Name:_____ Birth Date:_____

Chief Complaint: _____

When did your spine problem first begin? _____

Did your pain start because of an: Accident at work Motor vehicle accident

If there was an accident, what caused the pain ._____

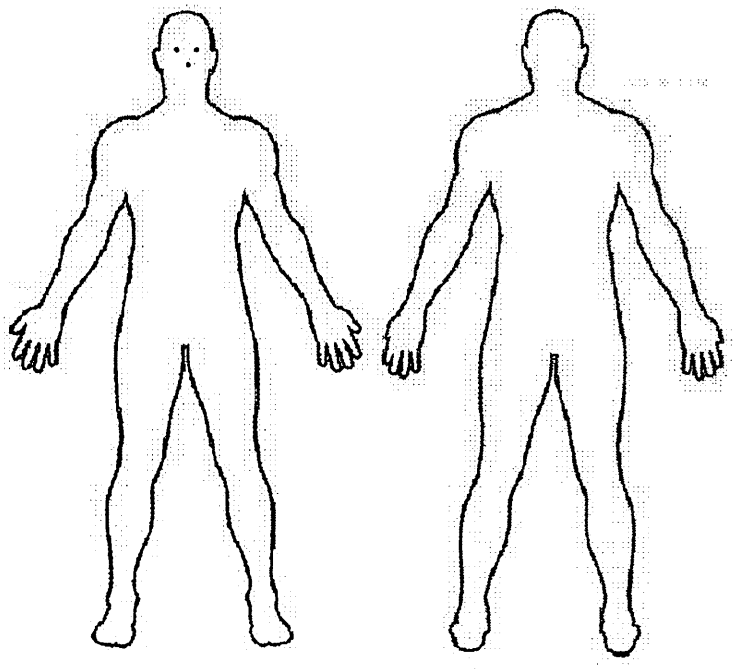
Workers Compensation Claim? [ ] Yes [ ] No

Do you have any problems controlling your bowel and / or bladder? [ ] Yes [ ] No

Hand dominance: Right Left

Mark the areas of your body where you feel pain, numbness or weakness. Use the appropriate symbol.

Numbness or pins/needles OOOOOOOOOOO
Aching or cramping XXXXXXXXXXXXX
Muscle weakness +++++++++++++++



Right Left Left Right

NEW NECK PAIN: ***Circle*** *all those that apply*

Chief Complaint: *Neck Headache Right Shoulder Left Shoulder Right Upper Extremity Left Upper Extremity*

Overall Neck Pain: *1...2...3...4...5...6...7...8...9...10* ***Overall Upper Extremity Pain:*** *1...2...3...4...5...6...7...8...9...10*

Neck pain: choose most applicable:

Neck pain > Upper extremity pain *Upper extremity pain > neck pain* *Upper extremity pain = neck pain*

NECK PAIN	ARM PAIN QUALITY	NUMBNESS	WEAKNESS
Aching	Aching	None	None
Burning	Burning	Right Shoulder	Right Shoulder
Stabbing	Stabbing	Right Arm	Right Arm
Throbbing	Throbbing	Right Forearm	Right Forearm
Tingling	Tingling	Right Thumb	Right Thumb
		Right Long Finger	Right Long Finger
Constant	Constant	Right Small Finger	Right Small Finger
Intermittent	Intermittent		
		Left Shoulder	Left Shoulder
		Left Arm	Left Arm
Gradually Worsening	Gradually Worsening	Left Forearm	Left Forearm
Rapidly Worsening	Rapidly Worsening	Left Thumb	Left Thumb
Gradually Improving	Gradually Improving	Left Long Finger	Left Long Finger
Rapidly Improving	Rapidly Improving	Left Small Finger	Left Small Finger

NEW BACK PAIN: ***Circle*** *all those that apply*

Chief Complaint: *Mid-Back Low Back Sacrum Right Buttock Left Buttock Right Lower Extremity Left Lower Extremity*

Overall Back Pain: *1...2...3...4...5...6...7...8...9...10* ***Overall Lower Extremity Pain:*** *1...2...3...4...5...6...7...8...9...10*

Back pain: choose most applicable:

