide you the very highest level of care, we ask that you take time to fill out the enclosed forms. We strive to provide our patients with outstanding care and service. Please do not hesitate to call us with any questions prior to your appointment.

Please arrive fifteen minutes prior to your appointment time with the forms **COMPLETED** in **BLACK INK** to avoid delay of your appointment.

REMINDER: IT IS VERY IMPORTANT TO BRING YOUR ACTUAL X-RAYS/ MRI/ CT IMAGES TO YOUR OFFICE VISIT (NOT JUST THE RADIOLOGY REPORT).

Your appointment is scheduled for _____ at _____ with:

- ☐ Dr. Ramin Raiszadeh
- ☐ Dr. Paul D. Kim
- ☐ Dr. Sunil Jeswani
- ☐ Dr. Sabareesh Natarajan
- ☐ Dr. Evan Nigh

Location:

☐ Alvarado Office
6719 Alvarado Road, Suite 308
San Diego, CA 92120

☐ Escondido Office
2125 Citracado Parkway, Suite 310
Escondido, CA 92029

☐ North Coastal Office
6185 Paseo Del Norte, Suite 140
Carlsbad, CA 92011

☐ El Centro Office
1671 W Main Street, Suite A
El Centro, CA 92243

PLEASE FILL OUT THIS PACKET PRIOR TO YOUR APPOINTMENT

Spine and Brain
Institute of San Diego

PATIENT REGISTRATION

Patient Full Name: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security #: _____

Email: _____

Preferred method of contact: Home Mobile Work Email Other _____

Pharmacy Name & Number: _____

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

EMERGENCY INFORMATION: (Relative/Friend not living with you):

Emergency Contact Name & Phone Number: _____

Referring Physician: _____ Phone Number: _____

Patient Employer: _____ Phone Number: _____

Address: _____ City _____ State _____ Zip _____

Person Responsible for Payment: _____ Relationship: _____

Is This a Legal Case: □ Yes □ No

Attorney: _____ Phone: _____

Is This a Work-Related Injury: □ Yes □ No

DOB: _____ SS#: _____ EMPLOYER: _____

Primary Insurance: _____ Group#: _____

Certificate#/ID#: _____ Subscriber Name: _____

Secondary Insurance: _____ Group#: _____

Certificate#/ID#: _____ Subscriber Name: _____

Spine and Brain Institute of San Diego

CONDITIONS OF REGISTRATION AND AGREEMENT FOR PATIENTS OF SPINE AND BRAIN INSTITUTE OF SAN DIEGO, INC.

If the patient is a minor, the parent, legal guardian or authorized person (in writing) must sign.

MEDICAL CONSENT

The undersigned consents to any and all service that do not require informed written consent.

RELEASE OF INFORMATION

The undersigned acknowledges receiving Spine and Brain Institute of San Diego's Notice of Privacy Practices. Additional copies are available upon request.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as an agent or as a patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates him/herself to pay all monies due in accordance with the regular rates and terms of Spine and Brain Institute of San Diego. In addition, the undersigned understands that any deposit made for services incurred is merely a deposit, and that he/she will be financially responsible for all charges incurred.

Co-payments, co-insurance, payments for non-covered services and/or deductibles are due at the time of visit. Monies not collected at the time of visit will be the patient's responsibility.

All patient accounts are due and payable upon receipt of a billing statement. If it is necessary to employ professional collection agency and/or attorney to enforce this Agreement or to collect a judgment based on this Agreement, the patient or the person responsible for payment of fees related to the account that is the subject of this Agreement promises to pay all applicable interest, court costs and attorney fees.

The holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

The undersigned herby agrees to provide 24 hours advance notice for all canceled appointments. Should 24 hours advance notice not be provided, he/she understands that they may be charged a missed appointment fee.

The undersigned hereby authorizes Spine and Brain Institute of San Diego to check and/or verify all references and financial information about him/her that is pertinent to his/her account, including but not limited to credit reports.

