SPINE & PAIN MANAGEMENT

PATIENT INFORMATION SHEET

NAME: LAST ____ FIRST _________________________________ MI ______

ADDRESS: ____

CITY ____ **STATE** _______ **ZIP** ______________

DATE OF BIRTH *(MM/DD/YYYY)* _____ / ______ / __________ **SEX:** ☐ M ☐ F

HOME PHONE (______) __________________________ **CELL** (______) ________________________

WORK PHONE (______) __________________________ EXT __________

E-MAIL ADDRESS: ____

PRIMARY CARE DOCTOR ____

REFERRAL SOURCE (Physician Name, Friend, etc.): ____

SOCIAL SECURITY ______ / _____ / ______ **MARITAL STATUS**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ OTHER

EMERGENCY CONTACT ____ **PHONE** (______) ________________________

EMPLOYER NAME ____

ADDRESS ____

RESPONSIBLE PARTY: SELF GUARANTOR RELATIONSHIP _____________________________________

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER ____ ID # ________________________________

CLAIMS ADDRESS ____ GROUP # __________________________

POLICY HOLDER NAME ____ DOB _________________ SEX _______

SECONDARY INSURANCE CARRIER ____ ID # ______________________________

CLAIMS ADDRESS ____ GROUP # __________________________

POLICY HOLDER NAME ____ DOB _________________ SEX _______

I authorize Keeran Kumar, MD permission to treat and bill to my insurance carrier. I attest that the information above is true and current. I understand that I am responsible for any amounts not covered by insurance carrier and agree to pay my balance in a timely manner.

PATIENT SIGNATURE ____ **DATE** ______________________

SPINE & PAIN
MANAGEMENT

MEDICAL QUESTIONNAIRE

NAME: ______________________________________ **DOB** _________________ **HEIGHT**___________ **WEIGHT** _________

PAST MEDICAL HISTORY

- ☐ ARTHRITIS
- ☐ DIABETES
- ☐ HEART FAILURE
- ☐ STROKE
- ☐ SEIZURES
- ☐ ULCERS
- ☐ HEPATITIS
- ☐ HYPERTENSION/HIGH BLOOD PRESSURE
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ WEARS GLASSES/ CONTACTS
- ☐ HERNIA
- ☐ UTI(s)
- ☐ CANCER
- ☐ OTHER (SPECIFY):
- ☐ OSTEOPOROSIS
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ KIDNEY DISEASE
- ☐ ANEMIA
- ☐ FREE/EASY BLEEDING
- ☐ REFLUX/GERD
- ☐ HIV/AIDS
- ☐ EMPHYSEMA/COPD
- ☐ ASTHMA
- ☐ HEARING AIDS
- ☐ PNEUMONIA
- ☐ HEARTBURN
- ☐ MIGRAINES
- ☐ EPILEPSY
- ☐ COMPRESSION FRACTURE

PAST SURGICAL HISTORY

- ☐ LAMINECTOMY
  Year: _________ Level(s): ______________________
- ☐ SPINAL FUSION
  Year: _________ Level(s): ______________________
- ☐ BACK (SPECIFY)
- ☐ NECK (SPECIFY)
- ☐ APPENDIX
- ☐ GALL BLADDER
- ☐ TONSILS
- ☐ TUBAL LIGATION
- ☐ HYSTERECTOMY
- ☐ CESAREAN SECTION
- ☐ KIDNEY
- ☐ KNEE ARTHROPLASTY
- ☐ CATARACT/LENS
- ☐ BREAST MASECTOMY
- ☐ OTHER (SPECIFY):
- ☐ CARDIAC STENT
- ☐ HIP REPLACEMENT
- ☐ PROSTATE
- ☐ CANCER REMOVAL
- ☐ VASECTOMY
- ☐ HEART CATH
- ☐ ROTATOR CUFF
- ☐ CARPAL TUNNEL
- ☐ THYROID
- ☐ PACEMAKER

FAMILY HISTORY

FATHER: ☐ **ALIVE** ☐ **DECEASED** ☐ **UNKNOWN**

☐ NO HEALTH CONCERN	☐ ARTHRITIS	☐ BLEEDING DISORDER	☐ DIABETES	☐ HEART DISEASE
	☐ ASTHMA	☐ COPD	☐ STROKE	☐ HIGH CHOLESTEROL
	☐ MENTAL ILLNESS	☐ HEART ATTACK	☐ DEPRESSION	☐ CORONARY ARTERY
	☐ HYPERTENSION	☐ OSTEOPOROSIS	☐ NEUROLOGICAL:	☐ OTHER:
	☐ CANCER (TYPE:_____________________)			

