Northwest Neurosurgical Associates, LLC

Francisco X. Soldevilla, MD PHYSICIAN AND SURGEON

Ben Galloway, PA-C PHYSICIAN ASSISTANT

501 N. Graham St. MOB 2, Suite 445 Portland, OR 97227
(503) 885-8845 FAX (503) 885-8946 www.nwna.com

Dear Patient:

Enclosed is your packet of information for you appointment with Dr. Soldevilla or Ben Galloway, PA-C which is scheduled on : _____

PLEASE ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT TIME.

Complete ALL information and bring your insurance card or cards with you so that we may make a photo copy. We will, as a courtesy to you, bill your primary and secondary insurances. If your insurance company requires an incident report or additional information from you to process your claims, it is YOUR responsibility to comply with their request for such information. That way your claim can be processed and paid in a timely manner.

If your coverage is through a third party, motor vehical accident, or workman's compensation carrier, it is MANDATORY that you include your adjuster's name, phone number, claim nimber, date of injury/accident and mailing address. Should you have an attorney, also include their name and phone number.

IF YOU ARRIVE WITHOUT THIS INFORMATION, YOUR APPOINTMENT COULD BE CANCELLED OR RESCHEDULED.

Our appointments are scheduled well in advance and our schedules are full. If you need to change or cancel an appointment, please be courteous and call our office to make any changes. This needs to be done at least 72 hours in advance of your appointment.

Over the past years we have had a high number of no-show appointments which has translated to the delay of other new patients getting an appointment to see us. In an attempt to shorten the time for scheduling new patient appointments, we are instituting the following policy to more efficiently use our appointment times.

Our policy for no-show, missed, or late cancellation of appointments is a charge of $100 billed to the patient.

You may either call and speak to one of the office staff, or if after hours, leave a message with the answering service and they will notify us.

If you have any questions after receiving this packet, please call our office.

Thank you.
Patient Signature _____ Date _____

ACKNOWLEDGMENT & CONSENT

I understand that Northwest Neurosurgical Associates, LLC (referred to below as "This Practice") will use and disclose health information about me.I understand that my health information may include information both created and received by This Practice, may be in the form of written or electronic records, or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I understand and agree that This Practice may use and disclose my health information in order to:

* Make decisions about and plan for my care and treatment.
* Refer to, consult with, and coordinate among, and manage along with other health care providers for my care and treatment.
* Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
* Perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice and my rights regarding my health information.
I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be available in the examination room of This Practice.

I understand that I have the right to ask that some or all of my health information may not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.
By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient Signature _____ Date _____

Person/s who have my permission to discuss/access my medical information:

Name: Relationship:

_____ _____

_____ _____

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DATE: _____

NAME: _____ AGE: _____ WEIGHT: _____ HEIGHT: _____

REFERRING DOCTOR: _____ PRIMARY DOCTOR: _____

HISTORY OF PRESENT ILLNESS

When (month/year) did your spine problem first begin? _____

Under what circumstances did your pain begin?

Accident at work	[ ] Yes	[ ] No
Accident away from work	[ ] Yes	[ ] No
Motor Vehicle Accident	[ ] Yes	[ ] No
Sports	[ ] Yes	[ ] No
Unknown Cause	[ ] Yes	[ ] No

If your pain began from an injury at work, have you filed a Workers Compensation Claim? [ ] Yes [ ] No

If you were injured, did it involve:

Fall	[ ] Yes	[ ] No
Lifting object	[ ] Yes	[ ] No
Pushing	[ ] Yes	[ ] No
Struck by falling/moving object	[ ] Yes	[ ] No
Repetitive activity	[ ] Yes	[ ] No
Other	[ ] Yes	[ ] No

Did any of your present symptoms exist before your injury? [ ] Yes [ ] No

Please mark the sentence that best describes the effect of your condition/injury on your work:

[ ] I have missed no work because of this condition.
[ ] I have missed work, but I am now back at light duty.
[ ] I have missed work, but I am now back without limitation.
[ ] I have been off work since: (please give date) _____

Are your symptoms [ ] increasing [ ] decreasing [ ] staying the same

Is your pain: [ ] constant or [ ] intermittent

Do any of the following make your symptoms better? [ ] Laying down [ ] Sitting [ ] Standing [ ] Walking
[ ] Other _____

Do any of the following make your symptoms worse? [ ] Laying down [ ] Sitting [ ] Standing [ ] Walking
[ ] Other _____

Do you have any problems controlling your bowel and/or bladder? [ ] Yes [ ] No

Do you have any weakness? [ ] Yes [ ] No

If yes, label the pain diagram (page 2) where you are weak.