ELIGIBILITY GUARANTEE

The undersigned agrees that he/she must be eligible with their health insurance plan at the time of visit. The undersigned understands and agrees that Spine and Brain Institute of San Diego will not take responsibility for the refusal of an insurance company to pay for testing or treatment due to lack of insurance benefits. If he/she is unable to provide insurance coverage at time of visit, he/she has 30 calendar days to provide this information. If he/she is unable to provide eligible coverage within 30 calendar days, he/she will assume full financial responsibility for all charges incurred. In addition, should eligibility status of the patient's insurance terminate retroactively, he/she will be financially responsible for any services provided.

Patient Name (PLEASE PRINT) _____

OFFICE COPY

ASSIGNMENT OF MEDICARE BENEFITS

The undersigned request that payment of authorized Medicare benefits be made on the patient's behalf to Spine and Brain Institute of San Diego for a, services furnished to the patient by the physician. The undersigned authorizes any holder of medical information about him/her to be released to the Centers for Medicare and i. agents, as well as a, information necessary to pay the claim. If other health insurance coverage is indicated on Item 9 of the CMS-I500 claim form or elsewhere on other approved claim forms or electronically submitted claims, the undersigned signature authorizes release of the information to the insurer or agency. In Medicare-assigned cases, the physician agrees accept the charge determination of the Medicare as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

NON-RESPONSIBILITY

The undersigned agrees that Spine and Brain Institute of San Diego and its physicians shall not be responsible for the errors or omission of the employee or contractors of other health care providers who provide services to the undersigned in the course of their treatment by Spine and Brain Institute of San Diego. The undersigned certifies that he/she has read the foregoing, received a co, thereof and is the patient, the patient's legal representative or is fully authorized by the patient the patient's general agent to execute this Agreement and accept its terms.

COMMON INTEREST

The undersigned acknowledges that your physician may have a financial interest in the hospitals, surgery centers, imaging centers, service providers, laboratories and/or implantable and non-implantable devices that he or she chooses to utilize. As the patient you have the right to choose another surgeon, device or request services another facility.

Signature: _____ Date: _____

(Patient, custodian, guardian, conservator, or agent)

Patient Name (Please print): _____

If signed by other than patient indicate relationship to patient: _____

Witness: _____

I acknowledge that I received a copy of this document.

Signature: _____ Date: _____

OFFICE COPY

Spine and Brain Institute of San Diego

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Patient Name (PLEASE PRINT) _____

PATIENT COPY

Spine and Brain Institute of San Diego

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The undersigned acknowledges that your physician may have a financial interest in the hospitals, surgery centers, imaging centers, service providers, laboratories and/or implantable and non-implantable devices that he or she chooses to utilize. As the patient you have the right to choose another surgeon, device or request services another facility.

Signature: _____ Date: _____

(Patient, custodian, guardian, conservator, or agent)

Patient Name (Please print): _____

If signed by other than patient indicate relationship to patient: _____

Witness: _____

PATIENT COPY

Acknowledgement of Receipt of Notice of Privacy Practices

Spine and Brain Institute of San Diego
6719 Alvarado Road, Suite 308
San Diego, CA 92120

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____

Telephone: _____

If **not** signed by patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

Spine and Brain
Institute of San Diego

Ramin Raiszadeh, M.D.
Director of Clinical Research

Paul D. Kim, M.D.
Spine and Brain Institute of San Diego

Sunil Jeswani, M.D.
Spine and Brain Institute of San Diego

Sabareesh Natarajan, M.D.
Spine and Brain Institute of San Diego

Evan Nigh, M.D.
Spine and Brain Institute of San Diego

Sophea Bergen, PA-C
Physician Assistant

Stephanie Haua, PA-C
Physician Assistant

Amelia Luckow, PA-C
Physician Assistant

Controlled Substance/Narcotic Agreement

This agreement is between the patient and The Spine and Brain Institute of San Diego. It is agreed that narcotic medication will be given by Ramin Raiszadeh, M.D., Paul D. Kim, M.D., Sunil Jeswani, M.D., Sabareesh Natarajan, M.D., Evan Nigh, M.D., Sophea Bergen, PA-C, Stephanie Haua, PA-C, and/or Amelia Luckow, PA-C, on a regular basis to the patient ONLY if the following terms are met:

