

**\*\*\*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](http://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.

**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:**

**Secondary insurance info:**

Insurance Co:	Insurance Co:
Member ID:	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

<b>Patient Name:</b>		<b>Date:</b>
<b>Date of Birth:</b>	<b>Height:</b>	<b>Weight:</b>
<b>Referring Physician:</b>		<b>Primary Care Physician:</b>

I. What are you being seen for today?  Neck  Back  Other \_\_\_\_\_

II. Which side is affected?  Right  Left  Bilateral  
Are you?  Left handed  Right handed

III. Date of Injury or start of pain: \_\_\_\_\_  
How did the pain occur?  Injury  Chronic  Spontaneous  
Is this work related?  Yes  No  
Is this the result of a motor vehicle accident?  Yes  No

IV. Pain Description  
Quality of your pain?  Mild  Moderate  Severe  
Type of pain?  Sharp  Dull  Other: \_\_\_\_\_

V. Pain Calculation: Questions A and B should total 100%  
A. What percentage of your problem is due to back/neck pain?  
 0%  25%  50%  75%  100%  
B. What percentage of your problem is due to leg/arm pain?  
 0%  25%  50%  75%  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?  Yes  No

Does your pain disrupt your sleep?  Yes  No

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

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

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

Does your pain radiate?  Yes  No If so, where \_\_\_\_\_

VII. Pain medications?  
Anti-inflammatory agent  Yes  No Drug Name: \_\_\_\_\_

Pain Medication  Yes  No Drug Name: \_\_\_\_\_

Tylenol  Yes  No

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

**How many in the last 12 months?** \_\_\_\_\_ **Date of most recent injection:** \_\_\_\_\_

**Did you get any relief?**  Yes  No

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