If yes, is it [ ] Increasing [ ] Decreaseing [ ] Staying the same

Do you have any numbness? [ ] Yes [ ] No

If yes, label the pain diagram (page 2) where you are numb.

If yes, is it [ ] Increasing [ ] Decreaseing [ ] Staying the same

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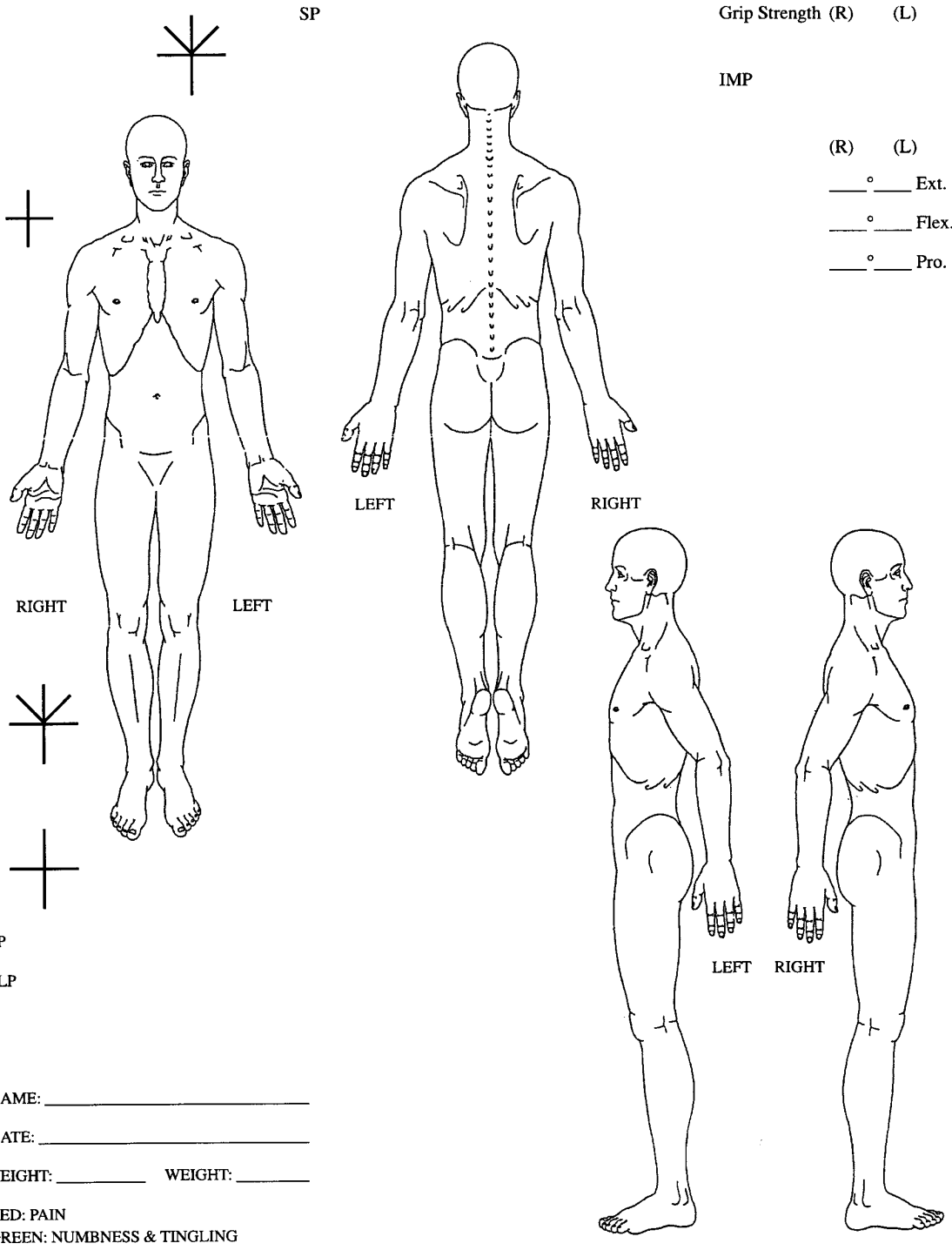
MARK THE LOCATION OF YOUR SYMPTOMS ON THE DIAGRAM BELOW.



