DR. AMIR VOKSHOOR

phone 310.574.0413 fax 310.574.0485

13160 Mindanao Way #300
Marina del Rey, CA 90292

7230 Medical Center Drive #503
West Hills, CA 91307

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Newport Beach, CA 92660

Re: New Patient Packet

To allow a thorough review of your information, please be sure you have included all your documents requested and that the new patient questionnaire is filled out completely. Upon completion, please fax back to 310.574.0485 or bring to your visit.

- A copy of ID and insurance card, front and back.
- MRI report and any other diagnostic reports i.e. EMG, CT Scan, etc.
- Epidural reports and /or operative reports, procedure reports
- Any medical records relevant to your spine concerns
- Please **BRING ALL FILMS/CD'S** with you on the day of your appointment.
- If **discussing surgery, please leave all your information with the surgery scheduler.** If you decide to take MRI, CT scan or X-ray, you are responsible to hand deliver back to office prior to your surgical date.

PRELIMINARY PATIENT APPOINTMENT/HISTORY/REGISTRATION SHEET

PLEASE PRINT CLEARLY **Date:** ____/____/_____

Referred To:

- ☐ Dr. Bray
- ☐ Dr. Khurana
- ☐ Dr. Melamed
- ☐ Dr. Vokshoor
- ☐ Dr. Port
- ☐ Dr. Vlachos
- ☐ D.I.S.C. Sports and Spine
- ☐

PATIENT NAME: _____
LAST FIRST

HOME ADDRESS: _____
STREET CITY STATE ZIPCODE

HOME PHONE: (____) ____-____ **FAX#:** (____) ____-____

WORK PHONE: (____) ____-____

CELL NO./PAGER: (____) ____-____ **EMAIL:** _____

DATE OF BIRTH: ____/____/_____ **SS#:** _____

SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

ETHNIC GROUP: ☐ CAUCASIAN ☐ BLACK ☐ ASIAN ☐ HISPANIC ☐ NATIVE AMERICAN ☐ OTHER:

RELIGIOUS PREFERENCE: _____

OCCUPATION: _____ **EMPLOYER NAME:** _____

EMPLOYER ADDRESS: _____
STREET CITY STATE ZIPCODE

EMPLOYER PHONE: _____ **EMERGENCY CONTACT:** _____

CONTACT PHONE AND RELATION TO YOU: _____

COMPLAINT: _____

☐ WORKERS' COMP (SEE PAGE 4) ☐ AUTO INJURY ☐ PERSONAL INJURY

PRIMARY INSURANCE: _____ ☐ HMO ☐ PPO ☐ POS

INSURANCE ADDRESS: _____
STREET CITY STATE ZIPCODE

INSURANCE PHONE: (____) ____-____ **GROUP#:** _____ **ID#:** _____

EFFECTIVE DATE: ____/____/_____ **COVERAGE CODE:** _____

SUBCRIBER'S NAME: _____
LAST FIRST

IF PATIENT IS NOT THE SUBSCRIBER:

DOB:____/____/____ **SS#:** (OF THE SUBSCRIBER) _____

SECONDARY INSURANCE: _____ ☐ HMO ☐ PPO ☐ POS

INSURANCE ADDRESS: _____
STREET CITY STATE ZIPCODE

INSURANCE PHONE: (____) ____-____ **GROUP#:** _____ **ID#:** _____

EFFECTIVE DATE: ____/____/____ **COVERAGE CODE:** _____

SUBCRIBER'S NAME: _____
LAST FIRST

MEDICARE#: _____ **PARTS B:** _____ **EFFECTIVE DATE:** ____/____/____ **PARTS A&B:** _____

PHYSICIAN INFORMATION

PATIENT NAME: _____ DATE: ____/____/_____
LAST FIRST

PLEASE PROVIDE THE DOCTOR WITH YOUR PHYSICIAN'S INFORMATION. WRITE DOWN AS MUCH INFORMATION YOU CAN PROVIDE, (I.E. NAME & CITY) SO THAT WE MAY KEEP THEM INFORMED OF YOUR PROGRESS.

