

PATIENT HEALTH QUESTIONNAIRE (Page 1)

Robert E. Scott, Jr., M.D.

Spine Care • Musculoskeletal & Sports Injuries • Neurodiagnostic Testing • Spinal Interventions

9834 Genesee, Suite 223B
La Jolla, CA 92037
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

Pharmacy Information: Pharmacy Name: _____ Phone: _____

Pharmacy 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

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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

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Name: _____ DOB/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.

Numbness
|| || ||

Pins and Needles
0 0 0 0 0

Burning
x x x x x

Stabbing
//////

Ache
^ ^ ^ ^ ^

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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)

LYING DOWN NIGHT TIME MOVING THERAPY SITTING STANDING BENDING BACK BENDING FORWARD
STIMULATOR UNIT CHIROPRACTIC ACCUPUNCTURE

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

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: _____

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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/Gastrointestinal 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 _____

Name: _____ Date: _____

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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 (or NKA if no known allergies):

Office Use Only:

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

Name: _____ Date: _____