NAME: _____

DATE: _____

HEIGHT: _____ WEIGHT: _____

RED: PAIN
GREEN: NUMBNESS & TINGLING

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Please Read: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage everyday activities. Please answer each section by circling to ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please just circle the one choice which closely describes your problem ***right now*** .

SECTION 1 -Pain Intensity
1. The pain comes and goes and is very mild.
2. The pain is mild and does not vary much.
3. The pain comes and goes, and is moderate.
4. The pain is moderate and does not vary much.
5. The pain is severe but comes and goes.
6. The pain is severe and does not vary much.

SECTION 2 -Personal Care
1. I have not changed my way of washing or dressing in order to avoid pain.
2. I do not normally change my way of washing or dressing even though it causes some pain.
3. Washing and dressing increase the pain, but I manage not to change my way of doing it.
4. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
5. Because of the pain, I am unable to so any washing and dressing without help.

SECTION 3 -Lifting
1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes extra pain.
3. Pain prevents me from lifting heavy weights off floor.
4. Pain prevents me from lifting heavy weights off floor, but I can manage if they are conveniently positioned.
5. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are convenient.
6. I can only lift very light weights, at the most.

SECTION 4 -Walking
1. Pain does not prevent me from walking any distance.
2. Pain prevents me from walking more than 1 mile.
3. Pain prevents me from walking more than 1/2 mile.
4. Pain prevents me from walking more than 1/4 mile.
5. I can only walk using a cane or crutches.
6. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 -Sitting
1. I can sit in any chair as long as I like without pain.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me from sitting more than 1 hour.
4. Pain prevents me from sitting more than 1/2 hour.
5. Pain prevents me from sitting more than 10 minutes.
6. Pain prevents me from sitting at all.

SECTION 6 -Standing
1. I can stand as long as I want without pain.
2. I have some pain while standing, but it does not increase with time.
3. I cannot stand for longer than 1 hour without increasing pain.
4. I cannot stand for longer than 1/2 hour without increasing pain.
5. I cannot stand for more than 10 minutes without increasing pain.
6. I avoid standing because it increases pain right away.

SECTION 7 -Sleeping
1. I get no pain in bed.
2. I get pain in bed, but it does not prevent me sleeping.
3. Because of pain, my normal night sleep is reduced by less than 1/4.
4. Because of pain, my normal night sleep is reduced by less than 1/2.
5. Because of pain, my normal night sleep is reduced by less than 3/4.
6. Pain prevents me from sleeping at all.

SECTION 8 -Social Life
1. My socail life is normal and gives me no pain.
2. My socail life is normal, but increases my pain.
3. Pain has no effect on my social life apart from limiting more energetic interests, e.g. dancing, ect.
4. Pain has restricted my social life and I do not go out very often.
5. Pain has restricted my social life to my home.

SECTION 9 -Traveling
1. I get no pain while traveling.
2. I get some pain traveling, but none of my usual forms of travel make the pain worse.
3. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
4. I get extra pain while traveling, which compels me to seek alternative forms of travel.
5. Pain restricts all forms of travel.
6. Pain restricts all forms of travel, except travel lying down.

SECTION 10 -Changing Degree of Pain
1. My pain is rapidly getting better.
2. My pain fluctuates, but overall is definitely getting better.
3. My pain seems to be getting better; slowly.
4. My pain is not getting better or worse.
5. My pain is gradually worsening.
6. My pain is rapidly worsening.

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Please list any doctors that you have seen for this spine problem.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Physical Therapy [ ] Never tried

[ ] Yes Last appointment: _____ Where: _____

What treatment was performed?

[ ] Exercises [ ] Stretching [ ] TENS unit [ ] Ultrasound [ ] Massage

[ ] Helpful [ ] Not helpful

Spine Injections [ ] Never tried

[ ] Yes Last injection: _____ Where: _____

[ ] Helpful [ ] Not helpful

Acupuncture [ ] Never tried

[ ] Yes Last treatment: _____ Where: _____

[ ] Helpful [ ] Not helpful

Chiropractics [ ] Never tried

[ ] Yes Last treatment: _____ Where: _____

[ ] Helpful [ ] Not helpful

Naturopath [ ] Never tried

[ ] Yes Last treatment: _____ Where: _____

[ ] Helpful [ ] Not helpful

Please list any spine surgeries. [ ] Never tried

1. _____

2. _____

3. _____

4. _____

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MEDICATIONS

Current **PAIN** Medications	Dose	# of pills in 24 hours	Prescribing Doctor
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Unprescribed pain medications [ ] Never tried

