J. Michael Graham, PH.D., M.D.

Northwest Spine Center

New Patient Information

Name: ____
Last *First* *Middle*

Address (mailing): ____

City: ________________________________ State: __________ Zip: ______________

Sex: [ ] M [ ] F Date of Birth: ______________ Age:____ Social Security #: ______________

Height: ___________ Feet ________ Inches Weight: ______________ pounds

Telephone Numbers: Home Phone: ________________________________

Work Phone: ________________________________

Cell Phone: ________________________________

Email Address: ____

Referring Physician: ____

Primary Care Physician: ____

Pharmacy Name: ___________________________ Phone Number: ________________

PATIENT EMERGENCY CONTACTS (Please provide name, relationship and best contact number)

(1) ________________________ Relationship: ________________ Ph. ________________

What is your chief complain or reason for your office visit today? __________________

____

____

____

____

When did the symptoms start?____

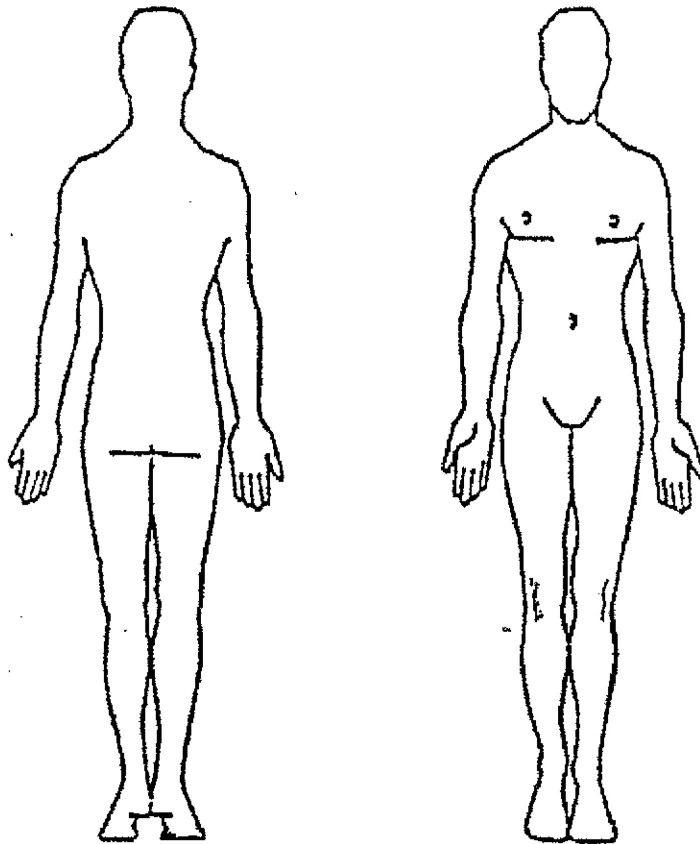
____

What type of treatment have you tried?_____________________________________

____

Pain Diagram

On these diagrams, please mark an "x" everywhere you feel pain and mark an "o" everywhere you feel numbness or tingling:



Visual Pain Scale

On a scale of 0 to 10 indicate how much pain you have. "0" means no pain and "10" is severe incapacitating intolerable pain.

0 1 2 3 4 5 6 7 8 9 10

Past Medical History

Select any of the following medical conditions that you currently have:

- ☐ None
- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Cardio: Hyperlipidemia/High Cholesterol
- ☐ Cardio: Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Other ___________________
- ☐ Hypercholesterolemia
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH (Benign Prostatic Hyperplasia)
- ☐ Prostate Cancer
- ☐ Pulm: Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Rheum: Fibromyalgia
- ☐ Rheum: Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke

Past Surgeries

Have you had any surgeries of the following surgeries?

- ☐ None
- ☐ Appendix (Appendectomy)
- ☐ Breast: Lumpectomy (Both Breasts)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Mastectomy (Both Breasts)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Gastric Bypass
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Other: ___________________
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Tonsillectomy
- ☐ Uterus: Hysterectomy
- ☐ Uterus (Hysterectomy): Cesearean Section
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer

Orthopedic History

- ☐ None
- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Handedness - Ambidextrous
- ☐ Handedness - Right
- ☐ Handedness - Left
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Other: ___________________
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Rickets
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fractur