Back pain > lower extremity pain *Lower extremity pain > back pain* *Lower extremity pain = back pain*

BACK PAIN QUALITY	LEG PAIN QUALITY	NUMBNESS	WEAKNESS
Aching	Aching	Left Buttock	Left Buttock
Burning	Burning	Left Anterior Thigh	Left Hip
Stabbing	Stabbing	Left Knee	Left Thigh
Throbbing	Throbbing	Left Shin	Left Ankle
Tingling	Tingling	Left Top of Foot	Left Big Toe
		Left Bottom of Foot	Left Calf
Constant	Constant		
Intermittent	Intermittent	Right Buttock	Right Buttock
		Right Anterior Thigh	Right Hip
Gradually Worsening	Gradually Worsening	Right Knee	Right Thigh
Rapidly Worsening	Rapidly Worsening	Right Shin	Right Ankle
Gradually Improving	Gradually Improving	Right Top of Foot	Right Big Toe
Rapidly Improving	Rapidly Improving	Right Bottom of Foot	Right Calf

The symptoms are better with:	Rest	Lying down	Bending forward	Bending backward
The symptoms are worse with	Bending forward	Bending backward	Sitting	Standing/Walking

TREATMENT - This section MUST be completed for surgery authorization

Physical Therapy [ ] never tried [ ] helpful [ ] not helpful Facility Name_____

Date Started_____ Date Ended_____

What treatment was performed? [ ] exercises [ ] stretching [ ] Tens unit [ ] Ultrasound [ ] massage

Spine Injections [ ] never tried [ ] helpful [ ] not helpful Doctor_____

Date Started_____ Date Ended_____

Chiropractics / Acupuncture [ ] never tried [ ] helpful [ ] not helpful Doctor_____

Date Started_____ Date Ended_____

Oral Steroids [ ] never tried [ ] helpful [ ] not helpful Doctor_____

Date Started_____

Medications Tried [ ] never tried [ ] helpful [ ] not helpful

Tylenol [ ] Advil [ ] Aleve [ ] Narcotic Pain Medications _____

Date Started_____ Date Ended_____

REVIEW OF SYMPTOMS

Are you having any of the symptoms / conditions **today**

Constitutional / General
Fever [ ] Yes [ ] No
Chills [ ] Yes [ ] No

Neurologic
Headache [ ] Yes [ ] No
Seizures [ ] Yes [ ] No

Pulmonary
Shortness of Breath [ ] Yes [ ] No
Asthma [ ] Yes [ ] No

Ears/Nose/Mouth/Throat
Dizziness [ ] Yes [ ] No
Difficulty Swallowing [ ] Yes [ ] No

Cardiovascular
Chest Pain [ ] Yes [ ] No
Irregular Heart Beat [ ] Yes [ ] No

Hematologic / Lymphatic
Anemia [ ] Yes [ ] No
Bleeding Problem [ ] Yes [ ] No

Endocrine
Diabetes [ ] Yes [ ] No
Fatigue [ ] Yes [ ] No

Psychiatric
Depression [ ] Yes [ ] No
Anxiety [ ] Yes [ ] No

Gastrointestinal
GERD [ ] Yes [ ] No
Ulcers [ ] Yes [ ] No

Genitourinary
Urgent Urination [ ] Yes [ ] No
Frequent Urination [ ] Yes [ ] No

Please list any spine surgeries [ ] None

Type of Spine Surgery	Date	Surgeon	Helpful
			Yes [ ] No [ ]
			Yes [ ] No [ ]
			Yes [ ] No [ ]
			Yes [ ] No [ ]

Oswestry Disability Index (version 2.1a)

This questionnaire to let us know how your back (or leg) is affecting your everyday life. Please mark one box in each section with the answer that most closely describes you today.

Pain Intensity
☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Personal Care (washing, dressing, etc.)
☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it is very painful.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but can manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, wash with difficulty and stay in bed.

Lifting
☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives me extra pain.
☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

Walking
☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than a quarter of a mile.
☐ Pain prevents me from walking more than 100 yards.
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Sitting
☐ I can sit in any chair as long as I like.
☐ I can sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than half an hour.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting at all.