[ ] Marijuana [ ] Alcohol [ ] Cocaine [ ] Someone else's prescribed medication

[ ] Other: _____

Current **NON-PAIN** Medications	Amount	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently taking: [ ] Aspirin [ ] Motrin [ ] Aleve [ ] Any other anti-inflammatory

If yes, what anti-inflammatory: _____

Are you taking blood thinner: [ ] Coumadin [ ] Plavix [ ] Aggrenox [ ] Other: _____

Please list all medications that you are allergic to: [ ] None

Medication:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to iodine? [ ] Yes [ ] No

Are you allergic to tape? [ ] Yes [ ] No

Do you have any skin reactions to jewelry or metals? [ ] Yes [ ] No

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Medical History

[ ] GERD	[ ] Emphysema	[ ] Lung Disease
[ ] Heart Failure	[ ] Gout	[ ] Fibromyalgia
[ ] Asthma	[ ] Thyroid Disease	[ ] HIV
[ ] High Blood Pressure	[ ] Depression	[ ] Anxiety
[ ] Cancer	[ ] Diabetes	[ ] Other: _____

LUMBAR: Type of Surgery	Date	Surgeon	Helpful	
1. _____	_____	_____	[ ] Yes	[ ] No
2. _____	_____	_____	[ ] Yes	[ ] No
3. _____	_____	_____	[ ] Yes	[ ] No
4. _____	_____	_____	[ ] Yes	[ ] No

CERVICAL: Type of Surgery	Date	Surgeon	Helpful	
1. _____	_____	_____	[ ] Yes	[ ] No
2. _____	_____	_____	[ ] Yes	[ ] No
3. _____	_____	_____	[ ] Yes	[ ] No

Please check/list all operations: [ ] None

[ ] Appendectomy	Date:	[ ] Heart Surgery	Date:
[ ] Tonsillectomy	Date:	[ ] Hysterectomy	Date:
[ ] Gall Bladder Removal	Date:	[ ] Prostate Surgery	Date:
[ ] Knee Arthroscopy	Date:	[ ] Surgery for Cancer	Date:
[ ] Knee Replacement	Date:	Type:_____	
[ ] Hip Replacement	Date:		
[ ] Eye Surgery	Date:	Other [ ] _____	
		Other [ ] _____	
		Other [ ] _____	

Blood Products/Transfusions?

[ ] Yes, if necessary I am able to be transfused with blood products

[ ] No, if necessary I am NOT able to be transfused with blood products

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REVIEW OF SYMPTOMS

HEIGHT: _____ WEIGHT: _____

GENERAL

[ ] Weight gain [ ] Weight loss [ ] History of falls [ ] Dizziness
[ ] Fever [ ] Sweats [ ] Chills
[ ] Insomnia [ ] Snoring [ ] Hypersomnia (sleep all the time)

SKIN

[ ] Rash [ ] Change in mole [ ] Lumps [ ] Easy bruising
[ ] Itching [ ] Change in nails [ ] Dryness

EYES

[ ] Glasses [ ] Double vision [ ] Glaucoma [ ] Cataracts
[ ] Pain [ ] Discharge

EARS

[ ] Pain [ ] Hearing loss [ ] Hearing aid [ ] Deafness
[ ] Tinnitus (ringing) [ ]Discharge

NOSE

[ ] Runny nose [ ] Discharge [ ] Nose bleeds

MOUTH/THROAT

[ ] Difficulty swallowing [ ] Hoarseness [ ] Dentures [ ] Mouth sores
[ ] Dry mouth [ ] Bleeding

BREAST

[ ] Lumps [ ] Pain

RESPIRATORY

[ ] Dry cough [ ] Productive cough [ ] Bloody cough [ ] Tuberculosis
[ ] Shortness of breath [ ] Pain with breathing [ ] Pulmonary embolism [ ] Wheezing

HEART/BLOOD VESSEL

[ ] Heart attack [ ] Angina [ ] High blood pressure [ ] Murmur
[ ] Leg/foot swelling [ ] Varicose veins [ ] Rheumatic fever [ ] Blood clots

