COMPREHENSIVE
SPINE & SPORTS CENTER

Campbell | Morgan Hill | Fremont
Ph: 408.356.5292
Fx: 408.356.5307
www.cssctr.com
help@cssctr.com

Intake Form

Name: _____ ❑ M ❑ F Birth Date: _____SS#: _____

Mailing Address: _____State: _____Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail:_____

Social Media (e.g. Twitter, Facebook, Yelp): _____

OK to leave messages on voicemail or email? ❑ Yes ❑ No

Is English your first language? ❑ Yes ❑ No Do you need an interpreter? ❑ Yes ❑ No

Preferred Language: _____

Current Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Race: ❑ American Indian or Alaskan Native ❑ Asian Native Hawaiian or Other Pacific Islander
❑ African American ❑ Caucasian ❑ Hispanic ❑ Other Race ❑ Refuse to Report

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic ❑ Refuse to report

Occupation: _____ Employer: _____

Primary Care Physician: _____ Phone: _____

Referred By: _____

Other physicians or health care providers that you are currently seeing including chiropractors, therapists, etc.

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone: _____

I authorize the release of any medical information necessary to process my claims to the insurance company, attorney or other physicians. I understand that I am responsible for all charges incurred. I further authorize my insurance to make direct payment to the Comprehensive Spine & Sports Center for all medical benefits.

Patient Signature: Date:

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Workers' Compensation Information

Insurance Carrier: _____

Date of Injury: _____ Claim #: _____

Claims Adjuster: _____ Phone: _____ Fax: _____

Job Title at time of injury: _____

Employer at time of Injury: _____

Occupation at time on injury: _____

Nurse Case Manager: _____ Phone: _____

Patient's Attorney: _____ Phone: _____

Employer's Attorney: _____ Phone: _____

Have you ever had a Worker's Compensation claim before? ❑ Yes ❑ No

If yes, please list separately all work injuries and body parts injured: _____

_____

List any other jobs or income source at the time of your injury: _____

Are you currently in litigation (lawsuit)? ❑ Yes ❑ No

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Patient: _____ Date:

Referral: How did you hear about us? ❑ Physician/Practice Name:

❑ Internet (Please specify): ❑ Other:

What do you hope to achieve today?_____

HISTORY OF PRESENT ILLNESS

How long have you noticed your pain? _____ Days_____ Weeks _____Months _____Years

Was there any injury/event that caused your pain? ❑ Yes ❑ No (Please describe your pain below):

_____

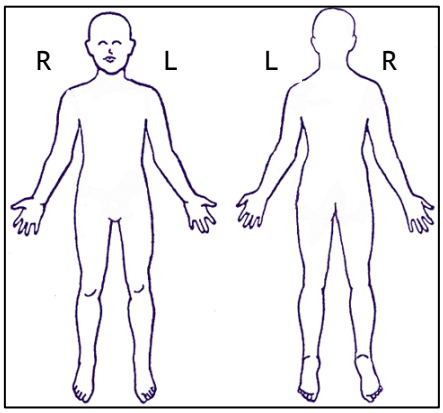
Where is your pain located?

❑ Neck/Mid Back/Low Back ❑ Buttock/Hip/ Legs

❑Shoulder/Elbow/ Hand ❑ Foot/Ankle

❑ Other _____

Where is the Pain?
(indicate in diagram below):



Rate your usual pain (CIRCLE NUMBER BELOW THAT BEST APPLIES):

No Pain 0 1 2 3 4 5 6 7 8 9 10 *The Worst Pain Imaginable*

Describe your pain (Check all that apply):

❑ Burning ❑ Sharp-Shooting ❑ Tingling ❑ Numbness

❑ Pinprick ❑ Stabbing ❑ Deep-pressure ❑ Tightness

❑ Spasms ❑ Other: _____

What makes the pain worse? _____

What makes the pain better? _____

Which of the following have been affected because of your pain? (Check all that apply):

❑ Household Chores ❑ Office Work ❑ Driving ❑ Walking/Running ❑ Sports ❑ Concentration

