SCRANTON ORTHOPAEDIC SPECIALISTS P.C.

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TIMOTHY J. SIEBECKER, D.P.M.

DATE: _____

Dear _____

Thank you for choosing our orthopaedic practice. This letter is a reminder of your upcoming appointment with Dr. _____ on _____ at _____.

In order to expedite the registration process, we ask you to bring the following:

1. All insurance information (Insurance cards). Also, bring Photo ID
2. If this is a Compensation injury, your Workmen's Comp Claim # and your Compensation Carrier address and phone number.
3. If Auto Accident related, your claim # and address and phone # or carrier.
4. A REFERRAL if you are a managed care participant. (Note: We are NOT allowed to see you if you do not have a referral form from your primary care physician.)
5. Please arrive 15 minutes early to complete paperwork.

We ask you to bring the actual films or copies of X-RAYS, MRI'S, BONE SCANS AND CAT SCANS AS WELL AS THEIR REPORTS, and any other pertinent test results.

If you were seen by another physician for the same problem, we ask that you hand carry any previous records, hospital records (operative reports) and any other reports (for example, nerve conduction studies, vascular studies). Please include any information regarding cortisone or epidural injections.

Enclosed is a history form (health questionnaire). Please bring the completed form with you to your appointment as well as the Authorization Form on the reverse of this page. Please bring an up to date list of your medications from your family doctor.

Payment is due at the time of service for co-payments and non-covered charges. We accept Mastercard, Visa and personal checks. If payment cannot be made at time of service, arrangements must be made with the Business Office at 307-1768 before your visit.

Directions to our office: Exit 190 off Route 81, make right, office is .3 miles on right.

Thank you for your cooperation. We look forward to meeting you.

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Dickson City, PA 18519
570-307-1767

SPINE NEW PATIENT INFORMATION QUESTIONNAIRE

Name:_____ Age: _____ DOB: _____ SS# _____

Address: _____ Telephone _____

Height: _____ Weight: _____ Hand Dominance: □ right □ left □ none
Language spoken _____ Race/Ethnicity _____

Referring MD: _____Send Report? ___Family MD: _____Send Report? ___

Reason for seeing doctor: _____

Have you been treated previously for this problem? ____ Yes ____ No

If yes, where and by whom? _____

Date of Injury or when you first noticed your symptoms: _____

How did your symptoms start? □ gradually □ suddenly

Please describe the injury or events leading to the onset of your symptoms: _____

_____

_____

Please describe how your symptoms have progressed since onset: _____

_____

Please describe your symptoms as they currently affect you: _____

_____

What questions would you like to have answered during your visit?_____

_____

Please rate your pain on a scale of 1 – 10 (0=no pain, 10=worst) _____

In percentages, how much pain is in your back/neck and how much in your legs/arms?
_____ in my back/neck _____ in my legs/arms = 100%

What is the character of your pain: □ electrical □ muscle cramp □ aching □throbbing
□ dull □ sharp

SPINE QUESTIONNAIRE, PAGE 2

What makes your symptoms better? _____

What makes your symptoms worse? _____

What medicine do you *currently* take for pain? _____

During the last month, how frequently have you been taking medicine for pain?
□ 3-4 times/day □ 1-2 times/day □ once every few days □ once a week □ not at all

Describe any part of your body that is numb: _____

Describe any part of your body that is weak: _____

What does your problem limit you from doing: _____

How far can you walk comfortably? □ around the home only □ a few blocks □ under a mile
□ about a mile □ a few miles □ no limitation

Please check and *list the approximate date* of any diagnostic tests for your spine:
□ x-rays □ MRI □ EMG □ CT scan or myelogram □ bone scan
□ discogram □ Other – please specify: _____

Have you had any injections in or around your spine? □ Yes □ No
If yes, when, where, type of injection, response to injection:_____

What treatments have you tried? □ Physical therapy □ Acupuncture □ Traction
□ chiropractic care
Your response to treatment: _____

Have you had surgery on your spine? □ Yes □ No
Date: _____ Surgeon: _____ Procedure: _____
Date: _____ Surgeon: _____ Procedure: _____

Have you noticed any recent changes in your bowel or bladder function? □ Yes □ No
Is your pain worse at night? □ Yes □ No Having fevers? □ Yes □ No
Are you having problems with your balance? □ Yes □ No
Coordination problems - difficulties buttoning clothes or change in handwriting? □ Yes □ No

Circle all health conditions for which you have been diagnosed:

Heart disease	History of blood clots	hypertension	blood disorder	GI disorder
Lung disease	asthma	tuberculosis	liver disease	hepatitis
Epilepsy	chemical dependency	diabetes	fibromyalgia	HIV
Osteoporosis	hypocholesterolemia	hypothyroidism	kidney disease	alcoholism
Cancer (type:_____)		Other: _____		

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____

SPINE QUESTIONNAIRE, PAGE THREE

Please describe and list the approximate date of any surgery you have had: _____

_____

_____

Please list ALL medications you currently take, the dosage and reason for taking each:

Medication	Dosage (Amount and frequency)	Reason

FAMILY HISTORY

	Alive (age and illness)	Deceased (age and illness)
Mother		
Father		
Siblings		
Spouse		
Children		

Smoking: □ current smoker □ former smoker □ never smoked

How much do you smoke most days? _____

How much alcohol do you drink in an average week? _____

Have you ever taken illicit drugs? □ Yes □ No **What?** _____

Have you retained an attorney because of your spine problem? _____

Occupation: _____ **Average # of hours worked/week:** _____

Work status: _____

Name and address of employer: _____

What are the physical requirements of your work? _____

_____

INSURANCE INFORMATION:

Company Name: _____

Subscriber name: _____ **Subscriber Date of Birth** _____

Policy #: _____

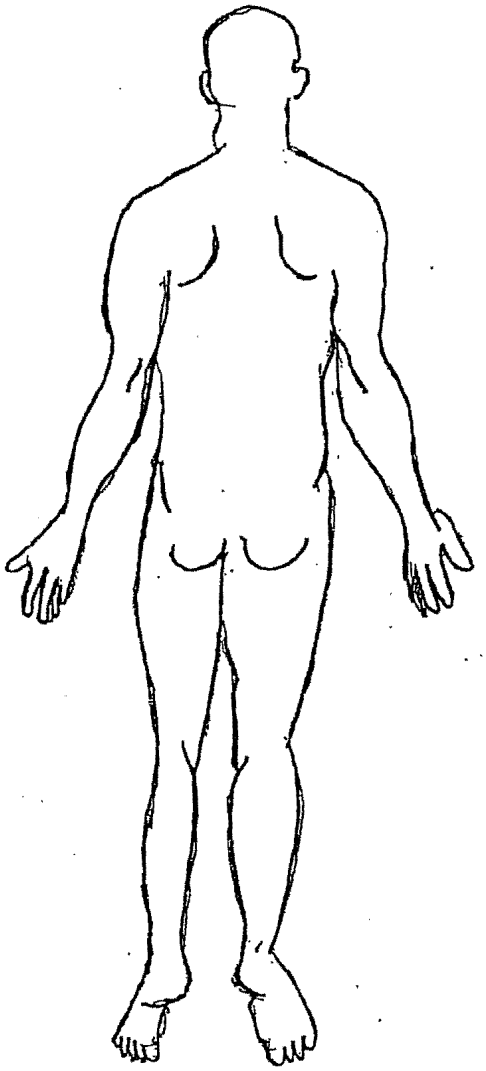
WORKERS COMPENSATION? ____ **Contact:** _____

EMERGENCY CONTACT NAME & PHONE: _____

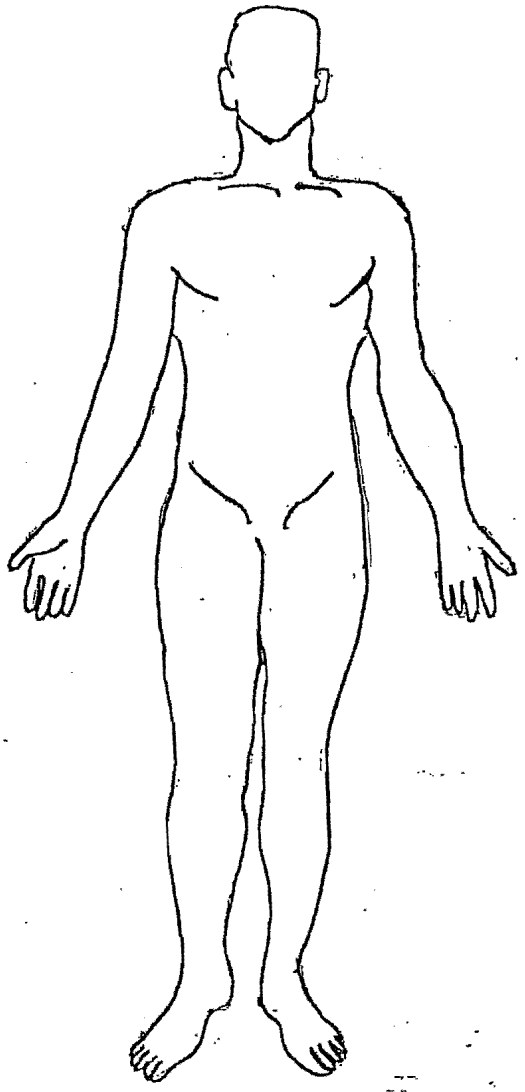
Mark the areas of your body where you feel the described sensation. Use the appropriate symbol. Mark all areas including any areas of radiation.

Pain xxxx
Numbness 0000
Tingling ////

BACK



FRONT



_____ On a scale of 1-10, if surgery could get rid of all symptoms, how likely would you be to have surgery?