REFERRING PHYSICIAN

PHYSICIAN NAME: _____
LAST FIRST

SPECIALTY: _____

PHYSICIAN ADDRESS: _____
STREET CITY STATE ZIPCODE

PHONE: (____) ____-____ *FAX: (____) ____-____

INTERNIST/PRIMARY CARE PHYSICIAN

PHYSICIAN NAME: _____
LAST FIRST

SPECIALTY: _____

PHYSICIAN ADDRESS: _____
STREET CITY STATE ZIPCODE

PHONE: (____) ____-____ *FAX: (____) ____-____

IF LEGAL CASE, PLEASE COMPLETE THE FOLLOWING INFORMATION:

ATTORNEY NAME: _____

ADDRESS: _____
STREET CITY STATE ZIPCODE

PHONE: (____) ____-____ *FAX: (____) ____-____

WORKERS' COMPENSATION INFORMATION (IF APPLIES)

INSURANCE: _____

ADDRESS: _____
STREET CITY STATE ZIPCODE

ADJUSTOR: _____ PHONE: (____) ____-____

CLAIM#: _____ DATE OF INJURY: ____/____/_____

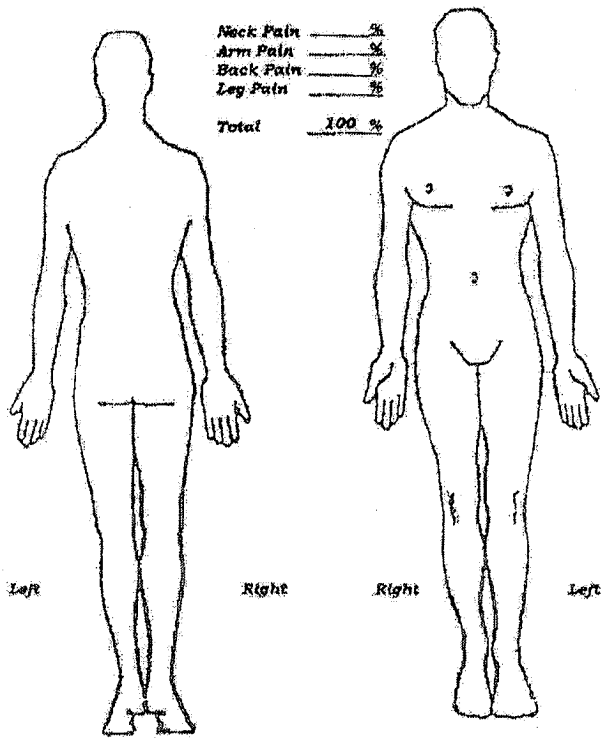
PLEASE USE THE BACK OF THIS FORM FOR ANY ADDITIONAL PHYSICIAN INFORMATION

ANY ADDITIONAL PHYSICIAN INFORMATION:

PAIN DESCRIPTION

Where is your pain right now?

Mark the areas on the body below where you feel the described sensations, using the appropriate symbols.
Mark the areas of radiation, including all affected areas.



Ache ^^^^^ ^^^^^

Numbness OOOOO OOOOO

Pins & Needles

Burning XXXXXX XXXXXX

Radiating Pain

How bad is your pain right now? (Indicate on the line.)

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

No Pain — Intermediate Pain — Worst Pain

I can tolerate my pain at a pain score of: _____

Please check the box that indicates the duration of your pain:

☐ Continuous ☐ Positional ☐ Intermittent (on/off) ☐ Unable to rate

_____ ___/___/_____

PATIENTS NAME DATE

PATIENT HISTORY

PATIENT NAME: _____ AGE: _____ DATE: ____/____/_____
LAST FIRST

REFERRED BY: _____ OCCUPATION: _____

1. WHEN DID SYMPTOMS FIRST START? _____ ARE THEY GETTING: ☐ WORSE ☐ BETTER ☐ STABLE

2. PLEASE DESCRIBE ALL PRESENT PAIN:
   a. BODY PARTS AFFECTED: _____
   _____
   b. TYPE OF PAIN: _____
   _____
   c. PAIN RADIATION (DESCRIBE): _____
   _____

3. PAIN RATING: PLEASE CIRCLE THE DEGREE OF PAIN YOU ARE CURRENT EXPERIENCING:

   0 5 10
   NO PAIN MODERATE PAIN SEVERE PAIN

4. PLEASE DESCRIBE ANY OTHER SYMPTOMS: _____
   _____
   _____

5. WHAT POSITION AND/OR MEDICATION RELIEVES YOUR PAIN? _____
   _____

6. DO YOU HAVE ANY PAIN, NUMBNESS, TINGLING OR WEAKNESS IN YOUR ARMS OR LEGS? PLEASE DESCRIBE: _____
   _____
   _____

7. ARE YOU PRESENTLY WORKING?

   ☐ FULL TIME ☐ PART TIME ☐ NOT PRESENTLY WORKING

   ☐ ON DISABILITY ☐ PARTIAL DISABILITY:

   IF YOU ARE ON DISABLITY/PARTIAL DISABILITY, WHEN DID IT BEGIN? _____

8. HAVE YOU HAD ANY TREATMENT (INCLUDING X-RAYS, TESTS, THERAPY, ETC.) OR SEEN ANY HEALTH PROVIDER FOR THIS INJURY? PLEASE DESCRIBE TREATMENT & TEST RESULTS: _____
   _____
   _____

9. HAVE YOU TRIED ANY HOME TREATMENTS OR MEDICATIONS? PLEASE DESCRIBE: _____

_____

10. PLEASE LIST PREVIOUS DIAGNOSIS AND TREATMENTS RECOMMENDED: _____

_____

11. PLEASE LIST ANY TEST YOU HAVE HAD IN THE PAST RELATED TO YOUR PROBLEM (MRI, X-RAY, ETC.):

TEST/STUDY	DATE	RESULT

12. HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY):

FATIGUE	HEARTBURN	NUMBNESS	CHEST PAIN
FAINTING	DIFFICULTY VOIDING	TINGLING	ULCERS
MEMORY LOSS	SHORTNESS OF BREATH	NERVOUSNESS	BOWEL PROBLEMS
DEPRESSION	SLEEP DIFFICULTY	LOSS OF APPETITE	EARLY AWAKENING
STRESS	WEAKNESS	URINARY INCONTINENCE	FACIAL PAIN
LOSS OF	ITCHING	NAUSEA	HEARING DIFFICULTY
CONCENTRATION	HEADACHES	VOMITING	

OTHER (PLEASE DESCRIBE): _____

13. ARE YOU RIGHT OR LEFT HANDED? ☐RIGHT ☐LEFT

14. ARE YOU PREGNANT? ☐ YES ☐ NO

15. PAST MEDICAL HISTORY: (PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD):

URINARY PROBLEMS	HEART DISEASE
PROBLEMS WITH EARS, EYES, NOSE, THROAT	RESPIRATORY
CIRCULATORY/CVA	PROBLEMS WITH ASTHMA, HAYFEVER
ARTHRITIS, GOUT	CANCER
LIVER PROBLEMS	HYPERTENSION
KIDNEY PROBLEMS	DIABETES, HYPOGLYCEMIA
DRUG ABUSE/ALCOHOL ABUSE	GATROINTESTINAL PROBLEMS, ULCERS
DEPRESSION OR PSYCHOLOGICAL PROBLEMS	

16. PLEASE EXPLAIN ANY OF THE ABOVE: _____

_____

17. HAVE YOU HAD ANY PRIOR SURGERIES? (PLEASE DESCRIBE): _____

_____

18. HAVE YOU HAD ANY PRIOR SPINE SURGERIES? ☐ YES ☐ NO IF YES, WHAT YEAR? _____

TYPE: _____

19. CURRENT MEDICAL STATUS:
ARE YOU CURRENTLY RECEIVING TREATMENT FOR ANY OTHER MEDICAL CONDITION? _____
_____

20. MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND THE DAILY DOSAGE:

MEDICATION	DOSAGE	DATE

21. ARE YOU TAKING ANY HERBAL OR VITAMIN SUPPLENTS? PLEASE LIST ALL HERBAL AND VITAMINS:
_____
_____
_____
_____

22. ARE YOU ALLERGIC TO ANY MEDICATIONS/FOODS/OTHER? DO YOU HAVE LATEX ALLERGY? PLEASE LIST:
_____
_____
_____
_____

23. FAMILY MEDICAL HISTORY:
   a. IS THERE A HISTORY OF SPINAL PROBLEMS IN YOUR FAMILY? ☐ YES ☐ NO
   b. IF YES, PLEASE DESCRIBE: _____
   c. IS THERE A FAMILY HISTORY OF OTHER MEDICAL PROBLEMS? (DESCRIBE): _____
   _____
   _____

24. SOCIAL HISTORY:
   a. AGE: _____ HEIGHT: _____ WEIGHT: _____ LBS/KGS (CIRCLE ONE) MARITAL STATUS _____
   b. CHILDREN: _____
   c. DO YOU SMOKE? IF SO, HOW MUCH? _____
   d. ALCOHOL INTAKE? IF SO HOW MUCH? _____
   e. IS THERE ANY HITORY OF ALCOHOL OR DRUG ABUSE? ☐ YES ☐ NO
   f. DESCRIBE USUAL PHYSICAL ACTIVITY/EXERCISE:
   TYPE: _____
   FREQUENCY: _____

ALTERNATE CONTACT INFORMATION &

RELEASE OF INFORMATION CONSENT FORM

Patient Name: _____ **Phone Number:** _____ (Home)

Patient Date of Birth: ____/____/_____ **Phone Number:** _____ (Other)

I. Alternate Contact Information Consent

D.I.S.C. Sport and Spine Center has my consent to:

Y N Leave medical information on *my* home answering machine.

