

NEW HAMPSHIRE NEUROSPINE INSTITUTE INITIAL EVALUATION

Today's Date: _____ Medical Records #: _____
 Last Name: _____ First Name: _____
 Date of Birth: _____ Age: _____ Male Female
 Height: _____ ft. _____ in. Weight: _____ lbs.
 Primary Care Physician (PCP): _____ Physician Specialists: _____
 Referred by: _____ Dominant Arm: Left Right

History:
 Date of injury or when pain began: ____/____/____
 Describe how injury occurred or how the symptoms began: _____

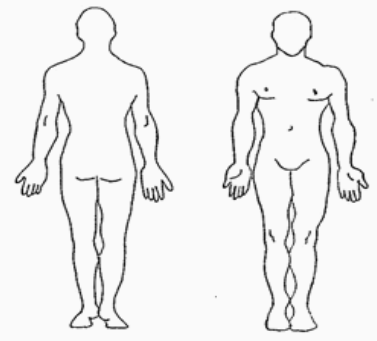
Did this happen at work? Yes No Was this a Motor Vehicle Accident? Yes No

Answer the following questions if this is a work related injury:
 Name of employer where injury occurred: _____
 Job title at time of injury: _____
 What is your current work status: Out of work Last day worked: ____/____/____
 Working with restrictions _____ hrs/day _____ days/wk _____ lbs. max
 Fully Duty Other _____
 How long had you worked at this job before the injury occurred: _____
 Prior to this injury, were you working: Fully Duty Limited / Modified Duty

Where did you first seek treatment: _____
 What other treatments have you tried: (fill in number of weeks) None
 Physical Therapy _____ wks Braces/Orthotics explain: _____
 Injections explain: _____ PCP _____ wks
 Oral Medications List: _____
 Other explain: _____
 What diagnostic tests (related to your current symptoms) have you had: (fill in approximate dates {month/year}) None
 X-rays ____/____ MRI ____/____ CT Scan ____/____ EMG's ____/____
 Arthrogram ____/____
 Have you had similar symptoms before this episode: No
 One episode Multiple episodes Most recent date: ____/____/____ (before this episode)

Present Status:
 What makes your pain worse? _____
 What relieves your pain? _____
 Describe your pain on a scale of 0-10 (0 = no pain at all; 10 = the worst pain you can imagine):
 At its worst: _____ Most of the time: _____ At its best: _____
 Do you use any assistive devices:
 No Cane(s) Crutches Wheelchairs Orthotic(s)/Brace(s) Walker
 Other _____
 Does an attorney represent you (if this is an injury)? Yes No

SHOW US WHERE YOUR PAIN IS LOCATED
 Mark these drawings according to where you hurt (if the back of your shoulder hurts, mark the drawing on the back of the shoulder, etc.)
Use these symbols for PAIN: A = Aching, S = Stabbing, B = Burning
N = Numbness (is a loss of sensation or the feeling of being "asleep" -- it is not painful).
P = Pins and Needles



Medical History: (check all that apply)

No medical conditions

Diabetes Heart Disease Stroke Asthma Depression Hepatitis (specify type: _____) Gout

High blood pressure Lung Disease Alcohol Abuse Drug Abuse Ulcer Disease Vascular Disease

Thyroid Disease Bleeding/Clotting problems Kidney Stones GERD (reflux/heartburn) Osteoarthritis

Rheumatoid Arthritis Cancer (type: _____) Other: _____

Have you had any previous surgery: (add dates) None

Tonsils <input type="checkbox"/>	Appendectomy <input type="checkbox"/>	Gallbladder <input type="checkbox"/>
Hysterectomy <input type="checkbox"/>	Heart <input type="checkbox"/>	Blood vessels <input type="checkbox"/>
Lung <input type="checkbox"/>	Kidney <input type="checkbox"/>	Stomach or intestinal <input type="checkbox"/>
Other(s): <input type="checkbox"/>		

List all of your current medications (Please include dosage and frequency): _____ No medications

Pharmacy: _____ Location: _____

Do you have any drug allergies: None

Yes List & describe what happens: _____

Social History:

Marital Status: Single Married Divorced Separated Widowed

Do you have any children: No Yes (number: _____)

Living situation: Live with spouse Live with significant other Live alone Nursing home

Live with parents Live with adult children Live with minor children

Smoking: Never smoked Quit _____ months ago Quit _____ years ago Yes _____ pks per day x _____ yrs.

Do you drink alcohol: No Yes If yes, how much alcohol do you drink each day: _____ drinks/day.

Have you had any weight changes in the past year: No Yes, gained _____ lbs. Yes, lost _____ lbs.

What is the last grade you completed: _____ Grade GED High School Graduate 2-yr Associates Degree Technical School

_____ yrs. College Bachelors Degree Post Graduate or Professional Degree

What is your race/ethnicity?: _____

What is your language preference? (If other than English): _____

Family History:

Do any of these diseases run in your immediate family (parents, brothers, sisters only):

No medical conditions

Diabetes Heart Disease Stroke Asthma Depression Hepatitis B High Blood Pressure

Lung Disease Alcohol Abuse Ulcer Disease Vascular Disease Thyroid Disease

Cancer (type: _____) Other: _____

Work History: (Skip if you have already filled out in section one)

Present employer: _____

Primary occupation: _____

How long have you worked at your current job: _____ months _____ years

Current work situation:

Working Paid leave Unpaid leave Unemployed Homemaker Student

Permanently disabled / retired due to health explain: _____ Retired not due to health

MD USE ONLY

RX:

Vital signs:

MD Notes:

Who is accompanying a minor?



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Prescriptions and Medication Refills

Name:

Acct #:

Prescriptions and prescription refills are issued during regular business hours only. Our on-call physicians will not provide prescription refills or prescribe medications at night or on weekends.

- 1) You need to contact the office Monday- Friday 8am- 4pm. If you need a prescription refilled, please call the office and leave a message on our medication refill line by choosing option 4. Leave a detailed message and you will be contacted by one of our staff within 4 hours.
- 2) If you lose your prescription it will not be refilled until it was due for a refill.
- 3) You will need to take the medication as prescribed as it will not be refilled early in the event you decided to take more medication.
- 4) We will not automatically take over a narcotic prescription that has been prescribed by another provider.
- 5) Narcotics will not be prescribed on a long term basis and it is expected that medications will be weaned over time. In the event you are involved in our pain management program, you will be required to sign a "Pain Treatment Agreement" which will outline our policies and procedures for managing your pain.

I, the undersigned, acknowledge that I have read and understand the NHNSI prescription policy and procedure.

Signature: _____

Date: _____