Standing
☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives me extra pain.
☐ Pain prevents me from standing for more than 1 hour.
☐ Pain prevents me from standing for more than half an hour.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

Sleeping
☐ My sleep is never disturbed by pain.
☐ My sleep is occasionally disturbed by pain.
☐ Because of pain I have less than 6 hours sleep.
☐ Because of pain I have less than 4 hours sleep.
☐ Because of pain I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Sex Life (if applicable) ☐ **n/a**
☐ My sex life is normal and gives me no extra pain.
☐ My sex life is normal but causes some extra pain.
☐ My sex life is nearly normal but is very painful.
☐ My sex life is severely restricted by pain.
☐ My sex life is nearly absent because of pain.
☐ Pain prevents any sex life at all.

Social Life
☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Traveling
☐ I can travel anywhere without pain.
☐ I can travel anywhere, but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain restricts me to journeys of less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from travelling except to receive treatment.

Name:_____ Birth Date:_____

Medications – Attach sheet if necessary [ ] Check if No Medications

Medication	*Strength/Directions*

Allergies– Attach sheet if necessary [ ] Check if No known drug allergies

Medication/Allergies	**Reaction**

MEDICAL HISTORY

Please check the box if you have any of the following conditions:

[] Anxiety
[] Arthritis
[] Asthma
[] Blood Disorder
[] Cancer
[] Depression
[] Diabetes
[] Epilepsy
[] Heart Disease
[] High Blood Pressure
[] High Cholesterol
[] Kidney Disease
[] Multiple Sclerosis
[] Osteoporosis
[] Seizures
[] Stroke

Height _____ **Weight** _____

Name:_____ Birth Date:_____

FAMILY HISTORY

Please check the box if anyone in your immediate family has had any of the following conditions:
(NOTE RELATIONSHIP PLEASE Specify maternal/paternal for grandparents ie: maternal grandfather)

[] Anxiety _____
[] Blood Disorder _____
[] Diabetes _____
[] High Blood Pressure _____
[] Multiple Sclerosis _____
[] Arthritis _____
[] Cancer _____
[] Epilepsy _____
[] High Cholesterol _____
[] Osteoporosis _____
[] Asthma_____
[] Depression _____
[] Heart Disease _____
[]Kidney Disease _____
[] Seizures _____

SOCIAL HISTORY

Current Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ]Partner

Living Status: [ ] alone [ ] with spouse [ ] with parents [ ] with roommate [ ] assisted living [ ] nursing home

Current Occupation:_____

Highest education level: [ ] Grade School [ ] Middle School [ ] High School [ ] College [ ] Post Graduate

Do you use tobacco now or in the past? [ ] Yes, use now [ ] Never used [ ] Previous user
Cigarettes How many per day? _____ How many years? _____
Cigars How many per day? _____ How many years? _____

Do you drink alcoholic beverages? [ ] Never [ ] Weekly [ ] 1-2 x week [ ] 3 x week

Have you ever felt the need to cut down on drinking? [ ] Yes [ ] No
Have you ever felt annoyed by criticism of your drinking? [ ] Yes [ ] No
Have you ever felt guilty about your drinking? [ ] Yes [ ] No
Have you ever felt the need for a morning eye-opener? [ ] Yes [ ] No

Have you tried illicit drugs? [ ] Yes, use now [ ] Never used [ ] Previous user What was the substance?_____

Please check / list all operations: [ ] none

[ ] Appendectomy When:_____
[ ] Tonsillectomy When:_____
[ ] Gall bladder removal When:_____
[ ] Knee arthroscopy When:_____
[ ] Knee replacement When:_____
[ ] Hip replacement When:_____
[ ] _____ When:_____
[ ] Eye Surgery When:_____
[ ] Heart surgery When:_____
[ ] Hysterectomy When:_____
[ ] Prostate surgery When:_____
[ ] Surgery for cancer When:_____
[ ] _____ When:_____
[ ] _____ When:_____

PATIENT FINANCIAL RESPONSIBILITY POLICY

Patient Financial Responsibilities
The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you. However, you as the patient, is required to provide the most correct and updated information regarding insurance. Our staff will request your insurance card at each and every appointment. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by your insurance plan at the time of service. Our collection policy also includes that unpaid past due balances may be forwarded to a collection agency or pursuing legal action.

