IMPORTANT

Notice of Medical Visit

St Charles Spine Institute
Benjamin Dirkx, D.O.
558 St Charles Drive # 200
Thousand Oaks, CA 91360
Telephone: (805) 379-2322 Fax: (805) 379-2373

www.stcharlesspine.com

Appointment Date: _____ Time: _____

All attached forms need to be completed by your appointment date.

Please arrive 20 minutes prior to your appointment with your paperwork completed.

****You will be rescheduled if forms are not completed.****

Please bring the following:

- Picture ID such as Driver's License and Insurance Cards
- X-Rays , MRI, CT Scans with CD/Films and Reports (within 2 years)
- Past EMG and Operative Reports
- Current Medication List
- Health Advance Directive

Should you need to cancel this appointment for any reason, please call our office at 805-379-2322 at least 48 hours in advance.

Thank you for your cooperation in this matter.

ST CHARLES
SPINE
INSTITUTE

BENJAMIN DIRKX, D.O.- Pain Specialist
Board Certified Pain Medicine

Patient Information

Title: Mr. Mrs. Miss Dr. Email:

Name: Birthday: Gender: M / F

Street Address: Suite/Apt #

City: State: Zip Code:

Home Phone: Mobile: Work:

Driver's License #: State Issued: SS Number:

Parent/ Spouse/ Guardian Details

Name: Date of Birth: Relation:

Address:

Phone: SS Number:

Primary insurance info:

Insurance Co:

Member ID:

Secondary insurance info:

Insurance Co:

Member ID:

Employer Details

Employer Name: Occupation: Employment Status:

Address: Phone:

Background Information

Marital Status: Married Single Divorced Widowed Separated Live-in

Preferred language:

Physician and Referral Details

Primary Physician: Phone:

Referring Physician/ Source:

Benjamin Dirkx, D.O

Please fill out this form in its entirety and fill in the bubbles completely.

PATIENT INFORMATION

Patient Name:		**Date:**
Date of Birth:	**Height:**	**Weight**
Referring Physician:	**Primary Care Physician:**	

I. What are you being seen for today? O Neck O Back O Other _____

II. Which side is affected? O Right O Left O Bilateral

Are you? O Left handed O Right handed

III. Date of Injury or start of pain: _____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this work related? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

IV. Pain Description

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other: _____

V. Pain Calculation: Questions A and B should total 100%

A. What percentage of your problem is due to back/neck pain?

O 0% O 25% O 50% O 75% O 100%

B. What percentage of your problem is due to leg/arm pain?

O 0% O 25% O 50% O 75% O 100%

VI. General Questions

How would you rate your pain? Place a circle on the pain level below:

No pain 0| 1 2 3 4 5 6 7 8 9 10 very severe pain

Have you had any change in bowel or bladder function? O Yes O No

Does your pain disrupt your sleep? O Yes O No

Does pain or weakness keep you from doing your regular activities? O Yes O No

Did you attend physical therapy for greater than 6 weeks? O Yes O No

Did you experience relief from physical therapy for greater than 3 weeks? O Yes O No

Does your pain radiate? O Yes O No If so, where _____

VII. Pain medications?

Anti-inflammatory agent O Yes O No Drug Name: _____

Pain Medication O Yes O No Drug Name: _____

Tylenol O Yes O No

Have you had any injections/epidurals? O Yes O No

How many in the last 12 months?_____ Date of most recent injection: _____

Did you get any relief? O Yes O No

If Yes, how much? O > 50% O > 80%

VIII. Have you had any testing? O MRI O EMG/NCS O X-ray O CT Scan

Medical History

Do you have or have you had:	Yes	No		Yes	No
Asthma/COPD	O	O	Cancer	O	O
Diabetes	O	O	High Blood Pressure	O	O
Acid Reflux Disease	O	O	Heart Attack	O	O
Osteoporosis	O	O	Hypertension	O	O
Emphysema	O	O	Seizures	O	O
Stroke	O	O	Arthritis	O	O
Gout	O	O	Thyroid Disease	O	O
Kidney Problems	O	O	Blood Clots	O	O

Social History

Marital status: O Single O Married O Widowed O Divorced

Do you smoke? O Yes O No O Have Previously

If yes,

How many packs/ day? O <1 O 1-2 O >2

How many years have you smoked? O 1-4 O 5-10 O >11

Do you consume alcohol? O Yes O No

How often do you consume alcohol? O Daily O Social O Never

Do you exercise regularly? O Yes O No

In the past did you consume alcohol? O Yes O No

Working status: O Full time O Part Time O Student O Unemployed

Family History

Father	O Arthritis	O Cancer	O Diabetes	O Stroke	O Heart Trouble	O Lung Disease
Mother	O Arthritis	O Cancer	O Diabetes	O Stroke	O Heart Trouble	O Lung Disease
Siblings	O Arthritis	O Cancer	O Diabetes	O Stroke	O Heart Trouble	O Lung Disease
Grandparents	O Arthritis	O Cancer	O Diabetes	O Stroke	O Heart Trouble	O Lung Disease

Review of Systems

Constitutional Fatigue O Yes O No