1. By signing a contract for narcotic administration, the patient indicated that he/she has understood the discussion about the use of narcotic medications, including side effects, and is agreeable to start this treatment under the terms set by The Spine and Brain Institute of San Diego.
2. I will take medications only as prescribed. I will not exceed the prescribed dose even if I perceive it to be necessary. No early refills will be given if I run out of medication early.
3. I am fully responsible for the safekeeping of my medication. Lost or stolen medication will not be replaced.
4. I will never share my medications with others.
5. I will not use illicit drugs or abuse alcohol.
6. No narcotic prescriptions will be refilled after hours or on weekends.
7. I will not drive a vehicle or use dangerous equipment while taking my pain medications. I am aware that if I have narcotics in my system while operating a vehicle, I may be subject to a DUI.
8. I am aware that narcotic medications are addicting.
9. I am aware that suddenly stopping these medications may be dangerous.
10. I will inform The Spine and Brain Institute of San Diego of any new medications written by any other provider.
11. We typically prescribe medication for after surgery or extenuating circumstances; If you have a pain management doctor, you must return to them for chronic pain management.

I fully understand the explanations regarding the benefits and the risks of this method of treatment. I agree to the use of narcotic medication in the treatment of my pain.

This has been fully explained to me, I have read it or have had it read to me, and I understand it. I have had the opportunity to ask questions, and have received acceptable answers. I agree to the terms of this contract.

Date: _____

_____ _____

(Patient Signature) (Print Patient Name)

_____ _____

Witness Signature (**Office Staff Only**) (Print Witness Name)

Main Office:
6719 Alvarado Road
Suite 308
San Diego, CA 92120
t: (619) 265-7912
f: (619) 265-7922
https://www.sbiosd.com

Patient Name (PLEASE PRINT): _____

HT: _____WT: _____R ☐ or L ☐ Handed

HISTORY OF CURRENT INJURY

Chief Complaint: _____

Exact date(s) of injury or onset of symptoms: _____

_____

Detailed description of the injury (PLEASE INCLUDE WHEN, WHERE, AND MECHANISM OF INJURY?): _____

_____

_____

_____

_____

Is there any litigation pending?

Workers Comp ☐ Disability Claim ☐ Social Security Claim ☐ Lawsuit ☐

If this is a work-related injury, please provide the date you first report the injury to your employer: _____

List what treatments have been provided for this injury:

	Providers	When: (DATE RANGES)	Treatment/How Many:	Benefit: (YES/NO)
MEDS				
PT				
CHIRO				
ACUPUNCTURE				
INJECTION				
OTHER				

Have you had any tests for this problem? If so, please include approx. date and facility.

☐ X-Ray _____ ☐ MRI _____ ☐ CT _____

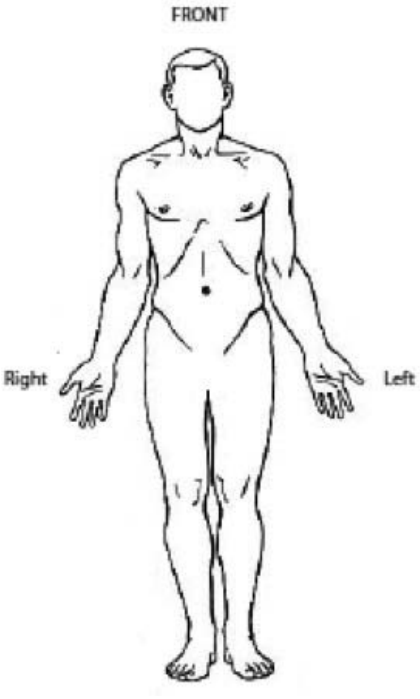
☐ EMG _____ ☐ Bone Scan _____ ☐ EMG _____

