



Silicon Valley
SPINE INSTITUTE
 svspine.com

Jeffrey D. Coe, MD
 Orthopaedic Spine Surgeon

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 Orthopaedic Spine Surgeon

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 Physical Medicine & Rehabilitation

Renee V. Wall, PA-C
 Physician Assistant

Lauren M. Bradley, PA-C
 Physician Assistant

Spinal Reconstructive Surgery
 Minimally Invasive Spinal Surgery
 Spinal Disc Arthroplasty Surgery
 Adult and Pediatric Spinal Deformity Surgery
 Cervical Spine Surgery
 Therapeutic and Diagnostic Spinal Injections
 Electrodiagnosis

221 East Hacienda Ave
 Suite A
 Campbell, CA 95008

Tel: (408) 376 3300
 Fax: (408) 374 8830

PATIENT INFORMATION

Name of Patient _____ Date of Service _____

Address _____
Number Street City State Zip Code

Home Phone _____ Cell/Alternate Phone _____

Social Security Number _____ - _____ - _____ Date of Birth _____ Age _____

Single Married Divorced Widowed Sex: Female _____ Male _____

Date of Injury _____ Date Last Worked _____

Name of Employer at Time of Injury _____

Address of Employer at Time of Injury _____

Occupation at Time of Injury _____

Length Employed at Time of Injury _____

Name of Current Employer _____

Current Occupation _____

Referred by _____

Current and/or Most Recent Primary Treating Physician for this Injury _____

Preferred Pharmacy: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES

Adjuster: _____ Date of Injury: _____

Name of Insurance Company _____

Address _____

Claim Number _____ Insurance Company Phone _____

Fax _____

Name of Attorney _____ Phone _____

Fax _____

Address _____

Nurse Case Manager _____ Phone _____

Fax _____

Name: _____

Date: _____

PAIN DIAGRAM

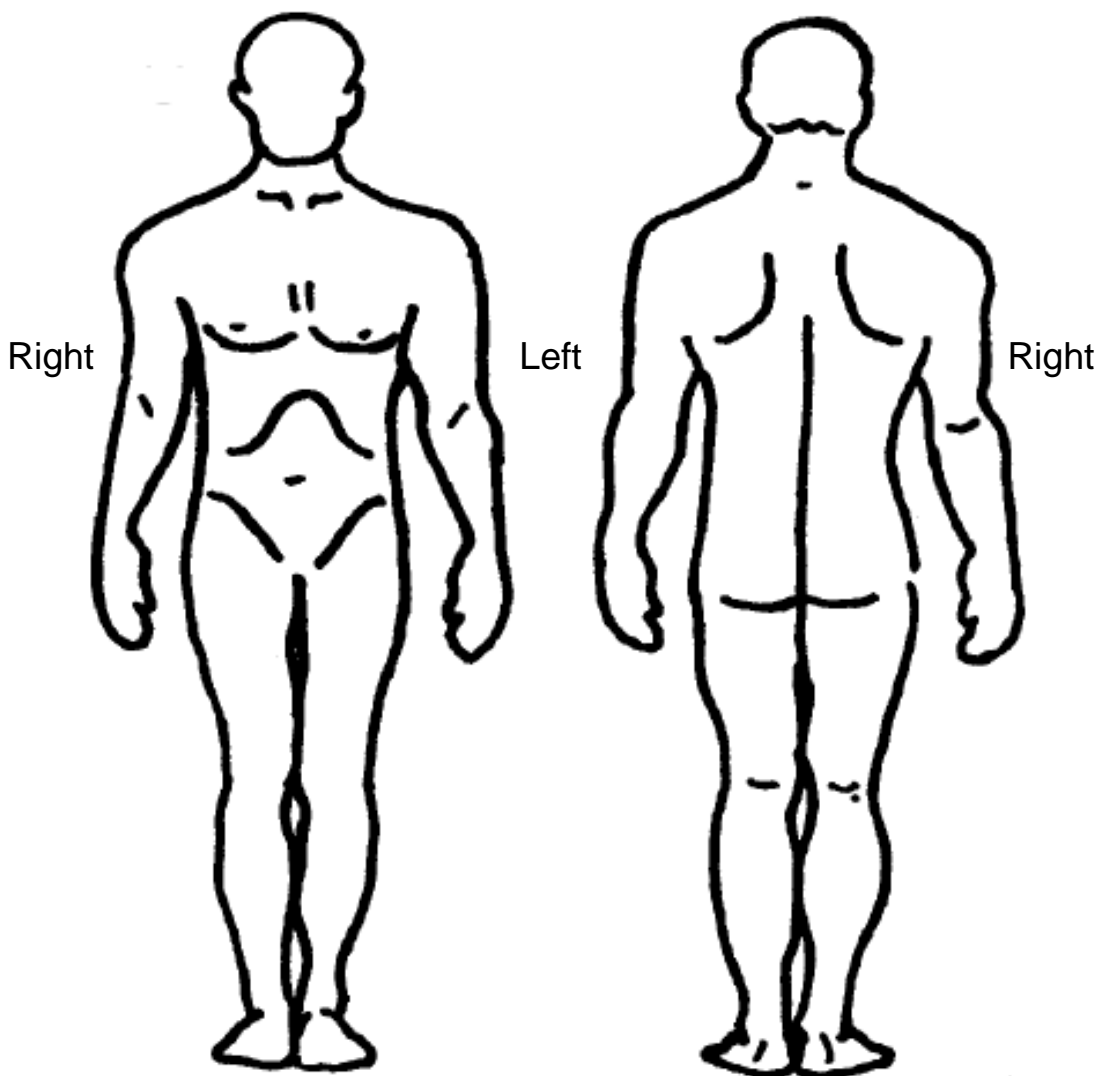
Using the symbols below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, draw in your face.

Major Pain – XXX
Secondary Pain – ///
Numbness – OOO

Tingling – YYY
Burning – ZZZ
Draw a line for radiating pain

Front

Back



Make any comments you feel are important:

Health History Questionnaire

Name: _____ Age: _____ Date of Birth: _____

Pain History Background

How long have you had this pain?	Months	Years
Which best describes the quality of your current pain complaint?		
<input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Aching <input type="checkbox"/> Stabbing <input type="checkbox"/> Dull <input type="checkbox"/> Other: _____		
How often do you have pain?		
<input type="checkbox"/> Constant <input type="checkbox"/> Occasional (several times per week) <input type="checkbox"/> Intermittent (several times per day) <input type="checkbox"/> Rarely (several times per month)		
What makes your pain worse?		
<input type="checkbox"/> Bending/Twisting <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Exercise <input type="checkbox"/> Standing <input type="checkbox"/> Weather change <input type="checkbox"/> Lying <input type="checkbox"/> Heat <input type="checkbox"/> Cold <input type="checkbox"/> Stress <input type="checkbox"/> Other: _____		
What makes your pain better?		
<input type="checkbox"/> Nothing <input type="checkbox"/> Rest <input type="checkbox"/> Heat <input type="checkbox"/> Cold <input type="checkbox"/> Medications <input type="checkbox"/> Exercise/activity <input type="checkbox"/> Other: _____		
Is your pain associated with other symptoms?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Appetite change <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Gait abnormality (difficulty walking) <input type="checkbox"/> Numbness, where _____ <input type="checkbox"/> Muscle weakness, where _____ <input type="checkbox"/> Other: _____		
Since your present pain began, have you experienced the following?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Urinary incontinence/dysfunction <input type="checkbox"/> Bowel incontinence/dysfunction		
Has the pain affected your sleep?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the pain affected your mood? If yes, how?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Pain History

<input type="checkbox"/> Work related injury	Date: _____	<input type="checkbox"/> Auto accident	Date: _____
<input type="checkbox"/> Fall or other trauma	Date: _____	<input type="checkbox"/> Following surgery	Date: _____
<input type="checkbox"/> Following illness	Date: _____	<input type="checkbox"/> Pain just began	Date: _____
<input type="checkbox"/> Other			

What diagnosis, if any, have you been given for your current pain?

Work-Up

Have you had Radiologic Imaging for your current pain complaint? (MRI, X-ray, CT) If yes, what studies have been done?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had and Electromyography (EMG) used to test nerve function? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a Discogram (discography)? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you undergone a Functional Capacity Evaluation (FCE)? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Treatment for Current Pain Complaint

Have you had Surgery intended to treat your current pain complaint? If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been treated by another Pain Medicine Physician/Clinic? If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you undergone formal Physical Therapy (PT) for your current pain complaint? If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever been treated by a Chiropractor? If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you had previous Injections? (Including epidural steroid injections, joint injections, trigger point injections, medial branch blocks, nerve blocks, etc.) If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you undergone a Radio Frequency (RF) Procedure? If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have or have you had a Pain Medicine Pump?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have or have you had a Spinal Cord Stimulator?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you been evaluated/treated by a Psychiatrist, Pain Psychologist, and/or Counselor for aspects relating to your current pain complaint? If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you had any other treatment for your current pain complaint? If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you tried pain medications to treat your current complaint that you are NO LONGER Taking?			
Drug Name:	Dose:	Prescribed by:	Reason for stopping:
General Medications (Not for your current pain complaint)			
Please list medications you are currently taking. Include prescription drugs, over the counter (OTC) and herbal supplements			
Medication:	Dose:	Frequency:	Prescribed by:
Medications for your current pain complaint			
Please list medications you are currently taking. Include prescription drugs, over the counter (OTC) and herbal supplements			
Medication:	Dose:	Frequency:	Prescribed by:

Allergies			
Do you have any known drug allergies:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy	Reaction		
Past Medical History			
Do you have a bleeding disorder?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently pregnant or believe that you may be pregnant?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently being treated for an infection?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a pacemaker?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with any of the following?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Stomach Ulcer or GI Bleed	<input type="checkbox"/> Constipation	<input type="checkbox"/> Seizure	<input type="checkbox"/> Asthma
<input type="checkbox"/> Reflux/Heartburn	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Headache	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Urinary Incontinence
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Bowel Incontinence
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Peripheral Neuropathy	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other:
Have you ever been treated for cancer? If yes, what type: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had mental health treatment?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any surgery not previously described? If yes, describe			<input type="checkbox"/> Yes <input type="checkbox"/> No
Social History			
Current occupation: <input type="checkbox"/> None <input type="checkbox"/> Homemaker <input type="checkbox"/> Student			
Present employment status: <input type="checkbox"/> Fulltime <input type="checkbox"/> Part time <input type="checkbox"/> Retired <input type="checkbox"/> Disability <input type="checkbox"/> Worker's Comp			
Do you have any physical work restrictions?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If not currently working, what was your last job?			
If not currently working, how long have you been out of work?			
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how many? What are their ages?			
What is your highest level of education?			
<input type="checkbox"/> High school <input type="checkbox"/> Vocational degree <input type="checkbox"/> College <input type="checkbox"/> Advanced degree <input type="checkbox"/> Other:			
Do you use tobacco? <input type="checkbox"/> Never <input type="checkbox"/> Yes, packs per day _____ <input type="checkbox"/> Former use			
Do you use alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Regularly <input type="checkbox"/> Rarely			
Have you used recreational (street) drugs in the last 5 years?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list:			
Do you have a history of prescription drug abuse?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of sexual abuse?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of physical abuse?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you receiving workers compensation?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you receiving disability?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an application pending or do you intend to apply for workers compensation or disability?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a pending lawsuit for your pain or injury?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of attorney:			
Family History			
Please list medical problems of your immediate family, such as diabetes, heart disease, etc		Are you adopted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relation (Mother, Father, Sister, Brother, Child)	Medical Diagnosis		

Review of Systems

General:		Gastrointestinal:	
Recent weight gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been in good health	<input type="checkbox"/> Yes <input type="checkbox"/> No	Appetite change	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin:		Blood in stool	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in bowel habits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry skin/itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gallbladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head-Eyes-Ears-Nose-Throat:		Indigestion/heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurry vision/double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoids or piles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea/vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact lenses/glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	NSAID intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rectal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ob-Gyn:	
Hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	# of pregnancies:	
Loss of balance	<input type="checkbox"/> Yes <input type="checkbox"/> No	# of miscarriages:	
Neck stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Pap smear:	
Breast:		Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency of periods, every	Days
Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any pain with periods	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mass/lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Menopausal: If Yes, at what age?	
Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological:	
Cardiac:		Dizziness/fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular:	
Swelling of extremities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal bleeding or bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pulmonary:		Aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a Jehovah's Witness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain with breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine:	
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urologic:		Hormone therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dribbling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dysuria (pain with urination)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immune System:	
Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hematuria (blood in urine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of stone	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immunosuppressive disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nocturia (night time urination)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Musculoskeletal:	
Stress incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urgency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Joint swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No

<i>Surgery:</i>		<i>Other:</i>	
Anesthetic allergy/problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other problems other than the reason for your visit today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Iodine allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please Specify: _____	
Postoperative infections	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Postoperative complications	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Suture reaction	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tape allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Severe nausea/vomiting after anesthesia	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Waking-up problem after anesthesia	<input type="checkbox"/> Yes <input type="checkbox"/> No		



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Silicon Valley Spine Institute Medication Refill Policy

- Refills will be made only during regular office hours.
- Allow 2-3 business days for all refill requests to be processed.
- Refills will not be made at night, on holidays or weekends.
- Refills will not be made if I "run out early."
- I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- All refill requests must be faxed by your pharmacy by 10:00am Friday, anything faxed after that time will not be filled.
- Refills will not be made as an "emergency" on Friday afternoon.
- Prescriptions will not be filled by the on-call physician.

Please have your pharmacy fax a refill request to our office. Refills will be processed within 2-3 business days and faxed to your pharmacy.

Certain medications require a hand written scrip every time a refill is needed. In this case please call our office and let us know 2-3 business days before you run out so the physician will be able to write a new prescription for you.

Remember, your physician is in surgery 2-3 days a week and will not always be able to write the new prescription/refill your medication on the day it is requested.

I have been fully informed and will comply with the medication refill policy established by Silicon Valley Spine Institute.

Patient Name: _____

Patient Signature: _____ Date: _____



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**PATIENT DESIGNATION OF
PRIMARY TREATING PHYSICIAN**
(California Labor Code section 4601)

Date: _____

Patient Name: _____

Date of Birth: _____

I **DO** **DO NOT** know who my Primary Treating Physician is.
(Circle one)

My Primary Treating Physician's name is: _____

TO CHANGE YOUR PRIMARY TREATING PHYSICIAN PLEASE COMPLETE BELOW.

I hereby request the following physician of Silicon Valley Spine Institute as my
"Primary Treating Physician" pursuant to section 4601 of the California Labor Code.

____ Jeffrey D. Coe, MD ____ Konrad H. Ng, MD

PATIENT SIGNATURE: _____

OFFICE ONLY

- ____ ***I will accept*** this patient as their Primary Treating Physician.
- ____ ***I will not accept*** this patient as their Primary Treating Physician.
- ____ **I will continue to treat this patient on a consulting basis ONLY.**
- ____ **I will no longer see or treat this patient.**

Physician Signature: _____

Recommendations for new Primary Treating Physician (if applicable): _____

*The physician retains the right to assume medical care for the patient or refer the patient to another
Primary Treating Physician for continued treatment at any time.*