MOTHER: ☐ **ALIVE** ☐ **DECEASED** ☐ **UNKNOWN**

☐ NO HEALTH CONCERN	☐ ARTHRITIS	☐ BLEEDING DISORDER	☐ DIABETES	☐ HEART DISEASE
	☐ ASTHMA	☐ COPD	☐ STROKE	☐ HIGH CHOLESTEROL
	☐ MENTAL ILLNESS	☐ HEART ATTACK	☐ DEPRESSION	☐ CORONARY ARTERY
	☐ HYPERTENSION	☐ OSTEOPOROSIS	☐ NEUROLOGICAL:	☐ OTHER:
	☐ CANCER (TYPE:_____________________)			

SIBLING(S): ☐ **ALIVE** ☐ **DECEASED** ☐ **UNKNOWN**

☐ NO HEALTH CONCERN	☐ ARTHRITIS	☐ BLEEDING DISORDER	☐ DIABETES	☐ HEART DISEASE
	☐ ASTHMA	☐ COPD	☐ STROKE	☐ HIGH CHOLESTEROL
	☐ MENTAL ILLNESS	☐ HEART ATTACK	☐ DEPRESSION	☐ CORONARY ARTERY
	☐ HYPERTENSION	☐ OSTEOPOROSIS	☐ NEUROLOGICAL:	☐ OTHER:
	☐ CANCER (TYPE:_____________________)			

Comments:

Keeran Kumar, MD | 320 Santa Fe Dr. Suite 308 | ENCINITAS, CA 92024
PHONE: (858) 764-3837 | FAX: (760) 230-6566

SPINE & PAIN
MANAGEMENT

SOCIAL HISTORY

OCCUPATION: ___________________________________

☐ RETIRED ☐ CURRENTLY WORKING

☐ DISABLED

MARITAL STATUS: _________________________

☐ I LIVE WITH RELATIVES ☐ I LIVE ALONE

☐ I LIVE WITH FRIENDS

TOBACCO USE: ☐ Y ☐ N ☐ QUIT (YEAR _________)

ALCOHOL USE: ☐ FREQUENT ☐ RARELY

☐ NEVER

RECREATIONAL DRUGS: ☐ Y ☐ N

ALLERGIES

List severity (mild or severe) with its associated reaction.

____

____

____

____

____

☐ NO KNOWN MEDICATION ALLERGIES

REVIEW OF SYSTEMS

☐ FEVER/CHILLS
☐ WEIGHT GAIN
☐ WEIGHT LOSS
☐ LEG CRAMPS
☐ SHORTNESS OF BREATH
☐ EASY FATIGUE
☐ JOINT STIFFNESS
☐ MUSCLE STIFFNESS
☐ HEADACHE
☐ CHEST PAIN
☐ NAUSEA/VOMITING
☐ INSOMNIA
☐ ITCHING OR RASH
☐ SEDATION
☐ CONSTIPATION
☐ SWEATING
☐ HIGH STRESS LEVELS
☐ OTHER:

MEDICATIONS

List **DOSAGE** and # of pills per day if possible,
including pain, OTC, and **BLOOD THINNERS** you are currently taking.

☐ I am currently not taking any medications.
☐ I am currently on blood thinners as listed below.
Cardiologist/prescriber: ________________________

____

____

____

____

____

____

HISTORY OF PRESENT ILLNESS

1. **DATE/MONTH/YEAR OF ONSET** (PLEASE BE AS SPECIFIC AS POSSIBLE): __________________________________
2. **ARE THE SYMPTOMS A RESULT OF AN INJURY?**

   ☐ NO ☐ AUTO ACCIDENT ☐ FALL INJURY ☐ SPORT INJURY ☐ OTHER:

3. **PAIN SCORE:**

   With 10 being the worst, most debilitating amount of pain, please rate your pain/symptoms as best as you can:

   a. ON AVERAGE (without medications): **1 2 3 4 5 6 7 8 9 10**

   b. AT ITS WORST: **1 2 3 4 5 6 7 8 9 10**

   c. WITH MEDICATIONS (if applicable): **1 2 3 4 5 6 7 8 9 10**

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SPINE & PAIN MANAGEMENT

PRIMARY LOCATION(s) OF PAIN:

☐ Low back ☐ Mid-back
☐ Neck
☐ OTHER: ____
____
☐ Pain radiates from/to (ex: from low back to both legs):
____
☐ Pain does not radiate (focal pain).

