Appt Date:________________ Name:______________________________

Comprehensive Orthopaedics, SC

7401-104th Ave Suite 110
Kenosha, WI 53142
(262) 764-5595

10400 75th St, Suite 304
Kenosha, WI 53142
(262) 764-5595

NEW PATIENT SPINE SURVEY

Name: ______________________________ Age:__________ Date of Birth:_____/_____/_____

Who referred you to our office?______________________________

Who is your Primary Care Physician?______________________________

What problem do you have related to your neck or back / arm or leg?______________________________

____

What percentage of your **overall discomfort** is in your neck/back?__________%
What percentage is in your shoulder, arm / hip, buttock, leg? ________% Total percentages should equal 100%

When did this problem begin?______________________________

What would you like the doctor to do for you today?______________________________

____

PART 1: Injury / Trauma

Did a **SPECIFIC** accident of injury cause your problem? ☐ **NO** (Skip to part 2 on page 2) ☐ **YES** (complete this section)

Date of injury: _____/_____/_____ (The doctor will discuss the details of your injury with you during your appointment.)

Mark only one:

- ☐ I never had back/neck problems **in this area of my spine** before this injury.
- ☐ I had back/neck problems **in this area of my spine** before, but they resolved completely before this injury.
- ☐ I have had back/neck problems **in this area of my spine**, and this injury made the problem worse.

Mark all that apply:

- ☐ This injury occurred at work.
- ☐ My injury did not occur at work.
- ☐ I have filed a claim through worker's compensation.
- ☐ I have not taken nor am I planning to take legal action related to this injury.
- ☐ I am considering legal action as a result of this injury.
- ☐ I have engaged an attorney or taken legal action as a result of this injury.
- ☐ Legal action related to this injury is closed or settled.

FOR OFFICE USE ONLY. DO NOT WRITE IN THE BOX BELOW.

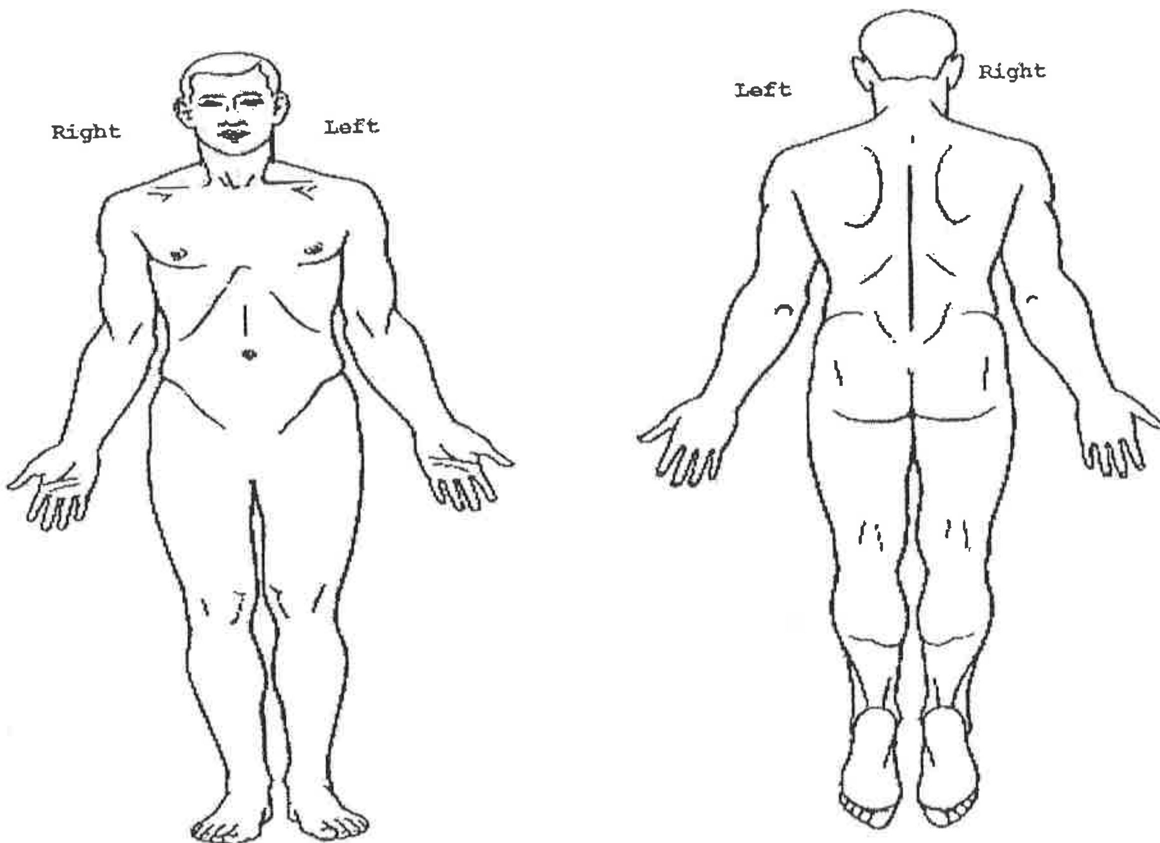
NOTES:

Name:______________________________

PART 2: Pain & Numbness

Does your neck or back problem cause you pain? ☐ **NO** ☐ **YES** (Please complete this section.)

This section pertains to pain, numbness, and tingling. Use a pen to mark your pain with an "X" on the figures below. Use a pen to mark your numbness and tingling with an "O" on the figures below.



Pain Scores

On the scale from 0-10 next to the questions below, **0 means no pain at all,** higher numbers represent more pain, **and 10 represents the worst pain imaginable.** Please make a circle around a number to answer each of the following questions:

What number would you give **ALL OF YOUR PAIN most of the time?** 0 1 2 3 4 5 6 7 8 9 10

What number would you give **ALL OF YOUR PAIN when you feel your *very worst*?** 0 1 2 3 4 5 6 7 8 9 10

What number would you give **ALL OF YOUR PAIN when you feel your *very best*?** 0 1 2 3 4 5 6 7 8 9 10

My leg pain is, ☐ Worse than ☐ Same as ☐ Less than, my back pain.

My arm pain is, ☐ Worse than ☐ Same as ☐ Less than, my neck pain.

Name:______________________________

PAIN DESCRIPTION

Please mark all boxes that describe your pain:
☐ Burning ☐ Sharp/Stabbing ☐ Tingling ☐ Aching ☐ Throbbing
☐ Shooting ☐ Pulling or tearing ☐ Cramping ☐ Other (describe) ______________________________

Please mark the most appropriate responses below:
☐ My pain began suddenly.
☐ My pain began gradually.
☐ My pain interrupts my sleep.
☐ I have had neck or back pain before, *but it was different from what I feel now.*

My pain:
☐ Is worse in the morning.
☐ Is worse during my work day.
☐ Is worse at the end of the day.
☐ Keeps me up at night.
☐ Does not vary much over the course of the day.

This ☐**is** ☐**is not** the first time I have had **this type of pain.**
My pain is present ☐ all day long ☐ > 1/2 the day ☐ < ½ the day ☐ occasionally

My pain is **made worse** by (mark all that apply):
☐ Walking ☐ Running ☐ Sitting ☐ Standing ☐Climbing Stairs ☐ Bending ☐ Lifting ☐ Lying down in a bed
☐ Driving ☐ Heat ☐ Ice ☐ Back Exercises or stretches ☐ Frequent changes of position
☐ Playing sports (list):__________________________ ☐ Other (please describe):______________________________
☐ **Nothing in particular makes the pain worse.**

My pain is **made better** by (mark all that apply):
☐ Walking ☐ Running ☐ Sitting ☐ Standing ☐Climbing Stairs ☐ Bending ☐ Lifting ☐ Lying down in a bed
☐ Driving ☐ Heat ☐ Ice ☐ Back Exercises or stretches ☐ Frequent changes of position
☐ Playing sports (list):__________________________ ☐ Other (please describe):______________________________
☐ **Nothing in particular makes the pain better.**

My numbness or tingling is made worse by (mark all that apply):
☐ Walking ☐ Running ☐ Sitting ☐ Standing ☐Climbing Stairs ☐ Bending ☐ Lifting ☐ Lying down in a bed
☐ Driving ☐ Heat ☐ Ice ☐ Back Exercises or stretches ☐ Frequent changes of position
☐ Playing sports (list):__________________________ ☐ Other (please describe):______________________________
☐ Nothing in particular makes the pain worse.

Because of my pain, I am unable to do the following activities:
☐ Walk over ________yards/miles ☐ Run ☐ Sit longer than ________min/hours ☐ Stand longer than ______ min/hours
☐ Climb stairs ☐ Bend ☐ Lift over ______lbs. ☐ Lay down in a bed ☐Drive longer than______min/hours
☐ Playing sports (list):__________________________ ☐ Other (please describe):______________________________

Overall, which **single word or phrase** would you use to describe your pain most of the time?
☐ Trivial/Minimal ☐ Annoying ☐ Limiting ☐ Disabling ☐ Unbearable

Recently, my pain has (mark only one):
☐ Gone away ☐ Been getting better ☐ Been getting worse ☐ Stayed about the same

Recently, my numbness and tingling has (mark only one):
☐ Gone away ☐ Been getting better ☐ Been getting worse ☐ Stayed about the same

Name:________________________

PART 3: Associated Problems

This section deals with problems that occur in some people with spinal problems.
***Please mark all that apply to you**

☐ Headache
☐ Uncontrollable pain
☐ Leakage of urine or urine staining
☐ Leaking of bowel contents
☐ Weight loss **unexplained by diet or exercise**
☐ Fevers
☐ Chills
☐ Sweats
☐ A heavy sensation in my legs
☐ Frequent stumbling or falling
☐ I am unable to stand up straight
☐ Impotence
☐ I cannot look forward unless I bend my knees
☐ Frequent Infections
☐ Clumsiness in my hands
☐ Difficulty walking or a change in the way I walk (describe):________________________
☐ Weakness (please describe):________________________
☐ Other (please describe):________________________
☐ **I HAVE NONE OF THE ABOVE PROBLEMS**

PART 4: Diagnostic Tests and Non-Surgical Treatment

What tests have you had to evaluate your spinal problem? (Mark all that apply)
☐ X-rays ☐ MRI ☐ CT Scan ☐ Myelogram ☐ Nuclear Bone Scan ☐ Blood Tests ☐ Discogram
☐ EMG or Nerve Conduction tests ☐ Bone Density Scan (a test to evaluate osteoporosis)
☐ Other:________________________
☐ **I have had no tests to evaluate this problem**

Please mark to show all treatments you have had, *and indicate how helpful that treatment was.*

Treatment				
☐ **Physical Therapy:**..................................	☐*very helpful*	☐*somewhat helpful*	☐ *did nothing*	☐*made me worse*
☐ **Back Exercise Program:**.....................	☐*very helpful*	☐*somewhat helpful*	☐ *did nothing*	☐*made me worse*
☐ **Chiropractor:**..	☐*very helpful*	☐*somewhat helpful*	☐ *did nothing*	☐*made me worse*
☐ **Epidural Steroid Injection:**....................	☐*very helpful*	☐*somewhat helpful*	☐ *did nothing*	☐*made me worse*
☐ **Facet Blocks/Injections:**	☐*very helpful*	☐*somewhat helpful*	☐ *did nothing*	☐*made me worse*
☐ **Local or "Trigger Point" Injection:**.......	☐*very helpful*	☐*somewhat helpful*	☐ *did nothing*	☐*made me worse*
☐ **Massage:**...	☐*very helpful*	☐*somewhat helpful*	☐ *did nothing*	☐*made me worse*
☐ **Brace, corset, other support:**...............	☐*very helpful*	☐*somewhat helpful*	☐ *did nothing*	☐*made me worse*
☐ **Alternative therapy or supplements (please list below):**				
________________________	☐*very helpful*	☐*somewhat helpful*	☐ *did nothing*	☐*made me worse*
________________________	☐*very helpful*	☐*somewhat helpful*	☐ *did nothing*	☐*made me worse*

☐ **I have had none of the above treatments**

What **medications** have you tried **for pain related to your spinal problem,** including pain radiating into arms and legs?
☐ I have taken no medication for my spinal problem

Medication #1________________ Dose__________Times per day______ ☐Mark if you take currently
☐*very helpful* ☐*somewhat helpful* ☐ *did nothing* ☐*made me worse (explain):*________________

Medication #2________________ Dose__________Times per day______ ☐Mark if you take currently
☐*very helpful* ☐*somewhat helpful* ☐ *did nothing* ☐*made me worse (explain):*________________

Medication #3________________ Dose__________Times per day______ ☐Mark if you take currently
☐*very helpful* ☐*somewhat helpful* ☐ *did nothing* ☐*made me worse (explain):*________________

Medication #4________________ Dose__________Times per day______ ☐Mark if you take currently
☐*very helpful* ☐*somewhat helpful* ☐ *did nothing* ☐*made me worse (explain):*________________

If you need more space, please list any additional medications on reverse side and mark here ☐.

Name:______________________________

PART 5: Previous Spinal Surgery

Please answer the following questions about your **previous spinal surgery.**
☐ I have never had any spinal surgery **(please skip to part 6 on this page).**
☐ I have had the following surgical procedure(s) on my spine:

Procedure #1:______________________________**Approximate Date:**______________ **Surgeon:**________________
☐ I would rate the outcome of this surgery as **poor** (problem the same or worse)
☐ I would rate the outcome of this surgery as **good** (problem improved or stabilized)
☐ I would rate the outcome of this surgery as **excellent** (problem dramatically improved or resolved)
If you were better after this operation, how long did your improvement last?______________________________

Procedure #2:______________________________**Approximate Date:**______________ **Surgeon:**________________
☐ I would rate the outcome of this surgery as ☐ poor ☐ good ☐ excellent
If you were better after this operation, how long did your improvement last?______________________________

Procedure #3:______________________________**Approximate Date:**______________ **Surgeon:**________________
☐ I would rate the outcome of this surgery as ☐ poor ☐ good ☐ excellent
If you were better after this operation, how long did your improvement last?______________________________

☐ Mark if additional procedures are listed on the reverse side of this page.

The following questions apply to your **most recent (or only) spinal operation. Please mark where indicated all that apply.**
My pain is in the ☐same place ☐ a different place as it was before my surgery
My pain severity is ☐ less ☐ just as bad ☐ worse than before I had surgery

If you had **multiple surgical procedures** on your spine, **please compare how you feel now to how you felt before you had any surgery.** (Mark all that apply):
☐ NOT APPLICABLE – I have had only **one** surgical procedure
My pain is in the ☐same place ☐ a different place as it was before my surgery
My pain severity is ☐ less ☐ just as bad ☐ worse than before I had surgery

PART 6: A. Medical History

Please circle any problems you have experienced:
☐ I have **no medical problems**

AIDS
Anemia
Anxiety
Arthritis
Asthma
Bipolar Disease
Cancer: **type:**_________
Colon Polyp
Congestive Heart Failure
COPD/Emphysema
Deep Blood Clots
Drug Dependency
Depression
Diabetes
Diverticulosis
Ear trouble
Endometriosis
Enlarged Prostate
Fibromyalgia
Gastritis
Glaucoma
Gout
Head Injury
Alcohol Dependency
Heart Attack/Angina
Hepatitis C
High Blood Pressure
HIV
Irregular Heart Beat
Irritable Bowel Syndrome
Jaundice
Kidney Disease
Kidney Stones
Liver Disease
Lupus
Osteoporosis
Peripheral Vascular Disease
Polio
Psychological Problem
Rheumatoid Arthritis
Scoliosis
Seizures
Sexually Transmitted Disease
Stroke
Thyroid Disease
Tuberculosis

Other Medical Problems:____

Name:______________________________

PART 6: B. Medications/Allergies

**** Please list all medications that you are currently taking**

Medication:	Dose/Frequency	Medication:	Dose/Frequency

☐ **Please mark here if you need more space, and use the space on page 8 to list any additional medications.**

Are you on any blood thinners?______________________________

Medication Allergies:

☐ I do not have any known allergies or reactions to medication.

☐ **I have had the following allergic or negative reactions to medication:**

Medication:	Reaction:

PART 6: C. Other Surgeries

Surgery

Please list any other surgery you have had in the past. **Please do not include spinal surgery.**

(List additional surgeries on the reverse side)

Surgery:	Approximate Date:

What **doctors** have you seen in the past 3 years for your **spine problem?**

Doctor :	Problem:

Name:______________________________

PART 7: Social History

What is you current occupation?____________________________ Number of years at this job:________________

Mark **all boxes that apply** to you work or school status:

☐ I have **not** missed time from work or school because of my spinal problem.

☐ I have missed time for work or school because of pain (If so, how long?)______________

I am currently working: ☐ Full time ☐ Part Time ☐ Regular Duty ☐ Modified Duty

☐ What are you restrictions, if any?____

☐ I am unable to work at all because of my spinal problem.

- ☐ I am unable to work because of a problem unrelated to my spine (describe:______________________)
- ☐ The last date I worked was ______/______/______
- ☐ I have been receiving worker's compensation since ______/______/______
- ☐ I have been on disability since ______/______/______

What is your **marital status**?

- ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

What is your **living situation** (mark all that apply)?

- I live with: ☐ my parents ☐ my children ☐ my spouse ☐ relatives (other than my spouse, parents or children)
- ☐ roommate(s) or significant other ☐ I live alone

Please mark your highest level of **education** (mark only one):

- ☐ Did not complete high school ☐ Completed high school ☐ Some College ☐ Bachelor's degree
- ☐ Advanced degree

Please **mark all** personal habits that apply to you:

☐ I never smoked cigarettes

☐ I quit smoking _______years/months ago, but previously smoked for ________years.

☐ I smoke cigarettes: ☐ less than ½ pack per day ☐ ½-1 pack per day ☐ 1-1 ½ packs per day ☐ 1 ½-2 packs per day ☐ > 2 packs per day

☐ I have smoked for _______years (please answer even if you have quit).

☐ I chew tobacco ☐ I smoke cigars (______per day)

☐ I drink alcohol: ☐never ☐less than once a week ☐ 1-7 times per week ☐ 1-2 times per day ☐ 3+ drinks per day

☐ I am in recovery from a drinking problem

☐ Recreational drug use (List:____)

☐ Height:______________ ☐Weight:______________

PART 8: Family History

Please mark all boxes below to indicate any problems that **run in your family.**

☐ Diabetes

☐ Hypertension (High Blood Pressure)

☐ Heart Disease

☐ Seizures

☐ Bleeding Disorder

☐ Reactions to Anesthesia (please describe):____

☐ Cancer (type):________________________

☐ Osteoporosis

☐ Osteoarthritis (also known as degenerative arthritis)

☐ Rheumatoid Arthritis

☐ Stroke or Aneurysm

☐ Other Medical Illness (describe):____

Name:________________________

PART 9: Review of Systems

In the past month have you experienced any of the following? Please circle all that apply. Be sure to notify your primary care physician.

Blurred Vision	**New Moles**	**Stress**	**Fainting**
Dry Eyes	**Skin Rash**	**Poor Sleep**	**Seizures**
Hearing Problems	**Tremors**	**Swelling of Feet**	**Bleeding Problems**
Nasal Congestion	**Constipation**	**Swollen Glands**	**Infections**
Sore Throat	**Diarrhea**	**Blood Clots**	**Dizziness**
Cough	**Chest Pain**	**Weight Loss**	**Fatigue**
Shortness of Breath	**Fevers**	**Weight Gain**	**Nausea/Vomiting**
Bloody Sputum	**Chills**	**Ulcers**	**Urination Problems**
Abdominal Pain	**Night Sweats**		

Thank you for taking the time to complete this survey. Your answers will help the doctor to better understand your problem. Please use the space below for any additional comments, or to write any information that did not fit in the space provided elsewhere on the survey.

Please do not write below this line

MD COMMENTS:

Comprehensive Orthopaedics, S.C.

Jonathan D. Main, MD[1]
Sports Medicine & Orthopaedic Surgery

Michael Didinsky, DO[3]
Spine & Orthopaedic Surgery

Joshua M. Gershtenson, MD[1]
Hand, Upper Extremity & Orthopaedic Surgery

Hardik A. Vashi, DO[2]
Physical Medicine & Rehabilitation

Michael J. Slimack, DO[3]
Joint Replacement & Orthopaedic Surgery

Michael A. Engel, DPM[5]
Podiatric Surgeon

Thomas S. Werbie, MD[1]
Orthopaedic Surgery

Michael J. Nute, DPM[5]
Podiatric Surgeon

John C. Pick-Jacobs, DO
Sports Medicine

Benjamin J. Lasee, MD
Orthopaedic Surgeon

Primary Office Location:

7401 104th Avenue, Suite 110
Kenosha, WI 53142
Phone: (262) 764-5595
Fax: (262) 764-9314
www.comportho.com

Today's Date: ______________________________

Patient Name: ______________________________

Date of Birth: ______________________________

Body Part: ______________________________

Doctor Seen: ______________________________

Is this a work related injury?

_____:Yes _____:No

If Yes, please complete the following:

What is the date of injury? ______________________

How did the injury occur? ______________________

Have you filed a claim with your company? __________

What is your claim number? ____________________

Which company is the claim paid through? __________

What is the name and phone number of your adjuster?

____

To be completed by the front desk:

FD Representative name: __________________
WC details entered on fee ticket/appointment notes? __________
WC info entered into insurance field? __________
WC info verified open and active? __________
WC alert entered onto chart? __________

[1]Diplomate, American Board of Orthopaedic Surgeons
[2]Diplomate, American Board of Physical Medicine & Rehabilitation
[3]Diplomate, American Osteopathic Board of Orthopedic Surgeons
[4]Diplomate, American Board of Family Medicine
[5]Diplomate, American Board of Podiatric Medicine

COMPREHENSIVE ORTHOPAEDICS, S.C.
Patient Acknowledgement & Record of Disclosures

I, ______________________, ______________________ acknowledge that I have received, and/or
Patient Name Date of Birth
been advised of the written Notice of Privacy Practices from Comprehensive Orthopaedics, SC.

☐ The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

I wish to be contacted in the following manner (check all that apply):

Telephone Number: ______________________

☐ Leave message with detailed information

☐ Leave message with call back number only

Alternate Telephone: ______________________

☐ Leave message with detailed information

☐ Leave message with call back number only

Written Communication

☐ Can mail to Home address: ______________________

☐ Can Email to this address: ______________________

☐ Can mail/fax to Work address: ______________________

I consent to have my personal health information disclosed to: (3rd party friend/family or other)

Name: ______________________ Phone#: ______________ Relationship: ______________

Name: ______________________ Phone#: ______________ Relationship: ______________

____

Patient (or Guardian) Signature **Date**

____

Printed Name

This form MUST be filled out NEATLY & COMPLETELY or it will be considered VOID.

Comprehensive
Orthopaedics, S.C.

Patient Financial Policy

At Comprehensive Orthopaedics, S.C. we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Our fees for services are based on the level of professional skill required, the severity and complexity of the injury or illness, as well as the time spent treating you. The **patient or guarantor** is responsible for seeing that the entire bill is paid in full. Your clear understanding of our Financial Policy is important to our professional relationship.

Insurance: Billing of insurance is a courtesy we provide our patients and is not required by law. Please notify us if your insurance carrier or policy has changed.

Copayments: Your insurance contract REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay prior to each visit.

Non-Covered Services: If your insurance plan determines that a service is not covered for any reason you will be responsible for payment of the charges. **Durable Medical Equipment (DME):** Some DME items may not be covered by your insurance plan and you will be asked to pay a portion at the time of service. All items are new when given and cannot be returned.

Non-Participating Insurance Plans or "Out of Network": It is the responsibility of the patient to verify whether Comprehensive Orthopaedics, S.C. contracts with your insurance plan. Any outstanding balances are the responsibility of the patient. Insurance companies sometimes use the phrase "usual and customary" or "out of network" when discussing our fees. Insurance companies set their own "usual and customary" rates based on a wide geographic area and the fees we charge may differ.

Referrals: If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral you may be required to reschedule.

Workers Compensation/Other Accident Cases: In order for us to file a claim with your work comp or other liability carrier you must provide complete billing information. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. We will bill major medical insurance.

Self-Pay/Uninsured: Payment in full is required for all self-pay/uninsured patients. For new patients, a deposit of $200 is required on the day of your appointment **before** being seen by the provider and $75 copays at any follow up appointments. Any fees remaining will be billed to you following your appointment. By initialing here, I acknowledge I have received the Self-Pay agreement. _____

Urgent Care: During our after-hours Urgent Care, our financial policy will revert back to a self-pay/Uninsured status until your Insurance can be verified.

Minors of Divorced Parents and Child Custody Cases: Both parents are financially responsible for care rendered to minor children. We do not get involved in divorce situations and the parent with whom the child resides with will be financially responsible and any statements will be mailed directly to that parent.

Post-Operative Surgery Charges: Following most surgical procedures, related office visits are included and will not be charged during 90 day post-operative period. Services such as x-rays, casting and materials, Durable Medical Equipment, and injections are not included in the post-operative period.

Responsible Party: I have read the financial policy and understand that I will be responsible for all Comprehensive Orthopaedics, S.C. charges incurred regardless of my insurance status including expenses incurred in collecting the amounts owed, including attorney's fees, court costs and/or the collection agency fee. Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25 fee per check returned.

IN THE EVENT THAT I "NO SHOW" MY APPOINTMENT WITHOUT CALLING THE OFFICE AT LEAST 24 HOURS IN ADVANCE, I UNDERSTAND I MAY INCUR A $50.00 "NO SHOW" FEE. IN ADDITION, COMPREHENSIVE ORTHOPAEDICS, S.C. RESERVES THE RIGHT TO TERMINATE MY CARE FOR NON-COMPLIANCE AT ANY TIME.

Payment for services may be paid by cash, personal check, Visa, MasterCard, Discover, or American Express.
Please sign that you have read and agree to this Financial Policy.

Patient Name (Print): ______________________________

Responsible Party Signature: ______________________________ Date: ______________