☐ CT/Myelogram _____ ☐ Discography _____ ☐ Other (Please Specify) _____

Spine and Brain Institute of San Diego

Patient Name (PLEASE PRINT): _____

CURRENT COMPLAINTS



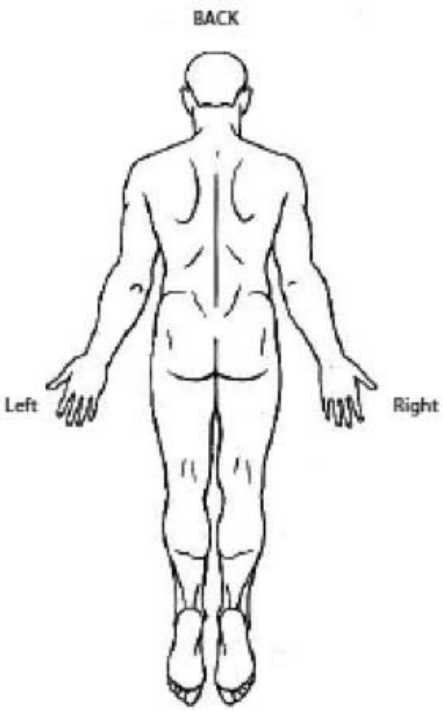
Where is your pain?

Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
Total	100	%

PLEASE INDICATE IN THE ABOVE TABLE THE PERCENTAGE OF PAIN THAT YOU CURRENTLY FEEL IN YOUR LEGS, ARMS, NECK AND BACK.

Use the body diagram to show where you feel the following sensations.

Ache	AAA
Numbness	000
Burning	XXX
Stabbing	///
Pins and Needles	–––



What makes the pain worse?

☐ Prolonged Sitting ☐ Prolonged Standing ☐ Walking ☐ Bending Forward
☐ Bending Backward ☐ Coughing / Sneezing ☐ Other: _____

What reduces the pain?

☐ Lying down ☐ Standing ☐ Sitting ☐ Injections
☐ TENS unit ☐ Muscle Relaxant Pills ☐ Walking ☐ Anti-inflammatory Pills
☐

Other: _____

On a scale from 0 to 10, mark your level of pain discomfort with 0 being none and 10 being unbearable. (CHOOSE ONE).

NECK/ARM PAIN	LOWER BACK/LEG PAIN
Neck Pain	Back Pain
None 0 2 4 6 8 10 Unbearable	None 0 2 4 6 8 10 Unbearable
Right Arm Pain	Right Leg Pain
None 0 2 4 6 8 10 Unbearable	None 0 2 4 6 8 10 Unbearable
Left Arm Pain	Left Leg Pain
None 0 2 4 6 8 10 Unbearable	None 0 2 4 6 8 10 Unbearable

Spine and Brain Institute of San Diego

Patient Name (PLEASE PRINT): _____

OCCUPATIONAL HISTORY

Occupation: _____

Are you working? Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Not working ☐

FILL OUT ONLY If Work Related Injury: Please complete the following questions on this page:

Please list the following for the past 5 years:

Employer	Job Title	Dates of Employment	Dates of Light Duty	Dates of Full Duty

At time of injury please give your general job description (INCLUDE ANY MACHINERY OR VEHICLES USED):

_____

_____

NORMAL WORK ACTIVITIES: (PLEASE COMPLETE THE FOLLOWING SECTION IN REFERENCE TO A WORK DAY AT THE TIME OF INJURY)

Work Hours: _____ Number of days per week: _____

In a normal work day, how many hours do you sit _____, stand _____ and walk _____?