Y N Leave medical information on *my* personal cell phone.

Y N Contact me at *my* place of employment.

Y N Leave medical information on voice mail at *my* place of employment.

Y N Leave medical information on *Family*, *Friends* or *Co-Workers* voice mail **(circle those that apply).**

Y N Leave/discuss medical information on *Family*, *Friends* or *Co-Workers* e-mail **(circle those that apply).**

(Messages will not be left on answering machines or voice mail if the recorded greeting does not include confirmation of your name or phone number.)

II. Family/Friends/Co-Workers Release of Information Consent

I Authorize D.I.S.C. Sport and Spine Center to discuss any information regarding my care with below-mentioned family member(s), friend(s) or co-worker(s).

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

_____ ____/____/_____

PATIENT OR PATIENT GAURDIAN'S SIGNATURE DATE

This Authorization is valid until revoked by the patient orally or in writing at any time. The exception is when communication has already occurred as instructed in this consent.

D.I.S.C. Sports and Spine Center
310.574.0400 phone · 310.574.0401 fax
Marina del Rey · Beverly Hills
www.discmdgroup.com

AUTOMOBILE INJURY HISTORY

PATIENT NAME: _____ DATE OF ACCIDENT: ____/____/_____
LAST FIRST

TIME: ____:____

WHERE DID ACCIDENT HAPPEN? _____

DESCRIBE ACCIDENT IN YOUR OWN WORDS: _____

_____

_____

_____

WHAT WAS YOUR POSITION IN CAR? ☐DRIVER ☐PASSENGER.

IF PASSENGER, WHERE WERE YOU SITTING? ☐ FRONT ☐ RIGHT REAR ☐LEFT REAR ☐ MIDDLE SEAT

DID YOUR VEHICLE STRIKE ANOTHER VEHICLE? ☐ YES ☐ NO

WAS YOUR CAR STRUCK BY ANOTHER VEHICLE? ☐ YES ☐ NO

WAS THE IMPACT FROM: ☐ THE FRONT ☐ THE RIGHT SIDE ☐ THE LEFT SIDE ☐ THE REAR

AT THE TIME OF IMPACT, WERE YOU: ☐ LOOKING STRAIGHT AHEAD ☐ LOOKING RIGHT ☐ LOOKING LEFT

WERE BOTH HANDS ON THE STEERING WHEEL? ☐ YES ☐ NO

WAS YOUR FOOT ON THE BRAKE? ☐ YES ☐ NO

WERE YOU BRACED FOR IMPACT? ☐ YES ☐ NO

WHERE IN THE CAR WERE YOU AFTER THE ACCIDENT? _____

WERE YOU WEARING A SEATBELT? ☐ YES ☐ NO

DID YOU STRIKE ANYTHING IN THE VEHICLE AT TIME OF IMPACT? ☐ YES ☐ NO

IF YES, SPECIFY: ☐STEERING WHEEL ☐DASHBOARD ☐WINDHIELD ☐SIDE DOOR ☐ARM REST ☐SIDE WINDOW

PLEASE STATE PART OF BODY: ☐CHEST ☐CHIN ☐KNEE ☐SHOULDER ☐HAND ☐HEAD

IMMEDIATELY FOLLOWING THE ACCIDENT, HOW DID YOU FEEL? _____

_____

WERE YOU UNCONSCIOUS? ☐YES ☐NO

IN A DAZE: ☐YES ☐NO

DID YOU GO TO THE HOSPITAL? ☐YES ☐NO

IF YOU WENT TO THE HOSPITAL, WHEN?

AT TIME OF ACCIDENT?: ☐YES ☐NO

HOW DID YOU GET TO HOSPITAL?

AMBULANCE: ☐YES ☐NO

PRIVATE TRANSPORTATION: ☐YES ☐NO

DID THE AMBULANCE ATTENDANTS PLACE YOU IN ANY OF THE FOLLOWING:

NECK COLLAR? ☐YES ☐NO SPLINTS?: ☐YES ☐NO BRACE?: ☐YES ☐NO

NAME OF HOSPITAL:_____

ATTENDED BY DR.:_____

WERE YOU X-RAYED AT THE HOSPITAL?: ☐YES ