NEW PATIENT PACKET

Interventional Spine of Vermont

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Williston, VT 05495

Phone: (802) 404-2004 Fax: (888) 506-2885

Please complete the entire form and have it ready before the start of your appointment. Please arrive at least **15 minutes** prior to the start of your appointment and have the following information with you:

1. **Photo ID and Insurance Card(s)**: We will make a copy of this information at your first appointment.
2. **Medication List:** Please bring just a list, you do not need to bring the medications with you.
3. **Previous Imaging (X-Ray, CT Scan, MRI, etc.)**: If you have had any previous testing, please bring copies of those with you to the visit. They will be helpful in assessing your case.
4. **Co-Payments**: If your insurance requires a co-payment, they will be required at time of visit.

Your time is important to us! We ask that you arrive at least 15 minutes prior to your appointment. If you are more than 05 minutes late, we may ask that you reschedule to the next available slot.

If you have any questions about this packet, feel free to call us prior to your appointment.

Demographic Information

Name: _____ [] He/him [] They/theirs [] She/hers
Date of Birth: _____

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

Home Phone: _____ Cell Phone: _____ E-mail: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referred By: (friend, physician, etc...) _____

Race: Asian [] African American [] Caucasian [] Hispanic Latino [] Native American
[] Pacific Islander []Asian [] Other [] Decline to Answer

Primary Language: _____

Employment [] Working [] Not Working. Were You Injured at work? []Yes [] No

Employer: _____ Phone: _____

Employer Address: _____

Insurance

Primary: _____ Policy #: _____ Group #: _____
Subscriber: _____ Subscriber DOB: _____

Secondary: _____ Policy #: _____ Group #: _____
Subscriber: _____ Subscriber DOB: _____

Auto Accident: Is this injury covered by auto accident insurance? []Yes []No Date of Injury: _____
Insurance Carrier: _____ Claim #: _____
Carrier Address: _____ Name of Insured: _____
Adjuster: _____Phone: _____
Attorney: _____ Phone:_____

Workers Compensation: Is this injury covered by Workers Compensation? []Yes []No
Date of Injury: _____ Claim #: _____
Insurance Carrier: _____Address:_____
Name of Insured: _____
Adjustor: _____Phone: _____
Attorney:_____Phone: _____

Pharmacy Name: _____Phone: _____
Address:
_____

Full Name: _____ DOB: _____

Height: _____ Weight: _____ [] Right [] Left-Handed

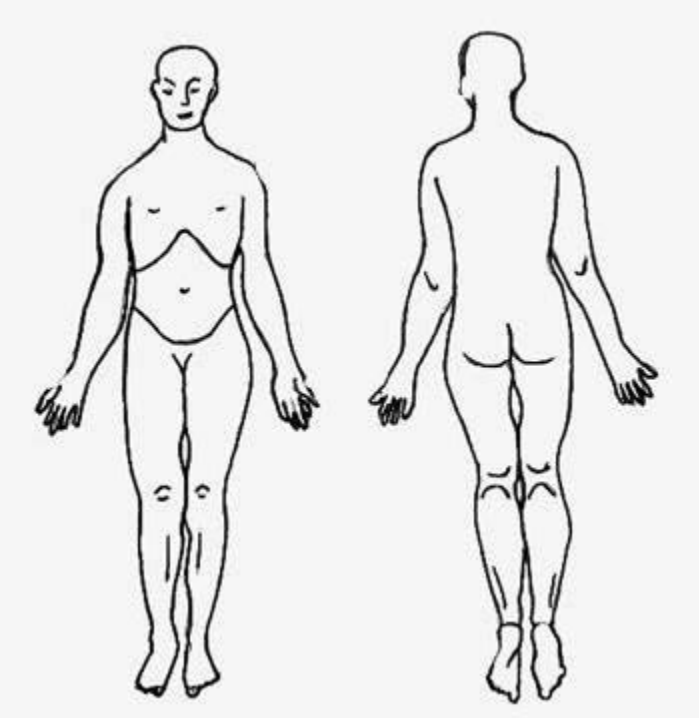
Please describe your problem:

_____

_____

_____

Shade in the area where you experience pain:



Place an X on the line that represents your pain today:

No Pain_____Worst Pain

1 2 3 4 5 6 7 8 9 10

Place an X on the line that represents your pain this past week:

No Pain_____Worst Pain

1 2 3 4 5 6 7 8 9 10

Do you need assistance with daily living? [] Yes [] No_____

_____

Full Name: _____ DOB: _____

Pain Inventory: Please check off all the following words that describe your pain:

[] Numb/Dull []Sharp []Tender []Shooting []Cramping []Firing/Exhausting
[]Tingling []Aching []Heavy []Stabbing []Throbbing [] Hot/Burning

Chronology:

When Did your pain start? _____
_____

Did anything happen that triggered it? _____
_____

What makes the pain better/worse? _____
_____

What is the duration of your pain? [] Constant []Constant but variable in intensity
[]Intermittent []Episodic

Previous Treatment:

[] Xray []CT Scan []MRI Scan []Myelogram []EMG []Bone Scan

What other treatments have you tried (check all that apply)?

[] Surgery []Physical Therapy []Acupuncture []Epidural/Steroidal
Injections []Non-Steroidal Anit-inflammatory medications []Chiropractic []Non-prescription
Drugs []Other:
_____

What treatments worked best? _____
How much better did you feel? _____ %
What treatments were least effective? _____

Are you taking any blood thinners (Plavix, Coumadin, Lovenox, etc.)? [] Yes []No
_____

Are you allergic to any medications? contrast dye? Latex? [] Yes []No
_____

Full Name: _____DOB: _____

Medications:

1. Name: _____ Dose: _____Time: _____
2. Name: _____ Dose: _____ Time: _____
3. Name: _____ Dose: _____ Time: _____
4. Name: _____ Dose: _____ Time: _____

Past Medical History:

[] Anemia	[]Depression	[] High Blood Pressure	[]Rheumatic Fever
[]Anxiety	[]Diabetes	[]HIV	[]Seizure
[]Arthritis	[]Emphysema	[]Kidney Problems	[]Stroke
[]Asthma	[]Eye Problems	[]Liver Problems	[]Substance Abuse
[]Blood Clots	[]Heart Disease	[]Loss of Bladder Control	[]Thyroid Problems
[]Cancer/Tumor	[]Hepatitis	[]Loss of Bowel Control	[]Tuberculosis
[]COPD	Other: _____		[]Ulcer

Past Surgical History (please be specific as possible and include dates**):**

1._____
2. _____
3._____
4._____

Social History:

Marital Status: [] Single []Married [] Divorced [] Widowed [] Separated [] Other _____

Could you be pregnant? [] Yes [] No How Many Weeks? _____ Due: _____

How many children do you have? _____

Highest level of education completed:
[]GED [] High School [] Trade School []2 yr College []4 yr College [] Masters [] Other: _____

Do you use tobacco? [] No []Former []¼ Pack Day []½ Pack Day []Pack day []1+Pack Day

Do you drink alcohol? [] No []Former Amount Per Day: _____

Full Name: _____DOB_____

Are you currently using the following?

[] None []Marijuana []Cocaine []Heroin []PCP []Other: _____

Have you used any of the following in the past?

[] None []Marijuana []Cocaine []Heroin []PCP []Other: _____

Are you Currently Working?

[] Retired []Short Term Disability []Long Term Disability []Unemployed
[]Yes Occupation: _____ ___Employer: _____

Duties at Work?

[] Lifting []Bending []Standing []Reaching []Other: _____

Do any family members suffer from a chronic illness? [] Yes []No
please describe: _____
_____