- Copayments are due at the time of service per your insurance policy.
- We do not bill for copayments. If payment is not received at time of service, a $20 charge will be added.
- Coinsurance, deductibles and non-covered items are due at the time of service.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

These charges may include:

- Charge for returned checks $30.00
- Charge for missed appointments without 24 hours prior notice $100.00
- We asses a 3% surcharge for credit card transactions. We impose a surcharge on credit cards that is not greater than the cost.

Motor Vehicle Accidents
Motor Vehicle accident information must be provided prior to your scheduled appointment. If you want us to bill your automobile insurance, please provide us with the insurance company name, address and phone number, claim number, adjusters name and phone number. We will bill your automobile insurance as a courtesy but you are responsible for all balances.

Workers Compensation
Workers Compensation information must be provided prior to your scheduled appointment. Your services will need to be authorized by your Adjuster. If your claim is in litigation, we will need to have your attorneys name, address and phone number prior to treatment. If any of this information cannot be verified, your appointment may be rescheduled.

Disability Forms
A fee of $40.00 will be charged to complete disability forms. Payment is required prior to form completion. This fee is waived if you have surgery scheduled and up to 3 months after surgery.

Patient Authorization
By my signature below, I hereby authorize Oregon Spine Care and the physicians, staff and hospitals associated with Oregon Spine Care to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.
I understand that I must check one or more of the following types of health information to indicate that I authorize that information type to be released to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care.
By initialing one or more of the below, the health information I authorize to be released may include any of the following:

_____ Record of alcohol and/or drug abuse.
_____ Record of HIV (AIDS) result, diagnosis, and/or treatment.
_____ Record of psychiatric and/or psychological condition

By my signature below, I hereby authorize assignment of financial benefits directly to Oregon Spine Care and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
By my signature below, I authorize Oregon Spine Care to communicate by mail, phone, and/or voice mail message, according to the information I have provided below:

Please read and then choose YES or NO:
If you are unavailable, may we leave medical information, such as appointment reminders, lab results and financial information on your voicemail or with someone at your residence?
_____YES _____NO
If yes, please list name and relationship of person(s) we are authorized to discuss your medical care and/or account:

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

Oregon Spine Care LLC is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures.
I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient and/or Guardian Date
Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received a copy of our Notice of Privacy Practices for Oregon Spine Care, LLC or Robert L. Tatsumi MD PC.

Patient Name: _____

Patient Signature:_____

Date: _____

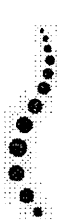
Name of Patient Legal Guardian or Representative: _____

Relationship to Patient: _____

Signature of Patient Legal Guardian Representative: _____

Date: _____

OFFICE STAFF USE: Oregon Spine Care, LLC or Robert L. Tatsumi MD PC have made good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices. Staff initials _____ Date: _____



Oregon Spine Care

Robert Tatsumi, MD
Alexander Ching, MD
Zach Knight-King PAC
Nicole Bangs, PAC
Joel Horst, PAC
Kelsey Gretzinger, PAC

DISCLOSURE OF PHYSICIAN OWNERSHIP FORM

Please carefully review the information contained in this notice.

1. In order to allow you to make a fully informed decision about your health care, our physicians would like to advise you that at some point during the course of your treatment, you may be referred to one of the following organizations, of which he has a financial interest.

Dr. Tatsumi: South Portland Surgery Center and Clearview MRI

Dr. Ching: Oregon Surgery Institute

2. Please note that you have the right to choose the provider of your healthcare service. Therefore, you have the option to use a healthcare facility other than those listed above for your services.

3. You will not be treated differently if you choose to use a different facility. If desired, we can provide information about alternative options.

4. If you have any questions concerning this notice, please feel free to ask our staff at Oregon Spine Care. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership Form, you acknowledge that you have read the foregoing notice.

Name of Patient : _____ *Signature of Patient:* _____

Date: _____

OFFICE USE ONLY

The patient identified above was provided with verbal disclosure of the above information on this date.

_____ _____

Employee Signature Date