TODAY'S DATE: _________________

PATIENT REGISTRATION – PLEASE PRINT

PATIENT: ____ BIRTHDATE: ___________________ AGE: __________

HOMEPHONE: (____)____________ CELL: (___)_____________ SOCIAL SECURITY #: ______________ SEX: M F
STREET / MAILING ADDRESS: ____
CITY: _____________________________ STATE: _____________ ZIP CODE: ______________________________
EMPLOYER: ________________________________ OCCUPATION: ______________________________________
EMPLOYER ADDRESS: ____
WORK PHONE: (____)______________________ MESSAGE PHONE: (___)_________________________________
EMAIL: ____
MARITAL STATUS: (select one) SINGLE MARRIED SEPARATED DIVORCED WIDOWED
PRIMARY CARE PHYSICIAN: ____

NAME OF PERSON RESPONSIBLE, IF OTHER THAN PATIENT: ____
RELATIONSHIP TO PATIENT: _____________________________________ PHONE: ________________________
EMERGENCY CONTACT: ____ PHONE: ________________________
TYPE OF INJURY: WORK RELATED AUTO ACCIDENT OTHER: __________ DATE OF INJURY: __________
ATTORNEY NAME: _______________________________ ATTORNEY'S PHONE #: __________________________
DATE LAST WORKED: _____________________________ DATE BACK TO WORK: __________________________
X-RAYS TAKEN WHERE? ___________________________ RECENT X-RAYS TAKEN WHEN? ___________________

INSURANCE OR WORK COMP INFORMATION: ***Please present your insurance card(s) to the receptionist.***

Please select one:

PRIMARY INSURANCE COMPANY: ___________
Mailing Address: _________________________
City: ___________________________________
State: __________________ Zip Code: _______
Telephone #: ____________________________
ID Number: ______________________________
Group Number: ___________________________

SECONDARY INSURANCE COMPANY: ___________
Mailing Address: ___________________________
City: _______________________________________
State: __________________ Zip Code: _________
Telephone #: _______________________________
ID Number: ________________________________
Group Number: ______________________________

Payment Policy: Payment is due at the time services are rendered unless other arrangements have been made. Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance, or any balance not paid by your insurance. Payment is the sole responsibility of the patient, patient's spouse, or parent of a minor.
Non-Authorized Visits: If your insurance carrier requires prior authorization or referral from your Primary Care Physician and the service you have scheduled has not been referred/authorized, you will be financially responsible for payment. **Co-Payments**: I understand that co-payments are due at the time of services. **Patient Authorization**: I hereby authorize the release of any medical information necessary to process my insurance claim. I hereby authorize payment of medical benefits to the named provider for services rendered. I also authorize Transamerica Occidental to release information regarding Medicare claims submitted by the named provider. I authorize The Spine and Orthopedic Center to release and obtain copies of information contained in my medical records, including copies of reports, office notes, x-rays, MRIs, CT Scans, and other similar medical records from other facilities.

PRINT NAME: ____ **DATE:** _________________________

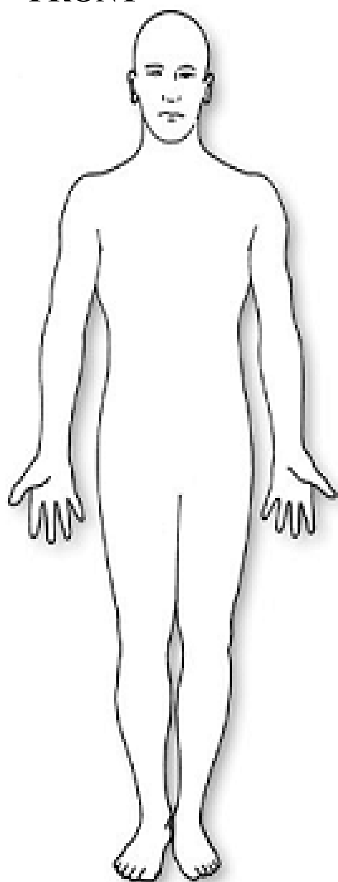
SIGNED: ____ **DATE:** _________________________

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322, www.mbc.ca.gov
On certain occasions, medications can be dispensed from our office; however, you have the right to request that a prescription be filled at a pharmacy of your choice.
Dr. Moelleken has ownership interest in Carrillo Surgery Center and Central Valley Surgery Center.

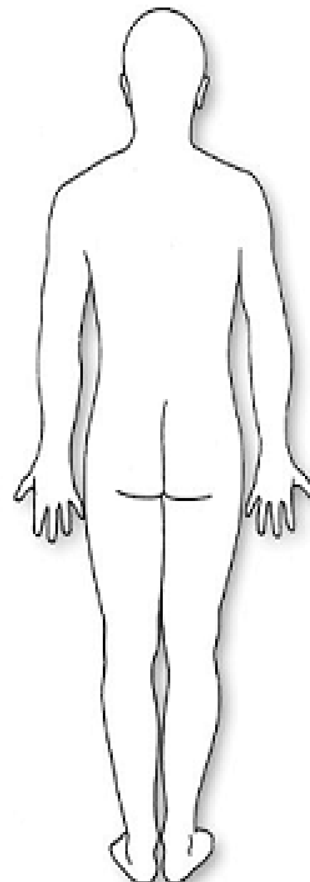
Date:_________________________________ **Patient:_______________________________**

Mark the area on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. Mark how bad it is on the pain scale in the section below:

FRONT **BACK**



● ● ● ● ●	**Numbness**
oooooo	**Pins & Needles**
xxxxxx	**Burning Pain**
///////////	**Stabbing Pain**
vvvvvv	**Aching Pain**



Right **Left** **Left** **Right**

Use the following scale to indicate the severity of your pain:

None		Annoying		Uncomfortable		Dreadful		Horrible		Agonizing
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No pain		**Mild Pain**		**Moderate Pain**		**Severe Pain**		**Very Severe Pain**		**Worst Possible Pain**

HISTORY OF PRESENT ILLNESS

1. **Please indicate how long you have had your present pain (select one):**

2. **When did your present pain begin? (date)______________________________**

3. **Please indicate how you present pain began (Select one):**

4. **What is the reason for today's visit? ____________________________________**

5. **Do you have any history of trauma? Yes No**

6. **Is the injury work related?**

   Yes No Unsure

7. **Is your current injury filed as a workers comp claim?**

   Yes No Unsure

8. **Have you ever had a workers comp claim in the past?**

   Yes No Unsure

9. **Using the following list of treatments, please indicate the effect of those that have been used in an attempt to heal your present injury:**

	Helpful	Not Helpful	Duration of Effect
Back School			
Hot Packs			
Ice			
TENS Unit			
Traction			
Arching Exercises			
Sit Up Exercises			
Epidural Block			
Facet Block			
Ultrasound			
Other			

10. Please indicate if you have had any of the following studies:

	Yes / No	What facility were they taken at?
Regular x-ray of spine		
CT scan		
EMG		
Myelogram		
Discogram		
MRI		

11. Are you (check one): Employed _______ Student ________ Retired_ ________

Unemployed _______

If you answered "Unemployed" or "Employed", please answer the following questions:

. How long have you been off work this year (select one):

B. Are you presently working? Yes _______ No _______

If you answered "Yes", please complete the following: 1.

Length of employment: Years: ____________ Months: __________

If you answered "No", please complete the following:

1. **What was the date last worked: ______________________**
2. **Why are you no longer working? ____**
3. **If because of this problem, since what date have you been out of work?: ________**
4. **Is your job still available? Yes ___________ No ___________**

. What is your job title? ____

. Was your reason for leaving work due to a back or neck problem: Yes No

12. Current source of income (select all that apply):

1. **Spouse**
2. **Employer**
3. **Social security**
4. **Disability**
5. **Unemployment**
6. **Workers compensation**
7. **Other funds**
8. **Private earnings**

CURRENT PAIN PROFILE

13. How would you compare your pain ratio (check one)?

14. Which of the following activities change the nature of your pain (check all that apply):

	Aggravates Pain	Relieves Pain	Neither
Sitting			
Standing			
Rising from sitting			
Leaning forward (brushing teeth)			
Walking			
Lying on your side			
Lying on your back			
Lying on your stomach			
Driving			
Coughing/Sneezing			
Bending forward			

Now go back and circle the boxes to indicate the most aggravating activity and the most relieving activity.

15. Please answer the following questions:

A. Unable to tolerate ____________**How long can you sit?**
B. About 15 minutes only ____________**How long can you stand?**
C. About 30 minutes only ____________**How long can you walk?**
D. About 45 minutes
E. About 1 hour
F. Indefinite period

Approximate Height:______________ **Approximate Weight:**___________

MEDICATIONS

16. **Please list any prior medications you have tried for your spine and orthopedic problems that gave you no or minimal relief: ____**

____

17. **Please list any prior medications you have tried for your spine and orthopedic problems that gave you significant relief: ____**

____

18. **Please list any medications you are currently taking for your spine and orthopedic problems. If insurance approval is required for these medications, it will greatly help if you complete this form since the information you provide may be very beneficial in getting your medications approved. Please be as detailed as you can.**

Medication #1:

Name:____________________Dose:__________Frequency:____________

How does this medication help your pain? ______________________________

____

If I take this medication, my pain level is________on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is ________ on a scale from 0 to 10, with 0 being less pain and 10 being more pain.

This medication helps me: ***(select one)***

How does this medication help you with function? Please list all ways that this medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.: ____________________

____

Please list any side effects you experience from this medication: ________________

____

Medication #2:

Name:____________________Dose:__________Frequency:____________

How does this medication help your pain? ______________________________

____

If I take this medication, my pain level is________on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is ________ on a scale from 0 to 10, with 0 being less pain and 10 being more pain.

This medication helps me: ***(select one)***

How does this medication help you with function? Please list all ways that this medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.: ______________________________

____

Please list any side effects you experience from this medication: ____________________

____

Medication #3:

Name:________________________**Dose:**____________**Frequency:**______________

How does this medication help your pain? ______________________________

____

If I take this medication, my pain level is__________**on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is** _________ **on a scale from 0 to 10, with 0 being less pain and 10 being more pain.**

This medication helps me: ***(select one)***

How does this medication help you with function? Please list all ways that this medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.: ______________________________

____

Please list any side effects you experience from this medication: ____________________

____

Medication #4:

Name:________________________**Dose:**____________**Frequency:**______________

How does this medication help your pain? ______________________________

____

If I take this medication, my pain level is__________**on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is** _________ **on a scale from 0 to 10, with 0 being less pain and 10 being more pain.**

This medication helps me: ***(select one)***

How does this medication help you with function? Please list all ways that this medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.: ______________________________

____

Please list any side effects you experience from this medication: ____________________

____

Please list any medications you are currently taking that are unrelated to your spine and orthopedic problems: ______________________________

____

19. Do you have any allergies to medication? If so, please list the medication and explain the reaction:

____

____

Past Medical History

Have you had a history of:

Heart:

- □ High blood pressure
- □ High cholesterol
- □ Chest pain, tightness
- □ Shortness of breath with 2 flights of stairs
- □ Cardiac testing or seen a cardiologist within the past 5 years (Stress test, ECHO)
  - □ Was told results were abnormal
- □ Irregular heart beat or murmur (palpitations)
- □ Heart attack
- □ Heart failure
- □ Sleeps with 2 or more pillows due to shortness of breath when lying flat
- □ Pacemaker or defibrillator
- □ Other Cardiac Conditions: ______________________________

Lung:

- □ Recent cough, cold or fever
- □ Asthma
- □ Emphysema/COPD
- □ Uses an inhaler
  - □ Daily
  - □ Few times per week
  - □ Few times per month
- □ Has had to go to the hospital for Asthma/COPD
  - □ Required a breathing tube
  - □ Required oral steroids (prednisone)
- □ PPD positive
  - □ Has been treated for TB
- □ Restrictive lung disease
- □ Obstructive sleep apnea
  - □ Uses CPAP or BIPAP at night
- □ Other Lung Problems: ______________________________

Neurologic:

- □ Epilepsy/Seizures
- □ Migraines or frequent headaches
- □ History of Stroke or "mini stroke" (TIA)
  - □ Residual weakness, blindness, language problems
- □ Loss of consciousness or passing out
- □ Carotid Artery Stenosis
- □ Required neurologic testing (Carotid ultrasound, EMG, Head CT)
- □ Experiences numbness or weakness
  - □ Upper extremities
  - □ Lowe extremities
- □ Other Neurologic problems: ______________________________

GI/Hepatic:

- □ Gastrointestinal reflux (GERD) or Heart Burn
  - □ Symptoms Daily
  - □ Well controlled
- □ Yellow jaundice
- □ Difficulty swallowing
- □ Bowel incontinence (uncontrolled loss of stool)
- □ Frequent constipation
- □ Frequent diarrhea
- □ Dark or bloody stool
- □ Pain with bowel
- □ Persistent/recurring belly pain
- □ AIDS/HIV
- □ Hepatitis (current or in the past)
  - □ A
  - □ B
  - □ C
- □ Liver Disease
  - □ Cirrhosis (□Alcoholic □Hepatitis related)
  - □ Other: ________________________________

Kidney/GU:

- □ Urinary incontinence (loss of bladder control)
- □ Burning with urination
- □ Frequent Urination
- □ Bleeding with urination
- □ Diabetes
  - □ Insulin dependent
  - □ Oral meds
  - □ Diet controlled
- □ Kidney Disease
- □ Dialysis

Hematologic:

- □ Has been told by doctor that they bleed easily or have bleeding disorder
- □ Has had a blood clot
  - □ Leg
  - □ Arm
  - □ Lung
  - □ Required heparin or Coumadin (warfarin) treatment

Endocrine:

- □ Thyroid problems
  - □ Hypothyroid
  - □ Hyperthyroid
- □ Cancer – Type: _________________________
  - □ Chemo
  - □ Radiation
  - □ Surgery

Musculoskeletal:

- □ Fever, chills, or sweats
- □ Arthritis- Type and joints affected: ______________________
- □ Neck pain
- □ Back pain
- □ Gout
- □ Calf cramp with walking
- □ Fibromyalgia
- □ rash

HEENT:

- □ Hoarseness
- □ Dentures or partials
- □ Loose tooth(teeth)
- □ Infected tooth(teeth)
- □ Hearing aids
- □ Vision problems (Retinal vein/artery occlusion, cataracts, glaucoma, blindness)

Psychiatric:

- □ Anxiety
- □ Depression
- □ Bipolar Disorder

□ ____

List all other major illnesses

Are you under a doctor's care for any medical condition? Yes____ No____

If yes, please explain: ____

Treatment History:

□ Orthopedic Surgeries:

1. Surgery:	Date:	Physician:
2. Surgery:	Date:	Physician:
3. Surgery:	Date:	Physician:

□ Spine Surgeries:

1. Surgery:	Date:	Physician:
2. Surgery:	Date:	Physician:
3. Surgery:	Date:	Physician:

□ Other Surgeries:

1. Surgery:	Date:	Physician:
2. Surgery:	Date:	Physician:
3. Surgery:	Date:	Physician:

Did you improve from your surgical procedure(s)?

Most recent surgery? Yes__________ No__________

□ **Have been told that there was trouble/difficulty with Anesthesia**:

- □ Difficult Airway
- □ Nausea/Vomiting
- □ Allergic Reaction: ____________________________________

Procedures:
□ Injections:

1. Type: Date: Physician:
2. Type: Date: Physician:
3. Type: Date: Physician:

Alternate Treatment Modalities
□ Chiropractic Treatment:
_______Visits,

□ Acupuncture Treatment:
1. Acupuncturist
_______Visits,

□ Physical Therapy:
_______Visits,

Family History
Has any family member (blood related) had any of the following? Please select each that apply:
□ Yes □ No Life-threatening reaction to anesthesia (malignant hyperthermia)?
□ Yes □ No Heart Attack before age 55?
□ Yes □ No Back pain?
□ Yes □ No Arthritis?
□ Yes □ No Tuberculosis
□ Yes □ No Migraine Headaches
□ Yes □ No Muscle or nerve disease? If so, what _______________________________
□ Yes □ No Cancers? If so, what type ____
□ Yes □ No Any other disease which might affect your treatment? Please list: ______________
____

Social History
How much alcohol do you usually drink?
□ None
□ 1 to 2 drinks per week
□ 1 to 2 drinks per day
□ 3 to 5 drinks per day
□ more than 5 drinks per day

□ Yes □ No Have you been treated for drug or alcohol abuse? Please clarify: _____________________________
____
□ Yes □ No Do you use street drugs? If yes, what? __________________________________
□ Yes □ No Have you been a cigarette smoker in the past 5 years?
□ Yes □ No Currently, do you smoke? If yes, how much per day? _______________________
How many years have you been smoking? _______________________________________

Are you: □ Single □ Separated □Married □Widowed □Divorced

Number of children, if any: __________________

□ Yes □ No Is there any chance you are pregnant?

OSWESTRY FUNCTION TEST

Complete this form only if you have back or leg problems (Page 6 and 7).

20. Please answer the following questions by placing the number of the most applicable on the blank lines:

1. How long have you had back pain?

_____________ About 1 week
_____________ About 1 month
_____________ About 3 months
_____________ About 6 months
_____________ About 1 year

2. How long have you had leg pain?

_____________About 1 week
_____________About 1 month
_____________About 3 months
_____________About 6 months
_____________About 1 year

21. Please check the one answer in each section that best applies to your condition.

PAIN INTENSITY

	I can tolerate my pain without having to use painkillers.
	My pain is bad, but I can manage without taking painkillers.
	Painkillers give me complete relief from my pain.
	Painkillers give me moderate relief from my pain.
	Painkillers give me very little relief from my pain.
	Painkillers have no effect on my pain and I do not use them.

PERSONAL CARE (WASHING, DRESSING, ETC)

	I can look after myself normally without causing extra pain.
	I can look after myself normally, but causes extra pain.
	It is painful to look after myself and I am slow and careful.
	I need some help but I manage my personal care.
	I need every day in most aspects of self-care.
	I do not get dressed, wash with difficulty , and stay in bed.

LIFTING

	I can lift heavy objects without extra pain.
	I can lift heavy objects, but it gives me extra pain.
	Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned.
	Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are conveniently positioned.
	I can only lift very light objects.
	I cannot lift or carry anything at all.

WALKING

	Pain does not prevent me from walking any distance.
	Pain prevents me from walking more than a mile.
	Pain prevents me from walking more than ½ mile.
	Pain prevents me from walking more than ¼ mile.
	I can only walk using a cane or crutches.
	I am in bed most of the time and have to crawl to the toilet.

SITTING

	I can sit in my chair as long as I like.
	I can only sit in my favorite chair as long as I like.
	Pain prevents me from sitting more than 1 hour.
	Pain prevents me from sitting more than ½ hour.
	Pain prevents me from sitting more than 10 minutes.
	Pain prevents me from sitting at all.

STANDING

	I can stand as long as I want without extra pain.
	I can stand as long as I want, but it gives me extra pain.
	Pain prevents me from standing more than 1 hour.
	Pain prevents me from standing more than ½ hour.
	Pain prevents me from standing more than 10 minutes.
	Pain prevents me from standing at all.

SLEEPING

	Pain does not prevent me from sleeping well.
	I can sleep well only by taking medication for sleep.
	Even when I take medication I have less than 6 hours sleep.
	Even when I take medication I have less than 4 hours sleep.
	Even when I take medication I have less than 2 hours sleep.
	Pain prevents me from sleeping at all.

SEX LIFE

	My sex life is normal and causes me no extra pain.
	My sex life is normal and causes me some extra pain.
	My sex life is nearly normal, but is very painful.
	My sex life is severely restricted by pain.
	My sex life is nearly absent because of pain.
	Pain prevents any sex life at all.

SOCIAL LIFE

	My life social life is normal and causes me no extra pain.
	My social life is normal, but increases the degree of pain.
	Pain has no significant effect on my social life apart from limiting my more energetic interests like dancing, etc.
	Pain has restricted my social life and I do not go out as often.
	Pain has restricted my social life to my home.
	I have no social life because of pain.

TRAVEL

	I can travel anywhere without pain.
	I can travel anywhere but it gives me extra pain.
	Pain is bad, but I manage journeys over 2 hours.
	Pain restricts me to journeys of less than 1 hour.
	Pain restricts me to short necessary journeys under 1/2 hour.
	Pain prevents me from traveling except to the doctor or hospital.

Neck Disability Index. Complete this form only if you have neck or arm problems. This questionnaire has been designed to give your doctor information as to how your pain has affected you in your everyday life activities. Please answer each section; select one letter, which best describes your status today.

Section 1-Pain Intensity

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

Section 2-Personal Care (Washing, dressing, etc.)

A. I can look after myself normally without causing all. extra pain.
B. I can look after myself normally but it causes me extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some extra help but manage most of my personal care. all.
E. I need help everyday on most aspects of self-care.
F. I do not get dressed, wash with difficulty and stay in bed.

Section 3-Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra with pain.
C. Pain prevents me from lifting heavy weights of off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are all. conveniently positioned.
E. I can only lift very lightweights.
F. I cannot lift or carry anything at all.

Section 4-Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want to with a slight pain in my neck.
C. I can read as much as I want to with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

Section 5-Headache

A. I have no headaches at all.

Section 6-Concentraion

A. I concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I wan to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I cannot concentrate at

Section 7-Work

A. I can do as much as I want to.
B. I can do my usual work but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do my work at

F. I cannot do any work at all.

Section 8-Driving

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want to with slight pain in my neck.
C. I can drive my car as long as I want moderate pain in my neck.
D. I cannot drive my car as long as I want because moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at

Section 9-Sleeping

A. I have no trouble sleeping at all.
B. My sleep is slightly disturbed (less than 1 hour sleep loss).
C. My sleep is mildly disturbed (1-2 hoursleep loss).
D. My sleep is moderately disturbed (2-3 hour sleep loss).
E. My sleep is greatly disturbed(3-5 hour sleep loss).
F. My sleep is greatly disturbed(3-5 hour sleep loss).

Section 10-Recreation

A. I am able to engage in all my recreational activities with no neck pain at all.
B. I am able to engage in all my recreational activities with some pain in my neck.

B. **I have slight headaches, which come infrequently.**
C. **I have moderate headaches, which come infrequently.**
D. **I have moderate headaches, which come frequently.**
E. **I have severe headaches, which come frequently**
F. **I have headaches almost all the time.**

C. **I am able to engage in most but not all of my usual recreational activities because of my neck pain.**
D. **I am able to engage in few of my usual recreational activities because of pain in my neck.**
E. **I can hardly do any recreational activities because of my neck.**
F. **I cannot do any recreational activities.**

ACTIVITIES OF DAILY LIVING COMMONLY MEASURED IN ACTIVITIES OF DAILY LIVING (ADL)*

<table>
<tr><th colspan="7">APPLICANT HAS DIFFICULTY WITH: MARK WITH AN "X" BELOW AND EXPLAIN WHERE INDICATED</th></tr>
<tr><th></th><th>Category of Activity</th><th>Activity</th><th>Without Difficulty</th><th>With Some Difficulty</th><th>With Much Difficulty</th><th>Mostly Unable To Do</th></tr>
<tr><td rowspan="16">1</td><td rowspan="16">SELF CARE, PERSONAL HYGIENE: Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating</td><td>Shower</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Bath</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Wash/Dry Body</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Wash and Dry Face</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Turn On/Off Faucets</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Brush Teeth</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Get On/Off Toilet</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Comb/Brush Hair</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dress Self</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Put On/Off Shoes/Socks</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Open a Carton of Milk</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Open a Jar</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Lift Glass/Cup to Mouth</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Make a Meal</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Lift Fork/Spoon to Mouth</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Describe other: bladder and bowel function difficulties, incontinence, retention, constipation?</td></tr>
</table>

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
2	**PHYSICAL ACTIVITY**: Standing, sitting, reclining, walking, climbing stairs	**Stand**				
		Sit				
		Recline				
		Rise From a Chair				
		Get In/Out of Bed				
		Climb Flight of 10 Stairs				
		Work Outdoors				
		Light Housework				
		Shop/Do Errands				
		Carry Groceries				
		Lift 5 lbs.				
		Lift 10 lbs.				
		Lift 20 lbs.				
		Lift 30 lbs.				
		Walk				
		Care for Children or Parents				
		Engage in hobbies: music or crafts, etc. Indicate hobby				
		Describe other: eating/chewing difficulty: TMJ				

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
3	**COMMUNICATION** writing, typing, seeing, hearing, speaking	**Write a Note**				
		Type a Message on a Computer/Typewriter				
		See a Television Screen				
		Use a Telephone				
		Speak Clearly				
		Hear Clearly				
		Describe Others:				
4	**NONSPECIFIED HAND ACTIVITIES:** grasping, lifting, tactile, discrimination)	**Pick Up Small Items**				
		Turn a Knob on a Door				
		Write With a Pen/Pencil				
		Steer Wheel of Car				
		Describe Other:				

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
5	**SENSORY FUNCTION:** hearing, seeing, tactile feeling, tasting, smelling	**Feel What You Touch**				
		Taste What You Eat				
		Smell What You Eat				
		Describe Other:				
6	**TRAVEL:** riding, driving, flying	**Get In/Out of a Car**				
		Drive a Car				
		Ride in a Car				
		Fly in a Plane				
		Ride a Bicycle				
		Describe Other:				

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
7	**SEXUAL FUNCTION:** orgasm, ejaculation, lubrication, erection	**Engage in sexual activity**				
		Describe specific difficulty: Orgasm, ejaculation, lubrication, erection				
8	**SLEEP:** restful sleep, nocturnal sleep pattern	**Get to Sleep**				
		Sleep Through the Night				
		Have Restful Sleep				
		Feel Refreshed After Sleep				
		Describe Specific Difficulty: (teeth grinding at night, excessive daytime fatigue, irritability, etc.)				

***This chart is meant to assist the examining physician to place the Applicant in certain impairment categories when determining whole person impairment under the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA) and in identifying body systems requiring referrals for Impairment evaluation.**
***Note: ADLS may indicate a serious condition requiring treatment.**

Cocchiarella, Linda, and B.J. Andersson Gunnar. Guides to the Evaluation of Permanent Impairment. Table 1-2: Activities of Daily Living. 5th Edition (2004). American Medical Association.4.

EPWORTH SLEEPINESS SCALE

Patient Name: **Date**:

Please rate your likelihood of falling asleep in the following situations: (select a number in each row)

	Never	Sometimes	Most Times	Always
Sitting and Reading	0	1	2	3
Watching Television	0	1	2	3
Sitting in a Public Place	0	1	2	3
Riding as a Passenger for 1 Hour	0	1	2	3
Lying Down to Rest in the Afternoon	0	1	2	3
Sitting and Talking to Someone	0	1	2	3
Sitting After a Non-Alcohol Lunch	0	1	2	3
Stopped in Traffic	0	1	2	3

TOTAL: ____________ /24

Patient Signature: ______________________________

(To sign, you can select Fill & Sign and hit Sign)

Class 1: 1%-9% impairment of the whole person. Reduced daytime alertness; sleep pattern such that individual can perform most activities of daily living.
Class 2: 10%-29% impairment of the whole person. Reduced daytime alertness. Interferes with ability to perform some activities of daily living.
Class 3: 30%-69% impairment of the whole person. Reduced daytime alertness; ability to perform activities of daily living significantly limited.
Class 4: 70%-90% impairment of the whole person. Reduced daytime alertness; individuals unable to care for self in any situations or manner.

Cocchiarella, Linda, and B.J. Andersson Gunnar. Guides to the Evaluation of Permanent Impairment. Table 13-4: Criteria for Rating Impairment Due to Sleep and Arousal Disorders. 5th Edition (2004). American Medical Association. 317.

INDIVIDUAL'S REPORT OF EFFECT OF PAIN ON MOOD

For each question below, select the number which most accurately describes how your pain over the past week has affected your mood.

1. **Rate your overall mood during the past week .**										
0	1	2	3	4	5	6	7	8	9	10
Extremely High/Good								Extremely Low/Bad		
2. **During the past week, how anxious or worried have you been because of your pain?**										
0	1	2	3	4	5	6	7	8	9	10
Not At All Anxious/Worried								Extremely Anxious/Worried		
3. **During the past week, how depressed have you become because of your pain?**										
0	1	2	3	4	5	6	7	8	9	10
Not At All Depressed								Extremely Depressed		
4. **During the past week, how irritable have you become because of your pain?**										
0	1	2	3	4	5	6	7	8	9	10
Not At All Irritable								Extremely Irritable		
5. **In general, how anxious are you about performing activities because they might make your pain/symptoms worse?**										
0	1	2	3	4	5	6	7	8	9	10
Not At All Anxious								Extremely Anxious		

(For Physician Use Only) *(Para el Uso del Médico Solamente)*

Sum Score of 1-5: ____________________

Total Pain Impairment Attributed to Mood State/5= ____________________

Mean Score= ____________________

Cocchiarella, Linda, and B.J. Andersson Gunnar. Guides to the Evaluation of Permanent Impairment. Table 18-4: Ratings Determining Impairment Associated with Pain: Individual's Report of Effect of Pain on Mood. 5th Edition (2004). American Medical Association. 577.

The Spine and Orthopedic Center
401 East Carrillo Street
Santa Barbara, CA 93101

PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION TO A DESIGNATED REPRESENTATIVE

Patient Name: ____

Address: ____

City, State, Zip: ____

I, (print your name) _______________________________ hereby authorize The Spine and Orthopedic Center to disclose health information regarding me, my medical condition and related information to the following representative(s).

____________________	____________________
Designated Representative (print)	Relationship to Patient (print)
____________________	____________________
Designated Representative (print)	Relationship to Patient (print)
____________________	____________________
Designated Representative (print)	Relationship to Patient (print)
____________________	____________________
Patient Social Security Number	Patient Date of Birth
____________________	____________________
Patient Signature	Date Signed
____________________	____________________
Witness Signature	Date Signed

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California Law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.

The Spine and Orthopedic Center
401 E. Carrillo Street
Santa Barbara, CA 93101
(805) 563-3307

PATIENT ACKNOWLEDGMENT OF RECEIPT OF:

NOTICE OF PRIVACY PRACTICES

This is to acknowledge that I have read and understand Section I of the document entitled "Notification of Privacy Practices" provided by The Spine and Orthopedic Center. Also, I have reviewed Section II of this document, which provides more detail. I understand that these Privacy Practices are effective beginning April 14, 2003. I further understand that this Acknowledgment of Receipt will be retained in my records for a period of six (6) years from the date indicated below.

Please sign your name and print your name and date on this acknowledgment form and return your signed acknowledgment to the Receptionist.

Signature:____

Printed Name:____

Date:____________________________________

The Spine and Orthopedic Center

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YO.U MAY BE USED AND DISCLOSED AND HOW YOU MAY REQUEST ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures of Your Health Information. Dr. Moelleken and his staff use health information about you for treatment, to obtain payment for treatment, and for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other healthcare providers and facilities to which you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization for routine care and for legal reasons as described in t e following pages, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. These requests must be in writing and we will charge you reasonable retrieval and photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that Dr. Moelleken made. If you believe that information in your records is incorrect, you have the right to request, in writing, that we correct the existing information.

Complaints: If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person below. You may also send a written complaint to the U. S. Department of Health and Information Services. The person listed below can provide you with the appropriate address.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgment of receipt of this notice. Before we make a significant change in our policies, we will notify our then current patients of such change. For more information about our privacy practices, please contact the person listed below.

The Spine and Orthopedic Center
401 East Carrillo St.
Santa Barbara, CA 93101
(805) 563-3307

OUR PRIVACY PRACTICES

The following are examples of the types of uses and disclosures of your protected healthcare information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures.

Treatment: Dr. Moelleken will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you. ***Payment:*** We may use or disclose, as needed, your protected health information in order to support our business activities. For example, when we review employee performance, we may need to look at what an employee has documented in your medical record. ***Business Associates:*** We will share your protected health information with third part "business associates" that perform various activities (e.g. billing, transcription services). Whenever an arrangement between Dr. Moelleken and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. ***Other:*** We may use or disclose certain health information in the course of providing you directly with information about treatment alternatives provided by Dr. Moelleken or upcoming appointment reminders.

Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing.

Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to object. If you are not present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

<u>Others involved in Your Healthcare:</u> Members of the clergy will be told your religious affiliation. <u>Emergencies:</u> In an emergency situation, your provider shall try to provide you a Notice of Privacy Practices as soon as reasonably practical after the delivery of treatment. <u>Communication Barriers:</u> We may use and disclose your protected health information if your provider attempts to attain acknowledgment from you of the Notice of Privacy Practices but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that you would agree.

OUR PRIVACY PRACTICES

Without Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization or opportunity to object:

Public Health: for public health purposes to a public health authority or to a person who is at risk of contracting or spreading your disease.

Health Oversight: to a health oversight agency for activities authorize by law, such as audits, investigations, and inspections.

Abuse or Neglect: to an appropriate authority to report child abuse or neglect, if we believe that you have been a victim of abuse, neglect, or domestic violence.

Food or Drug Administration: as required by the Food and Drug Administration to track products.

Legal Proceedings: in the course of legal proceedings.

Law Enforcement: for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.

Coroners, Funeral Directors, and Organ Donation: for the coroner, medical examiner, or funeral director to perform duties authorized by law and for organ donation purposes.

Research: to researchers when an Institutional Review Board has approved their research.

Soldiers, Inmates, and National Security: to military supervisors or Armed Forces personnel or to custodians of inmates, as necessary. Preserving national security may also necessitate sharing protected health information.

Workers' Compensation: to comply with workers' compensation laws.

Compliance: to the Department of Health and Human Services to investigate our compliance.

In general, we may use your protected health information as required by law and limited to the relevant requirements of the law.

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to request to inspect and obtain a copy of your protected health information. All requests must be in writing and reasonable retrieval time and fees, along with reasonable copying fees, will apply. We may refuse to provide access to certain psychotherapy notes or information for a civil or criminal proceeding.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for treatment, payment, or healthcare operations. You may also request that information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you request, but if we do agree, then we must behave accordingly.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis of this request.

You may have the right to have your provider amend your protected health information. You may request in writing an amendment of protected health information about you. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information.

You have the right to receive an accounting of certain disclosures Dr. Moelleken may have made. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations. It excludes disclosures we may have made to your, to family members, or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

The Spine and Orthopedic Center
401 East Carrillo Street
Santa Barbara, CA 93101
(805) 563-3307