GASTROINTESTINAL

[ ] Abdominal pain [ ] Change in appetite [ ] Heartburn [ ] Constipation
[ ] Indigestion [ ] Nausea [ ] Vomiting [ ] Hepatitis
[ ] Diarrhea [ ] Change in bowel movements [ ] Hemorrhoids

UROLOGY

[ ] Painful urination [ ] Frequent urination [ ] Blood in urine [ ] Night time urination
[ ] Urgency [ ] Bladder infections [ ] Genital/STD infection

HEMATOLOGIC

[ ] Anemia [ ] Bleeding problem [ ] Transfusion reaction [ ] Transfusions

ALLERGIC/ENDOCRINE

[ ] Food allergies [ ] Hay fever

NEUROLOGIC/PSYCHIATRIC

[ ] Tremors [ ] Seizures [ ] Memory problems [ ] TIA
[ ] Stroke [ ] Headaches [ ] Emotional problems
[ ] Depression [ ] Anxiety [ ] ADD/ADHD

MEN

[ ] Difficulty with erection [ ] Vasectomy [ ] Prostate hypertrophy [ ] Prostate cancer

GYNECOLOGY

[ ] Menstrual problems [ ] Vaginal itching/discharge [ ] Endometriosis

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SOCIAL HISTORY

Current Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] N/A
Number of children: _____ Ages of children: _____

Living Status [ ] Alone [ ] With spouse [ ] With parents [ ] With roommate

[ ] Assisted living [ ] Nursing home

Occupation: _____ How Long: _____

Previous Occupation: _____

Highest Education Level: [ ] Grade school [ ] Middle school [ ] High school [ ] College [ ] Post Grad

Are you on any type of disability? [ ] Yes [ ] No

Do you use tobacco now or in the past? [ ] Yes, use now [ ] Never used
[ ] Previous user, Quit _____ years ago

Cigarettes	How many per day? _____	How many years? _____
Cigars	How many per day? _____	How many years? _____
Smokeless	How many per day? _____	How many years? _____
Nicotine	[ ] Patch [ ] Gum	How many years? _____

Do you drink alcoholic beverages? [ ] Yes, drink now [ ] Never drank
[ ] Previous drinker, Quit _____ years ago

Beer	How many per day? _____
Wine	How many per day? _____
Other	How many per day? _____

Have you ever felt the need to cut down on drinking?	[ ] Yes	[ ] No
Have you ever felt annoyed by criticism of your drinking?	[ ] Yes	[ ] No
Have you ever felt guilty about your drinking?	[ ] Yes	[ ] No
Have you ever felt the need for a morning eye-opener?	[ ] Yes	[ ] No
Have you ever had, or been treated for, a drug or alcohol dependency problem?	[ ] Yes	[ ] No

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FAMILY HISTORY

Father [ ] Alive [ ] Deceased at age _____ Mother [ ] Alive [ ] Deceased at age _____

Sibling 1 [ ] Alive [ ] Deceased at age _____ Sibling 4 [ ] Alive [ ] Deceased at age _____
Sibling 2 [ ] Alive [ ] Deceased at age _____ Sibling 5 [ ] Alive [ ] Deceased at age _____
Sibling 3 [ ] Alive [ ] Deceased at age _____ Sibling 6 [ ] Alive [ ] Deceased at age _____

Please check the box if anyone in your immediate family has any of the following conditions (note relationship).

[ ] Hypertension	Mother	Father	Sister	Brother
[ ] Heart Attack	Mother	Father	Sister	Brother
[ ] Diabetes	Mother	Father	Sister	Brother
[ ] Epilepsy	Mother	Father	Sister	Brother
[ ] Stroke	Mother	Father	Sister	Brother
[ ] Cancer	Mother	Father	Sister	Brother
Cancer Type:	[ ] Prostate		[ ] Lung	[ ] Breast
[ ] Skin	[ ] Colon		[ ] Other: _____	
[ ] Gout	Mother	Father	Sister	Brother
[ ] Kidney Disease	Mother	Father	Sister	Brother
[ ] Thyroid Disease	Mother	Father	Sister	Brother
[ ] Asthma	Mother	Father	Sister	Brother
[ ] Rheum. Arthritis	Mother	Father	Sister	Brother
[ ] Blood Disorder	Mother	Father	Sister	Brother

Does anyone in your family have a spine problem? [ ] Yes [ ] No

If YES: (please circle) Mother Father Sister Brother

Neck Low Back

Have they had surgery? [ ] Yes [ ] No