Orthopedic Surgery

- ☐ None
- ☐ Achilles Tendon Repair
- ☐ ACL Reconstruction
- ☐ Ankle Fracture ORIF: Bilateral
- ☐ Ankle Fracture ORIF: Left
- ☐ Ankle Fracture ORIF: Right
- ☐ Bunion Correction
- ☐ Carpal Tunnel Decompression: Bilateral
- ☐ Carpal Tunnel Decompression: Left
- ☐ Carpal Tunnel Decompression: Right
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ CMC Arthroplasty
- ☐ Distal Radius ORIF: Bilateral
- ☐ Distal Radius ORIF: Left
- ☐ Distal Radius ORIF: Right
- ☐ Ganglion Cyst Excision
- ☐ IMN Femur: Bilateral
- ☐ IMN Femur: Left
- ☐ IMN Femur: Right
- ☐ IMN Tibia: Bilateral
- ☐ IMN Tibia: Left
- ☐ IMN Tibia: Right
- ☐ Joint Replacement: Hip (Both)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Knee (Both)
- ☐ Joint Replacement: Knee (Left)
- ☐ Joint Replacement: Knee (Right)
- ☐ Joint Replacement: Shoulder (Bilateral)
- ☐ Joint Replacement: Shoulder (Left)
- ☐ Joint Replacement: Shoulder (Right)
- ☐ Knee Arthroscopy: Bilateral
- ☐ Knee Arthroscopy: Left
- ☐ Knee Arthroscopy: Right
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression and Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
- ☐ Reverse Total Shoulder Replacement
- ☐ Revision of Total Hip Arthroplasty
- ☐ Revision of Total Knee Arthroplasty
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ Rotator Cuff Repair: Bilateral
- ☐ Rotator Cuff Repair: Left
- ☐ Rotator Cuff Repair: Right
- ☐ Shoulder Arthroscopy
- ☐ Trigger Finger Release

☐ Other: ________________

Orthopedic Family History

☐ None
☐ Charcot Marie Tooth Disease
☐ Diabetes
☐ Other: ________________
☐ Hypertension
☐ Multiple Hereditary Exostosis
☐ Osteoarthritis
☐ Osteoporosis
☐ Scoliosis

Pediatric History

☐ None
☐ Breech Position
☐ Cerebral Palsy
☐ Flatfeet (Pes Planovalgus)
☐ Genu Valgum
☐ Other: ________________
☐ Genu Varum
☐ Hip Dysplasia
☐ Neonatal Sepsis
☐ Pavlik Harness as Infant
☐ Spina Bifida
☐ Spondylolisthesis

Interventional Pain History

☐ None
☐ Epidural Injection(s) - Cervical
☐ Epidural Injection(s) - Thoracic
☐ Epidural Injection(s) - Lumbar
☐ Facet Injection(s) - Cervical
☐ Facet Injection(s) - Thoracic
☐ Other: ________________
☐ Facet Injection(s) - Lumbar
☐ Intrathecal Pump
☐ Medial Branch Block - Cervical
☐ Medial Branch Block - Thoracic
☐ Medial Branch Block - Lumbar
☐ Rhizotomy - Cervical
☐ Rhizotomy - Thoracic
☐ Rhizotomy - Lumbar
☐ Spinal Cord Stimulator

Current Medications and dosage

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

8) ____

9) ____

10) ____

Allergies

Are you allergic to any medication, anesthetic, or X-ray dye?

Yes _____ No _____

If Yes, which ones: ____

____

Social History

Marital Status: ☐ Single ☐ Cohabitating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you smoke? _____ Yes _____ No

If Yes, When did you start smoking? _____/_____/_____

How many packs per day? ____

Did you previously smoke? _____ Yes _____ No

How many packs per day?____

When did you quit? _____/_____/_____

Social History Details

☐ None

☐ Drug use

If yes, please elaborate: _________________

____

☐ IV Drug Use

If yes, please elaborate: _________________

____

☐ Other: ______________________

☐ Never drinks alcohol

☐ Drinks less than 1 alcoholic drink per day

☐ Drinks 1-2 alcoholic drinks per day

☐ Drinks 3 or more alcoholic drinks per day

☐ Patient feels safe at home

☐ Patient feels unsafe at home

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Driving Status

☐ Drives in the Daytime ☐ Drives at Night

How often do you exercise? ____

What is your caffeine use? ____

Occupation and Workplace: ____

Currently Working? _____ Yes _____ No

Place of Residence: ____

Review of Systems

Please check any symptoms you have had in the last six months

MUSCULOSKELETAL
- ☐ Joint pains
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Unsteady gait

NEUROLOGICAL
- ☐ Numbness
- ☐ Tingling
- ☐ Dizziness
- ☐ Headaches
- ☐ Tremors

CONSTITUTIONAL/SYMPTOM
- ☐ Fatigue
- ☐ Unexpected weight loss
- ☐ Fever
- ☐ Chills
- ☐ Weight gain

INTEGUMENTARY
- ☐ Poor healing wounds
- ☐ Rash
- ☐ Itching
- ☐ Scarring/keloids

HEMATOLOGIC/LYMPHATIC
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Enlarged lymph nodes

ALLERGIC / IMMUNOLOGIC
- ☐ Immunosuppression
- ☐ Allergic reaction to foods/environment

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Heart murmur
- ☐ Leg cramps

ENDOCRINE
- ☐ Excessive thirst or urination
- ☐ Heat/cold intolerance

EARS, THROAT, NOSE, AND MOUTH
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Hoarseness

EYES
- ☐ Redness
- ☐ Corrective lenses
- ☐ Blurred vision

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody/tarry stools

GENITOURINARY
- ☐ Frequent urination
- ☐ Difficult/painful urination
- ☐ Incontinence
- ☐ Blood in urine

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Hurts to breath

PSYCHIATRIC
- ☐ Nervousness
- ☐Anxiety
- ☐ Depression
- ☐ Hallucinations

Please check any of the following that pertains to you
- ☐ None
- ☐ Blood thinners
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Premedication prior to procedures
- ☐ Rheumatoid arthritis
- ☐ RSD
- ☐ Allergy to shellfish/iodine
- ☐ Allergy to latex
- ☐ Allergy to adhesive
- ☐ Under pain management
- ☐ Pregnancy or planning a pregnancy
- ☐ West Africa: Travel or Contact
- ☐ Ebola Risk: Fever >= 100.4 degrees (F) / 38.0 degrees (C)
- ☐ Ebola Risk: Resided or Traveled To Country with wide-spread Ebola transmission in the last 21 days
- ☐ Ebola Risk: Contact with an Ebola Patient without proper protective equipment in the last 21 days
- ☐ Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage

Family History

Please indicate with a check (√) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Other
ADD/ADHD									
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Bipolar disorder									
Bleeding problem									
Cancer, breast									
Cancer, colon									
Cancer, melanoma									
Cancer, ovary									
Cancer, prostate									
Crohn's disease									
Depression									
Diabetes									
Eczema									
Heart disease									
High blood pressure									
High cholesterol									
Hypothyroid									
Kidney disease									
Osteoporosis									
Rheumatologic disease									
Seizure disorder									
Stomach ulcers									
Stroke									
Substance abuse									
Suicide									
Ulcerative Colitis									
Other:									
Other:									
Other:									

INSURANCE INFORMATION

RESPONSIBLE PARTY (Must complete if responsible party is other than the insured or patient.)

[ ] Same as Patient [ ] Same as Insured - Relation to Patient: ______________________________

Name: _______________________________________ Employer: ____________ ____________

Address: ___________________________________ Phone: __________________________

City, State, & Zip:____ ____

Social Security#: ___________________________ Date of Birth: ________________________

PRIMARY INSURANCE (Must complete in its entirety in order for us to file with your insurance.)

Name of Policy Holder: _________________________ Policy Holder Date of Birth: _____________

Relation to Patient: __________________

Name of Insurance Company: ___________________ Insurance Phone #: _____________________

Policy Holder SS#: ___________________________ Policy Group #: _______________________

***** IS THE PATIENT COVERED UNDER ANY OTHER INSURANCE? YES /NO**

(If yes, please complete secondary insurance below)

SECONDARY INSURANCE (if applicable)

Name of Policy Holder: _________________________ Policy Holder Date of Birth: _____________

Relation to Patient: __________________

Name of Insurance Company: ___________________ Insurance Phone #: _____________________

Policy Holder SS#: _________________ ____________Policy Group #: _____________________

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance company; therefore, making me fully responsible for any charges incurred.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient and authorized to furnish the requested information. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered.

Furthermore, I hereby authorized insurance company payment of the medical or surgical benefits directly to J. Michael Graham, Ph.D., M.D. I understand that I am financially responsible for any and all charges not covered by insurance, including co-payments, policy deductibles, and co-insurance expect where my liability is limited by contract or State or Federal Law.

Patient/Responsibility Party Signature: ______________________________ Date: ______________

NORTHWEST SPINE CENTER

Conditions of Services

PATIENT ______________ ______________________________ DOB______________________

Assignment of Benefits and Release of Patient Healthcare Information

I hereby authorize Northwest Spine Center to release patient healthcare information, compiled from the medical records pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payer, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payer or agency.

I also hereby authorize payment of insurance benefits under the terms of my policy directly to Northwest Spine Center for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by Northwest Spine Center, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at time services are rendered or payment arrangements are to be made before your appointment.

X ______________________________ ________________

Patient/Guarantor Signature Date

Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at Northwest Spine Center.

X ______________________________ ________________

Patient/Guarantor Signature Date

Release of Patient Healthcare Information

I hereby authorize Northwest Spine Center to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission.

X ______________________________ ________________

Patient/Guarantor Signature Date

The above authorizations are valid unless you specify otherwise or revoke them in writing

NORTHWEST SPINE CENTER

Acknowledgement of Review of Privacy Practices

I, the undersigned, have reviewed the Northwest Spine Center Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Privacy Practices.

____ ______________

Signature of Patient or Representative Date

____

Print Name of Patient or Personal Representative

____

Capacity of Personal Representative (Parent, Guardian, Trustee, Executor)

____

House Address

____

City, State, Zip Code

Authorization to Release

Patient Name: ______________________________ DOB: ____________________

I, ______________________________, give my authorization to release my
Patient / Guardian

Protected health information results of my laboratory tests, x-ray and/or any other test results to the following designated representative(s):

PLEASE ANSWER ALL:

Initial yes answer only

YES / NO ________ My Spouse (name) ________________________

YES / NO ________ My child (name) __________________________

YES / NO ________ Other (name) _____________________________

YES / NO ________ Personal Representative ____________________

YES / NO ________ May leave on answering machine @ Home / Work / Cell

YES / NO ________ May email me at ____

________________ MAY NOT BE GIVEN TO ANYONE OTHER THAN PATIENT