How often do you lift and carry items? _____

How much weight would you normally be required to carry? _____

What is the heaviest object that you lift and how much does it weigh? _____

How often are you are required to do the following: (PLEASE CHECK ONE)

	Never	Occasionally	Frequently	Constantly
A. Bending				
B. Squatting				
C. Crawling				
D. Kneeling				
E. Climbing				
F. Walking on uneven ground				
G. Reach above shoulder level				
H. Reaching at shoulder level				

PAST INJURY HISTORY

Have you ever had any prior injuries to any of the body parts involved in this claim? _____

If so, please describe each injury to each body part & did you still have pain after any of the injuries?

_____

_____

Patient Name (PLEASE PRINT): _____

MEDICATION AND DOSAGE

Medication	Strength	# of pills per day

MEDICATION ALLERGIES: _____

PAST MEDICAL HISTORY:

_____

_____

PAST SURGICAL HISTORY:

Date	Procedure
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Who do you live with? _____

Do you smoke? Yes ☐ No ☐ Packs per day _____ for _____ years.

Do you drink alcohol? Yes ☐ No ☐ How much and how often? _____

Do you use illicit drugs? Yes ☐ No ☐ How much and how often? _____

FAMILY HISTORY (DO YOU HAVE A FAMILY HISTORY OF THE FOLLOWING?)

Heart Problems	Yes ☐ No ☐	Bleeding Problems	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Adverse Reaction to Anesthesia	Yes ☐ No ☐
Depression	Yes ☐ No ☐	Other: _____	

Patient Name (PLEASE PRINT): _____

REVIEW OF SYSTEMS

Are you currently having problems with:			Please describe all yes answers
GENERAL/CONSTITUTIONAL			
Unexpected Weight loss	Yes ☐	No ☐	
EAR, NOSE THROAT			
Sinus problems	Yes ☐	No ☐	
Difficulty swallowing	Yes ☐	No ☐	
Hearing loss	Yes ☐	No ☐	
SKIN			
Rashes/Infection/Sores	Yes ☐	No ☐	
CARDIOVASCULAR			
Chest pain, Angina	Yes ☐	No ☐	
Blood pressure	Yes ☐	No ☐	
Poor circulation	Yes ☐	No ☐	
Irregular heart beat	Yes ☐	No ☐	
RESPIRATORY			
Shortness of breath	Yes ☐	No ☐	
Bronchitis/Pneumonia	Yes ☐	No ☐	
GASTROINTESTINAL			
Heart burn, ulcers	Yes ☐	No ☐	
Diarrhea	Yes ☐	No ☐	
GENITOURINARY			
Urinary Incontinence	Yes ☐	No ☐	
Difficulty starting urination	Yes ☐	No ☐	
HEMATOLOGIC			
Easy bruising, bleeding	Yes ☐	No ☐	
ENDOCRINE			
Diabetes	Yes ☐	No ☐	
MUSCULOSKELETAL			
Osteoporosis	Yes ☐	No ☐	
PSYCHIATRIC			
Depression	Yes ☐	No ☐	
Narcotic drug addiction	Yes ☐	No ☐	
Alcoholism	Yes ☐	No ☐	
NEUROLOGIC			
Parkinsons	Yes ☐	No ☐	
ALLERGIC/IMMUNOLOGIC			
Latex allergy	Yes ☐	No ☐	
Hay fever	Yes ☐	No ☐	
EYES			
Blurry vision	Yes ☐	No ☐	
OTHER	Yes ☐	No ☐	

Patient Name (PLEASE PRINT): _____

ONLY FILL OUT IF YOU HAVE LOW BACK PAIN: Please fill out this sheet by checking one box in each section for the statement which best applies to you.

Section 1: Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ The pain is bad, but I can manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on my pain, I do not use them.

Section 2: Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without it causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and I stay in bed.

Section 3: Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g., on a table)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4: Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than 2 miles.
- ☐ Pain prevents me walking more than ¼ mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than thirty minutes.
- ☐ Pain prevents me from sitting more than ten minutes.
- ☐ Pain prevents me from sitting at all.

