# PATIENT HEALTH QUESTIONNAIRE (Page 1)

*Robert E. Scott, Jr., M.D.*
Spine Care • Musculoskeletal & Sports Injuries • Neurodiagnostic Testing • Spinal Interventions

9834 Genesee, Suite 223B
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Phone 858-277-7123
Fax 858-277-3470

***Please fill out **completely**. Failure to do so may delay payment of your claim. Indicate N/A if not applicable***

Patient (Last, First): _____ , _____

Sex: ☐ M ☐ F DOB:_____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Widowed

SSN: _____-_____-_____ Date of Injury: _____ Type of Injury: Job ☐ Auto ☐ Other ☐

Part of body: _____ ☐ Right ☐ Left ☐ Both

Patient Contact Information: Home #_____ Cell #_____

Address:_____

Street City State Zip

Employer Information: _____ Occupation: _____

Work #_____ Fax #_____

Employer Address: _____

Street City State Zip

EMERGENCY CONTACT: _____ Home # _____

Work # _____

Referred by: _____ ☐ Family ☐ Friend ☐ Insurance

☐ Physician ☐ Other _____

We feel it's very important that we keep contact with your physicians. Please fill out the information below so that we may be able to forward or call your physicians with pertinent information regarding your care. Thank you. *Please use additional space if necessary.

Referring Physician: _____

Phone #_____ Fax #_____

Address: _____

Street City State Zip

Primary Care Physician: _____

Phone #_____ Fax #_____

Address: _____

Street City State Zip

Attorney: _____

Phone #_____ Fax #_____

Address: _____

Street City State Zip

Name: _____, _____ Date: _____

Last First

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# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Notice and Acknowledgement of Privacy Practices:

Our practice reserves the right to modify the privacy practices outlined in the notice.

I acknowledge that I have received, been offered, or reviewed Robert E. Scott, Jr. M.D Notice of Privacy Practices.

I also, have been made aware that Robert E. Scott, Jr. M.D. is licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov

_____ _____
Patient Signature Date
Or Personal Representative Signature

If personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

If you would like any person (s) to be able to communicate with Dr. Scott or his staff about your care, please include their name below. You may add or subtract any person at any time.
You may discuss my care with the following person(s).

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____, _____ Date: _____
Last First

PATIENT HEALTH QUESTIONNAIRE (Page 3)

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Name:_____ Age:_____ Date:_____

DATE OF INJURY:_____

PLEASE DESCRIBE IN DETAIL HOW YOU WERE INJURED:

_____

_____

_____

EMPLOYER: _____
JOB TITLE: _____
JOB DUTIES:_____

HOW MANY (DAYS/MONTHS/YEARS) HAD YOU WORKED AT THAT JOB UNTIL THE INJURY DATE? _____

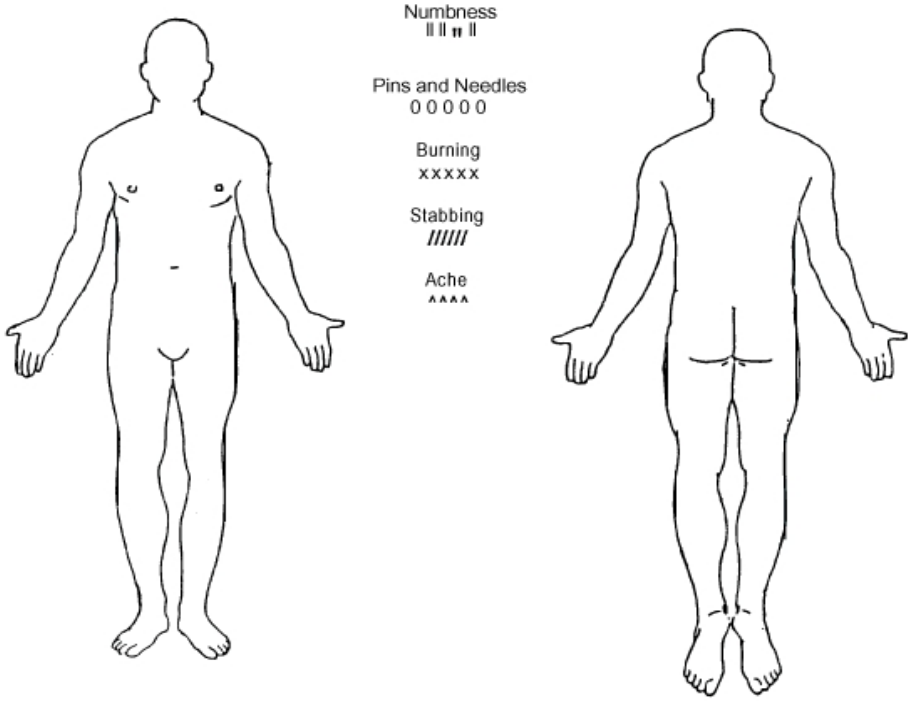
ARE YOU WORKING NOW?_____
IF YES, IS YOUR WORK MODIFIED? _____
IF NO, ON WHAT DATE DID YOU LAST WORK FOR THAT EMPLOYER?: _____

DO YOU HAVE ANOTHER JOB, INCLUDING A HOME BUSINESS?_____
IF YES, WHAT IS IT?_ _____

LIST ANY PREVIOUS WORK INJURIES AND ESTIMATE THE DATES AND YOUR PERMANENT RESTRICTIONS, IF ANY.
_____

HAVE YOU EVER INJURED THE SAME BODY PART BEFORE? IF YES, EXPLAIN. INCLUDING CAR ACCIDENTS.

_____




Name: _____, _____ Date: _____
Last First

# PATIENT HEALTH QUESTIONNAIRE (Page 4)

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Currently what is your pain level on a scale of 1 to 10? (please circle below)

1 2 3 4 5 6 7 8 9 10
(no pain) (extreme pain)

IS YOUR PAIN (Please Circle all that apply)

CONSTANT FREQUENT OCCASIONAL

SHARP BURNING DEEP SHOOTING

_____

WHAT RELIEVES YOUR PAIN? (CIRCLE ALL ANSWERS) SITTING STANDING BENDING BACK BENDING FORWARD
LYING DOWN NIGHT TIME MOVING THERAPY STIMULATOR UNIT CHIROPRACTIC ACCUPUNCTURE

WHAT MAKES IS WORSE? SITTING STANDING BENDING MOVING LIFTING LYING WALKING COUGHING SNEEZING

LIST DRUG ALLERGIES OR BAD REACTIONS: Include gastric problems with medications.

_____

LIST ALL (PRESCRIPTION AND NON PRESCRIPTION) MEDICINES: Include dose and schedule.

_____

LIST ALL OF YOUR MEDICAL CONDITIONS, PAST AND PRESENT:

_____

DO YOU HAVE PRIVATE HEALTH INSURANCE?_____
WHO IS YOUR DOCTOR?_____
Physician's Phone_____
Physician's Address_____

LIST ALL OF YOUR SURGERIES, INCLUDING DATES:

_____

HOW MUCH DO YOU SMOKE? _____ DRINK?_____
IF YOU QUIT, WHEN? SMOKE?_____ DRINK?_____
HISTORY OF DRUG OR ALCOHOL ADDICTION?_____

LIST ANY ILLNESSES THAT RUN IN YOUR FAMILY (INCLUDE DRUG OR ALCOHOL PROBLEMS)

_____

ARE YOU RIGHT OR LEFT HANDED?

TREATMENT HISTORY

Number of Physical Therapy Visits: _____
Number of Chiropractic Visits: _____
Number of Acupuncture Visits: _____
List of Other Treatments: _____
List of Imaging Studies (X-Rays/MRI) and Imaging Center: _____

Name: _____, _____ Date: _____
Last First

*REVIEW OF SYSTEMS*

Do you, or have you ever had:

*Cardiovascular System*

Yes No
- ☐ ☐ Heart disease
- ☐ ☐ Angina
- ☐ ☐ Chest Pain
- ☐ ☐ Heart Attack
- ☐ ☐ High Blood Pressure
- ☐ ☐ Do you use a CPAP machine?
- ☐ ☐ Do you have a heart stent?
- ☐ ☐ Irregular Heart Beat

Other_____

*Respiratory System*

Yes No
- ☐ ☐ Lung disease, TB
- ☐ ☐ Emphysema
- ☐ ☐ Asthma
- ☐ ☐ Wheezing
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Documented Sleep Apnea

Other _____

*Nervous/Musculoskeletal System*

Yes No
- ☐ ☐ Epilepsy
- ☐ ☐ Stroke
- ☐ ☐ Neuropathy
- ☐ ☐ Chronic Back Pain
- ☐ ☐ Acute Back Pain
- ☐ ☐ Neck Pain
- ☐ ☐ Joint Pain
- ☐ ☐ Severe Headaches

Other_____

*Endocrine/Gastrointestional System*

Yes No
- ☐ ☐ Ulcers
- ☐ ☐ Diabetes
- ☐ ☐ Kidney Disease
- ☐ ☐ Jaundice/Hepatitis
- ☐ ☐ Thyroid Disease

Other_____

*Social Habits/Other*

Yes No
- ☐ ☐ Do you smoke? If so, how much?_____
- ☐ ☐ Do you drink? If so, how much?_____
- ☐ ☐ Do you wear: ☐ Hearing Aids ☐ Contact lenses ☐ False Eye
- ☐ ☐ Do you currently have a cold or the flu?
- ☐ ☐ History of Bleeding tendency
- ☐ ☐ Drug or Alcohol addiction
- ☐ ☐ Females: Is there any possibility that you are pregnant at this time?
- ☐ ☐ Documented latex allergy

Other_____

## Current Medication List

| Medication Name (ex. Vicodin) | Dosage (ex.5 mg) | Usage (ex. 1-2 pills twice a day) | Start Date | Updates |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

☐ See Attached List (Please include patient name and date on list)

Please List any Allergies:

_____ _____ _____ _____
_____ _____ _____ _____

*Office Use Only:*

PMHx:
_____
_____
_____
_____
_____
_____

Ht:_____ Wt:_____ BP: _____ HR:_____ Temp: _____

Name: _____, _____ Date: _____
Last First