❑ Depression ❑ Anxiety ❑ Mood ❑ Appetite ❑ Sleep ❑ Relationships

Past Treatment:

Which of the following treatments/ evaluations have you tried for your pain? (Check all that apply):

❑ MRI ❑ X-Ray ❑ CT ❑ EMG ❑ Bone Scan ❑ Blood/Laboratory ❑ Epidurals ❑ Physical Therapy

❑ TENS ❑ Heating Pad ❑ Ice ❑ Injections ❑ Exercise ❑ Steroids

❑ Surgery ❑ Massage ❑ Medications ❑ Acupuncture ❑ Hypnotherapy

CURRENT MEDICATIONS:

Name of Medication	Strength (e.g. mg, mcg)	Number of Pills (e.g. once a day)	Frequency	Prescribing Physician

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What Pharmacy do you use (Name, Address, Phone Number)? _____

PAST MEDICAL HISTORY (Check all that apply):

❑ Brain ❑ Heart ❑ Lungs ❑ Liver ❑ Kidneys ❑ Diabetes ❑ Bleeding/Anemia ❑ Depression/ Bipolar ❑ Psychiatric ❑ Arthritis ❑ Fibromyalgia ❑ Headaches ❑ Suicide ideation/ attempts ❑ Alcohol/ Drug Problems ❑ State/ SS Disability ❑ Other: _____

ALLERGIES (List reactions): _____

PAST SURGICAL HISTORY (List all surgeries below or write N/A):

Surgery Type	Date of Surgery (Mo/Yr)	Surgeon

HOSPITALIZATION (List all hospital visits below or write N/A):

Reason for Most Recent Hospitalization or ER visit?	Date of Admission (Mo/Yr)	Name of Hospital

FAMILY HISTORY (Check all that apply):

❑ Stroke ❑ Seizure ❑ Heart ❑ Lungs ❑ Liver ❑ Kidney/ Bladder ❑Cancer ❑ Migraines ❑ Diabetes ❑ High Blood Pressure ❑ Thyroid Bleeding/ Anemia ❑ Stomach/ Bowel ❑ Fibromyalgia ❑ Gout ❑ Arthritis ❑ Suicide ideation/ attempts ❑ Depression/Bipolar ❑ Mental Disorders ❑ Alcohol/ Drug Problems ❑ State/ SS Disability ❑ Other: _____

SOCIAL HISTORY:

What is your highest level of education? _____

Are you employed? ❑ Full Time ❑ Part Time ❑ Unemployed ❑ Disability ❑ Retired

Employer: _____ Job Title: _____

Relationship Status: Are you: ❑ Single? ❑ Married? ❑ Separated? ❑ Divorced? ❑ Widowed?

Do you have children? ❑ Yes- How many? _____ ❑No

Smoking Status? Are you a: ❑ Current Smoker? How many packs a day? _____ ❑ Former Smoker? How many years since you smoked? _____ ❑ Never Smoker?

Do you drink alcohol? ❑ Yes How many glasses per day? _____ ❑ No

Do you use recreational drugs? ❑ Yes ❑ No

Have you ever abused drugs in the past? ❑ Yes ❑ No

Have you ever abused alcohol in the past? ❑ Yes ❑ No

Have you ever been treated at a drug or alcohol rehabilitation center? ❑ Yes ❑ No

Office Use Only: Ht:_____ Wt: _____ BP: _____ HR:

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Authorization for Use or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to as the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ , hereby authorize this medical practice to use and disclose health information related to my personal health, treatment or payment for treatment as follows:
This health information may be disclosed to:

_____

_____

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"):

_____

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.
Patient Signature:

_____

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CONDITIONS OF ADMISSION / CONSENT FOR SERVICES

Please read and sign the following agreement so that we may proceed with your care and treatment at the Comprehensive Spine & Sports Center.

CONSENT TO MEDICAL CARE: The undersigned hereby consent to the procedures that may be performed today as well as in the future during outpatient treatment, including emergency services, or other services rendered under the general and special instructions of my physician.