Patient Name (PLEASE PRINT): _____

BACK PAIN PATIENT (PAGE 2 OF 2)

Section 6: Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives extra pain.
- ☐ Pain prevents me from standing for more than one hour.
- ☐ Pain prevents me from standing for more than thirty minutes.
- ☐ Pain prevents me from standing for more than ten minutes.
- ☐ Pain prevents me from standing at all.

Section 7: Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets, I have less than six hours sleep.
- ☐ Even when I take tablets, I have less than four hours sleep.
- ☐ Even when I take tablets, I have less than two hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8: Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities. (e.g., lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.).
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to home.
- ☐ I have no social life because of pain.

Section 10: Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two hours.
- ☐ Pain restricts me to journeys less than one hour.
- ☐ Pain restricts me to short journeys under thirty minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Patient Name (PLEASE PRINT): _____

ONLY FILL OUT IF YOU HAVE NECK PAIN: Please fill out this sheet by checking one box in each section for the statement which best applies to you.

Section 1: Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not very much.
- ☐ The pain is severe but comes and goes.
- ☐ The pain is severe and does not very much.

Section 2: Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but can manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3: Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the heavy weights are conveniently placed (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4: Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5: Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches, which come infrequently.
- ☐ I have moderate headaches, which come infrequently.
- ☐ I have moderate headaches, which come frequently.
- ☐ I have severe headaches, which come frequently.
- ☐ I have headaches almost all the time.

Patient Name (PLEASE PRINT): _____

NECK PAIN PATIENT (PAGE 2 OF 2)

Section 6: Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7: Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8: Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 9: Driving

- ☐ I can drive my car without neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 10: Recreation

- ☐ I am able to engage in all recreational activities with no pain in my neck at all.
- ☐ I am able to engage in all recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I cannot do any recreational activities at all.

Spine and Brain
Institute of San Diego

( ) Routine

( ) STAT

Request of Medical Information

1. **Authorization**
   I authorize disclosure of medical information and health records as described below:
   Name of Patient:_____Date of Birth:_____
   Social Security Number: _____ - _____-_____ Telephone: (_____)_____-_____
2. **Record Holder**
   Name:_____
   Address:_____
   City, State, Zip:_____
   Phone:_____
   Fax:_____

   ☐ Spine and Brain Institute
   of San Diego
   6719 Alvarado Rd #308
   San Diego, CA 92120
   (619) 265 - 7912
   (619) 265 - 7922
3. **Records May be Released To**
   Name:_____
   Address:_____
   City, State, Zip:_____
   Phone:_____
   Fax:_____

   ☐ Spine and Brain Institute
   of San Diego
   6719 Alvarado Rd #308
   San Diego, CA 92120
   (619) 265 - 7912
   (619) 265 - 7922
4. **Type of Information**

   This authorization is limited to the following type(s) of information, marked by my initials:
   ( ) Medical Records ( ) Labs/ EKG ( ) X-Rays/MRI ( ) PT ( ) Billing ( ) Injection Reports
   ( ) Operative Reports ( ) Other_____
5. **Dates of Service:** From _____/_____/_____To _____/_____/_____
6. **Use of Information**
   The individual or entity above is permitted to use my information for the following purposes:
   ( ) Continuing Medical Care ( ) Second Opinion ( ) Personal ( ) Insurance ( ) Legal
   ( ) Transfer of Care ( ) Other (Please Specify)_____
7. **Duration:** This authorization is valid for one year from the date next to my signature unless noted here:_____
8. **Additional Copy**
   I further understand that I have a right to receive a copy of this authorization upon my request.
9. **Re-disclosure**
   A statement that protected health information used or disclosed pursuant to the authorization may or may not be subject to re-disclosure by the recipient and thus no longer protected by the Privacy Rule.
10. **Revocation**
    This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requester is specifically required or permitted by law.
11. **Explanation**
    I understand that my treatment is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
12. **Patient Billing:** I understand I will be charged $15 plus $0.25 per page for personal requests.
13. **Signature**
    Printed Name:_____

    Signature:_____Date/ Time:_____

    If signed by other than patient, indicate relationship to patient:_____

    Witness Signature:_____Date/Time: