WC

PLEASE PRINT

Robert Bruce Miller MD

2557 Mowry Avenue, Suite 22
Fremont, CA 94538
510-795-7746 Fax 510-795-7710

Date | Account No. | ☐ Consult ☐ Exam and Treat ☐ 2nd Opinion

PATIENT

Last Name | First Name | M.I. | Sex M F

Date of Birth | Age | Marital Status M W D S SEP | Social Security # | Driver's License #

Address | Home Phone ( )

Address | Work Phone ( )

City | State | Zip | Cell Phone ( )

Employer | Employer Fax ( )

Employer Address | Occupation

City | State | Zip | **Date of Injury (MANDATORY)**

Referring Doctor | Address

INDUSTRIAL INSURANCE CARRIER INFORMATION

Carrier Name | Phone ( )

Address | Fax ( )

City | State | Zip | Claim #

Claims Adjuster/ Nurse Case Manager

The practice of Robert Miller is frequently subject to emergencies. Although we try to maintain our office schedule, there are times when we must reschedule appointments. For this reason, it is very important that we have a phone number where you can be reached or where a message can be left.

Daytime phone number for emergencies: ( )

I hereby authorize Robert Bruce Miller, MD, Inc. to furnish the above-mentioned insurance company all information which said insurance company may request. In the event this claim is denied by my workers' compensation carrier, I will supply Robert Bruce Miller, MD, Inc. with my private insurance information and will be held financially responsible for all charges.

If you cannot keep your future appointments, notify the office at least 24 hours in advance.

Patient or Guardian Signature | Date

Robert Bruce Miller MD

Physical Medicine & Rehabilitation ❖ Musculoskeletal & Spine Medicine
Electrodiagnostic Medicine ❖ Interventional Spine & Pain Medicine

2557 Mowry Avenue, Suite 22, Fremont, CA 94538 ❖ 510-795-7746 Fax 510-795-7710 ❖ CA License A76380 ❖ Tax ID 68-0493112

NEW PATIENT QUESTIONNAIRE

Patient Name

Date of Visit | Date of Birth | Age Today

Height | Weight | BP | Pulse | Temp

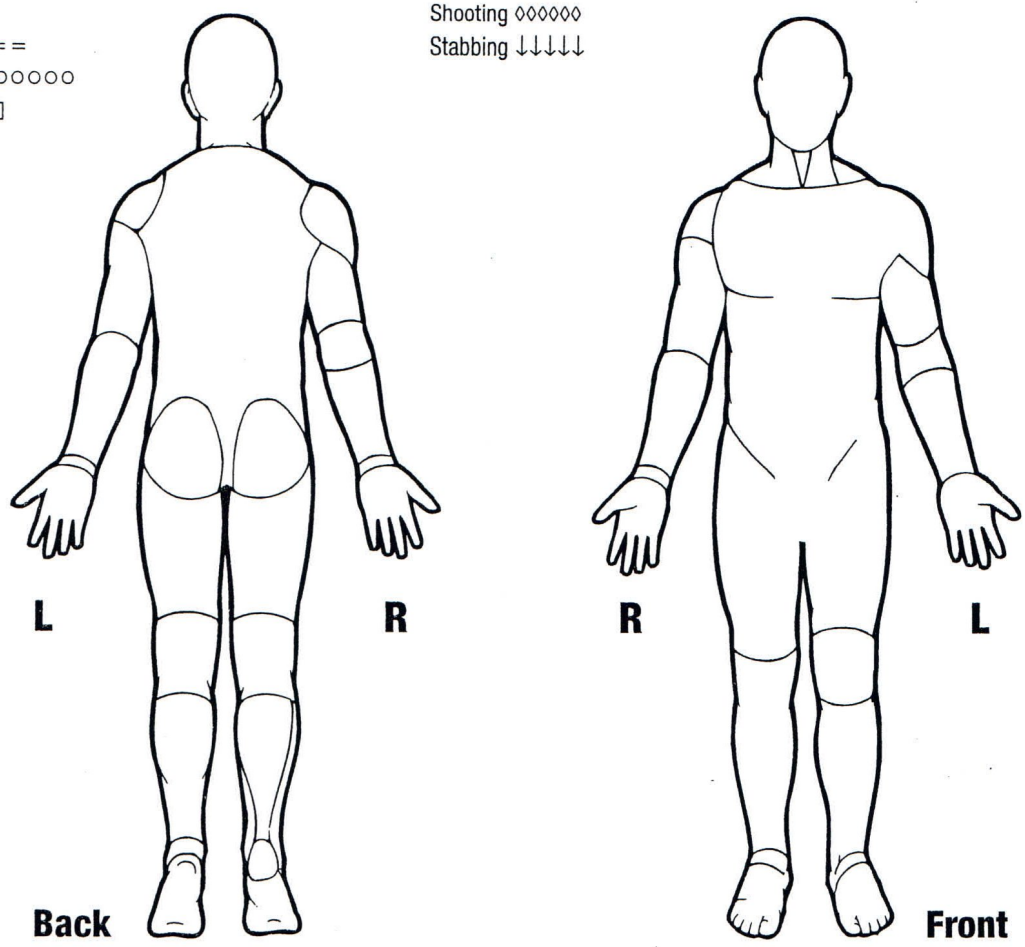
Who referred you to our office? ☐ Primary doctor ☐ Physical therapist ☐ Patient ☐ Other

Name | Address | Phone

PAIN DRAWING

1. Mark these drawings using the symbol that best describes your pain.

Burning ×××××
Numbness = = = = =
Pins and Needles ○○○○○
Tingling □□□□□
Shooting ◊◊◊◊◊
Stabbing ↓↓↓↓↓
Ache ^^^^^
Cramping +++++



2. Please rate your level of pain using these descriptions:

Severity:

- ☐ **Minimal pain (Min)**—an annoyance, causes no handicap in performance
- ☐ **Slight pain (Slt)**—tolerable, causes some handicap in performance of the activity precipitating pain.
- ☐ **Moderate pain (Mod)**—tolerable, causes marked handicap in the performance of the activity precipitating pain.
- ☐ **Severe pain (Sev)**—precludes performance of the activity precipitating pain.

Frequency:

- ☐ **Occasional (Occ)**—occurs roughly one fourth of the time.
- ☐ **Intermittent (Int)**—occurs roughly one half of the time.
- ☐ **Frequent (Fre)**—occurs roughly three fourths of the time.
- ☐ **Constant (Con)**—occurs roughly 90 to 100% of the time.

2. Location of pain:

☐ None ☐ Back ☐ Right leg and buttock ☐ Left leg and buttock

☐ Other (specify) _____

_____

3. Which hurts you more, your legs or back? (Check only ONE statement)

☐ Legs hurt much more than back

☐ Legs and back hurt about the same

☐ Back hurts much more than legs

____ % back pain ____ % leg pain

(Total of back and leg percentages should equal 100%)

4. How does the pain spread?

☐ From back to_____

☐ From neck to_____

☐ Does not spread

5. Is the pain worse in ☐ AM ☐ PM?

6. Do you experience lower extremity weakness with this pain? ☐ yes ☐ no

7. Mark the effect of each of the following on your pain:

	Increases	Decreases	No Change
a. Bending forward	☐	☐	☐
b. Bending backward	☐	☐	☐
c. Bowel movement	☐	☐	☐
d. Coughing/sneezing	☐	☐	☐
e. Driving	☐	☐	☐
f. Laughing	☐	☐	☐
g. Lying on your back	☐	☐	☐
h. Lying on your stomach	☐	☐	☐
i. Rising from sitting	☐	☐	☐
j. Sitting	☐	☐	☐
k. Standing	☐	☐	☐
l. Walking	☐	☐	☐
m. Walking up incline/stairs	☐	☐	☐
n. Walking down incline/stairs	☐	☐	☐

8. How did your current episode begin? ☐ suddenly ☐ gradually

Describe:_____

_____

_____

9. Is this a work-related injury? ☐ yes ☐ no

If yes, date of injury: _____

Describe:_____

_____

_____

10. Is your problem due to a car accident? ☐ yes ☐ no

If yes, date of injury: _____

Describe:_____

_____

_____

11. Please list all your medication allergies:

☐ No known drug allergies

_____

_____

_____

12. Please list all medications and doses that you are currently taking:

Medication _____

Dose _____ Frequency _____

Condition _____

Medication _____

Dose _____ Frequency _____

Condition _____

Medication _____

Dose _____ Frequency _____

Condition _____

Medication _____

Dose _____ Frequency _____

Condition _____

13. Who is your primary care physician?

_____

14. Please mark any of the following medical problems you have had:

a. ☐ Arthritis (not spine related)
b. ☐ Asthma
c. ☐ Cancer
d. ☐ Change in bowel movements
e. ☐ Change in urination
f. ☐ Colitis
g. ☐ Depression
h. ☐ Diabetes
i. ☐ Headaches
j. ☐ Heart disease/heart attack
k. ☐ Hepatitis
l. ☐ High blood pressure
m. ☐ HIV positive
n. ☐ Kidney/bladder infections
o. ☐ Kidney stones
p. ☐ Loss of consciousness
q. ☐ Loss of urine
r. ☐ Prostate problems
s. ☐ Psoriasis
t. ☐ Seizure
u. ☐ Stroke
v. ☐ Tuberculosis
w. ☐ Ulcerative colitis
x. ☐ Ulcers
y. ☐ Unexplained weight loss
z. ☐ ***None***

Other_____

Other_____

15. Have you had previous back surgery? ☐ yes ☐ no

If yes, how many surgeries?_____

16. After your most recent surgery, did you return to full function? ☐ yes ☐ no

Date of spine surgery	Type of surgery	% Improvement	How long did the improvement last?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

17. List all previous surgeries ***unrelated*** to your spine:

Date of surgery	Type of surgery	Describe recovery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

18. List previous diagnostic procedures:

Lumbar x-ray Facility_____

Year_____ Results _____

MRI Facility_____

Year_____ Results _____

Nerve conduction EMG Facility_____

Year_____ Results _____

19. What health care providers have you used for your current back condition? (Mark ALL that apply)

- ☐ Acupuncturist
- ☐ Chiropractor
- ☐ Emergency room
- ☐ General practitioner
- ☐ Immediate care clinic
- ☐ Internist
- ☐ Massage therapist
- ☐ Neurosurgeon
- ☐ Osteopath
- ☐ Orthopedic surgeon
- ☐ Pain clinic
- ☐ Physical therapist
- ☐ Rheumatologist
- ☐ Work hardening clinic
- ☐ Other_____
- ☐ ***None of the above***

20. Indicate the result of the following treatments on your spinal problem: (Circle ONE number in response to each of the following questions.)

	Helpful	Not Helpful	Worse	Never Tried
Acupuncture	1	2	3	4
Brace support	1	2	3	4
Botox	1	2	3	4
Chiropractic	1	2	3	4
Epidural injection	1	2	3	4
Facet injection	1	2	3	4
Hot packs	1	2	3	4
Ice	1	2	3	4
Physical therapy	1	2	3	4
TENS	1	2	3	4
Traction	1	2	3	4

21. Family History

Parent with history of significant back pain? ☐ yes ☐ no

Mother Age _____ ☐ Healthy ☐ Deceased – Date_____

Illnesses_____

Medications taken_____

Cause of death _____

Father Age _____ ☐ Healthy ☐ Deceased – Date_____

Illnesses_____

Medications taken_____

Cause of death _____

Relative Age _____ ☐ Healthy ☐ Deceased – Date_____

Illnesses_____

Medications taken_____

Cause of death _____

Relative Age _____ ☐ Healthy ☐ Deceased – Date_____

Illnesses_____

Medications taken_____

Cause of death _____

Relative Age _____ ☐ Healthy ☐ Deceased – Date_____

Illnesses_____

Medications taken_____

Cause of death _____

22. Do you smoke cigarettes? (Check only ONE statement)

- ☐ I have never smoked.
- ☐ Yes, _____ packs per day.
- ☐ No, I quit in the last 6 months.
- ☐ No, I quit more than 6 months ago.

23. Have you used alcoholic beverages (beer, wine, liquor) to relieve your current leg or back pain? (Check only ONE statement)

☐ No ☐ Yes, once in a while. ☐ Yes, often.

If yes, type of alcoholic beverage _____

Amount_____

24. How many children do you have? _____

How many live at home with you? _____

25. What type of home do you live in? How many stories? _____

☐ Apartment ☐ House ☐ Condo ☐ Townhouse

26. Function level:

- ☐ Function normally without restrictions, independent in leisure activities and activities of daily living. Unlimited walking distance.
- ☐ Mild limitation in function with some restrictions. Mildly limited in leisure activities and activities of daily living. Ambulate 5–6 blocks.
- ☐ Moderate limitation of function, but employable. Moderately limited in leisure activities and activities of daily living. Ambulate 1–2 blocks.
- ☐ Severe limitation of function, unemployable. Severely limited in leisure activities and activities of daily living. Ambulate 1–2 blocks.
- ☐ Invalid or bedridden due to back condition. Ambulate under 1 block.

27. Work status:

☐ currently working (specify occupation) _____

_____

☐ on paid leave	☐ back related	☐ unrelated to back
☐ on unpaid leave	☐ back related	☐ unrelated to back
☐ retired	☐ back related	☐ unrelated to back

Date last worked_____

28. Did you ever receive Worker's Compensation for your past back symptoms? ☐ yes ☐ no

REVIEW OF SYSTEMS

Do you experience any of the following? If yes, please describe. If no, check no.

Constitutional Symptoms

Fever	☐ yes	☐ no
Weight loss	☐ yes	☐ no

Describe: _____

Eyes

Double vision	☐ yes	☐ no
Blurring	☐ yes	☐ no
Trauma	☐ yes	☐ no
Glasses	☐ yes	☐ no

Describe: _____

ENT & Mouth

Deafness	☐ yes	☐ no
Sinusitis	☐ yes	☐ no
Ringing in the ears	☐ yes	☐ no
Hoarseness	☐ yes	☐ no
Dizziness	☐ yes	☐ no

Describe: _____

Cardiovascular

Chest pains	☐ yes	☐ no
Palpitations	☐ yes	☐ no
Hypertension	☐ yes	☐ no
Irregular beats	☐ yes	☐ no

Describe: _____

Respiratory

Shortness of breath	☐ yes	☐ no
Asthma	☐ yes	☐ no
Chronic lung disease	☐ yes	☐ no
Cough	☐ yes	☐ no
Cough up blood	☐ yes	☐ no

Describe: _____

Gastrointestinal

Appetite change	☐ yes	☐ no
Weight change	☐ yes	☐ no
Diarrhea/constipation	☐ yes	☐ no
Abdominal pain	☐ yes	☐ no

Describe: _____

Genitourinary

Difficulty passing urine	☐ yes	☐ no
Incontinence	☐ yes	☐ no
Painful urination	☐ yes	☐ no
Menstrual history/pregnancies	☐ yes	☐ no

Describe: _____

Musculoskeletal

Fractures/sprains	☐ yes	☐ no
Joint pain	☐ yes	☐ no
Joint swelling	☐ yes	☐ no
Arthritis	☐ yes	☐ no
Stiffness	☐ yes	☐ no
Muscle wasting	☐ yes	☐ no

Describe: _____

Skin/Breast

Change in color/temperature	☐ yes	☐ no
Rashes	☐ yes	☐ no
Lesions/scars	☐ yes	☐ no
Masses	☐ yes	☐ no
Ulcers	☐ yes	☐ no

Describe: _____

Neuro

Speech and swallowing difficulty	☐ yes	☐ no
Stroke	☐ yes	☐ no
Numbness/tingling	☐ yes	☐ no
Changes in sensation	☐ yes	☐ no
Seizures	☐ yes	☐ no
Weakness	☐ yes	☐ no
Visual changes	☐ yes	☐ no
Balance/incoordination problems	☐ yes	☐ no

Describe: _____

Psych

Depression	☐ yes	☐ no
Mood swings	☐ yes	☐ no
Hallucinations	☐ yes	☐ no
Sleep disturbances	☐ yes	☐ no

Describe: _____

Endocrine

Frequent thirst	☐ yes	☐ no
Frequent hunger	☐ yes	☐ no
Hyper/hypoactivity	☐ yes	☐ no
Growth/hair changes	☐ yes	☐ no

Describe: _____

Hematologic/Lymphatic

Bleeding tendency	☐ yes	☐ no
Lymph node pain/enlargement	☐ yes	☐ no
Anemia	☐ yes	☐ no

Describe: _____

Allergic/Immunologic

Dermatitis/eczema/itching	☐ yes	☐ no
Skin reactions	☐ yes	☐ no
Reactions to rubber gloves	☐ yes	☐ no

Describe: _____

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RECORDS RELEASE AUTHORIZATION

TO:

RE:
(Patient's Name)

I hereby authorize and request you to release and forward to Dr. Miller the information checked below:

- ☐ Complete Medical Records
- ☐ Medical Summary
- ☐ X-Rays
- ☐ Laboratory Data
- ☐ EMG Report/Films
- ☐ Myelogram Report/Films
- ☐ Other _____

Name

Date

Address

Signature

If relative,
state relationship.

Witness