PERSONAL VALUABLES: It is understood and agreed that Comprehensive Spine & Sports Center maintains a safe environment for personal belongings. The staff shall not be liable for the loss or damage to any money, jewelry, glasses, documents, clothing, electronic devices or other personal articles of unusual value.

FINANCIAL AGREEMENT: The undersigned, whether signing as a patient or representative of the patient, agrees to pay all charges for medical services not otherwise covered by health care benefits, in accordance with the rates and terms of the Comprehensive Spine & Sports Center. If the account is referred to an attorney or collection agency, the undersigned agrees to pay actual collection costs, including attorney's fees, together with interest at the legal rate.

ASSIGNMENT OF BENEFITS: The undersigned, whether signing as a patient or representative of the patient, authorizes direct payment to the Comprehensive Spine & Sports Center of any health care coverage benefits otherwise payable to or on behalf of the patient for medical services rendered by us, including emergency services, if any. Health care coverage benefits include Medicare, other governmental health care program benefits, as well as coverage under a Worker's Compensation, automobile, life/accident, and disability insurance plan. The undersigned authorizes release of medical information necessary to determine the eligibility and benefits payable and to submit and process claims for payment.

AUTHORIZES REPRESENTATIVE: The undersigned hereby authorizes the Comprehensive Spine & Sports Center, at its election but without obligation, to represent the patient regarding any application and appeal for eligibility and benefits pursuant to the patient's applicable health benefit plan, including Medicare, or other governmental program benefits relating to services rendered at Comprehensive Spine & Sports Center.

ADVANCED DIRECTIVE: An advanced directive is a document outlining the patient's medical wishes should he or she be unable to speak for themselves. It also designates a Healthcare Agent who is authorized to make medical decisions on the patient's behalf. Does the patient have an Advanced Directive? Yes ☐ No

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND UNDERSTANDS THIS FORM AND ACCEPTS AND AGREES TO ABIDE BY ITS TERMS.

Patient or Patient Representative Signature Date Relationship

Witness Signature (CSSCtr Staff Use Only) Date

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Patient Rules & Regulations

Our goal at Comprehensive Spine & Sports Center (CSSCtr) is to provide top quality care to our patients in a compassionate and professional environment. We do our best to stay on time with our scheduled and give you our undivided attention.

As a patient of the CSSCtr, we appreciate you following the rules and regulations of the practice which help us maintain our goals.

1. If you are unable to keep an appointment, kindly call our office at least 72 hours prior to your appointment. We can then reschedule your appointment to a more convenient time.

2. A $200 fee will be applied to all New Patient appointments not cancelled within the 72 hour period or if you fail to keep your appointment. A fee of $100 will be applied to all follow-up appointments not cancelled within 72 hours

3. Please arrive 15 minutes prior to your appointment time. It is important to have your questionnaire and registration forms completed. If the forms are not complete at the time of your appointment, or you are more than 15 minutes late, you may need to be rescheduled for a later date.

4. Cash payments and co-pays must be paid at the time of check-in.

5. We do not accept checks for the initial consultation.

6. If you have recently moved, had a change to your insurance, claims adjuster, attorney, primary treating physician, or had any other change to your personal information, please supply us with the new information. Please provide the new information within 10 days of the change so we can keep up to date records.
Phone: (408) 356-5292
Fax: (408) 356-5307
Mail: 3425 S. Bascom Ave., Ste. 200 Campbell, CA 95008

7.You are responsible for knowing the coverage and benefits of your particular insurance company. If you are not sure of the requirements of your insurance company, please check with them prior to obtaining medical services. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to ascertain beforehand what your portion of the charges will be and to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

Patient Signature | Print Name | Date

Witness Signature (Staff Use Only) | Print Name | Date

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Pain Disability Index Sheet

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please check the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____

Recreation: This category includes hobbies, sports and other similar leisure time activities.

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____

Social Activity: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____

Self Care: This category includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving getting dressed, etc.)

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____

Signature _____Date _____ Print Name