PLEASE DESCRIBE THE PAIN: (check all that apply)

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Dull
☐ Aching ☐ Stiff ☐ Throbbing ☐ Nagging
☐ Burning ☐ Electric ☐ OTHER:

OTHER SYMPTOMS ASSOCIATED:

☐ NUMBNESS ☐ TINGLING ☐ WEAKNESS
☐ INCONTINENCE

TIMING OF PAIN: (check all that apply)

☐ Constant ☐ Intermittent (comes and goes)
☐ Most severe in morning ☐ Most severe at night

MOVEMENTS THAT MAKE IT WORSE: (check all that apply)

☐ Bending at the waist ☐ Running / Walking
☐ Stairs ☐ Squatting
☐ Lifting heavy objects ☐ Sitting
☐ Standing ☐ Twisting
☐ Moving head to the (LEFT / RIGHT)
☐ Stretching
☐ Raising (ARMS / LEGS)
☐ OTHER:

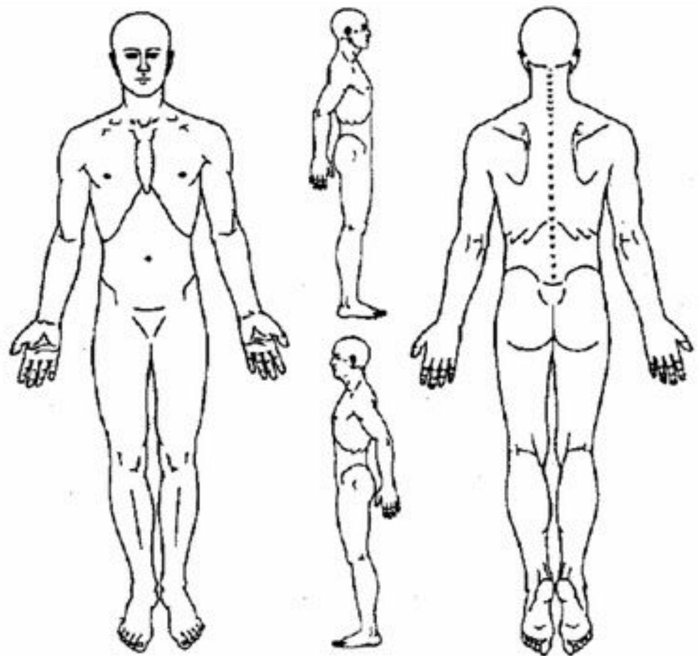
PRIOR SPINAL IMAGING

	MONTH/YEAR	FACILITY
☐ MRI	________________	____________________
☐ CT	________________	____________________
☐ NONE	________________	____________________

CONSERVATIVE CARE HISTORY:

	EFFECTIVE?	
☐ Heat or Ice packs	☐ Y	☐ N
☐ Physical therapy	☐ Y	☐ N
☐ Acupuncture	☐ Y	☐ N
☐ Chiropractic care	☐ Y	☐ N
☐ Massage therapy	☐ Y	☐ N
☐ Traction	☐ Y	☐ N
☐ TENS Unit	☐ Y	☐ N
☐ NSAID's	☐ Y	☐ N
☐ Bracing	☐ Y	☐ N
☐ Home Exercise Program	☐ Y	☐ N
☐ Epidural Injection(s)	☐ Y	☐ N
☐ OTHER:		

Please mark **X** where you feel pain and **O** where you feel numbness, tingling, or weakness.



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AUTHORIZATION FOR RELEASING HEALTH INFORMATION

NAME: Last ____ First ____

LAST 4 SSN: ___________ **DATE OF BIRTH:** _____ / _____ / _________ **PHONE NUMBER:** (_____)______-___________

I hereby authorize that Keeran Kumar, M.D. may obtain OR release the protected health information regarding the above named person to be used in treatment and diagnosis by Interventional Spine and Pain Management as well as any health provider authorized by the treating physician. I understand that this may include referrals, medical records, and radiology reports relevant to treatment.

I understand that records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

PROHIBITION OF DISCLOSURE: Alcohol and drug abuse information, if present has been disclosed from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR Part 2) prohibits recipients from making any further disclosure of this information except with specific written consent to the patient. DIV testing, ARC and/or AIDS related diagnosis is further prohibited from disclosure by state Regulations without the specific written consent of the patient. A general authorization for the release of information if held by another Party is not sufficient for this purpose.

RE-DISCLOSURE: Notice is hereby given to the patient of legal representative signing this authorization that Keeran Kumar, M.D. cannot guarantee that the recipient receiving the requested health information will not re-disclose it to others. Notice is hereby given to the recipient that law prohibits the re-disclosure of any health information regarding drug and or alcohol abuse, DIV and mental health treatment.

EXPIRATION:
Without my expressed revocation, the authorization will automatically expire upon satisfaction of the need for disclosure.

PATIENT SIGNATURE: ___________________________________ **DATE SIGNED:** _____ / _____ / ___________

OFFICE USE ONLY

DATE OF REQUEST: _____ / _____ / ________

PURPOSE: Information is to be used by Keeran Kumar, MD for:

☐ TREATMENT/RECORDS ☐ BENEFITS ☐ LEGAL ☐ OTHER:

ADDRESS/FACILITY OF REQUESTED INFORMATION: ____

____

PHONE: (_____)______-__________________

FAX: (_____)______-____________________

NOTES:

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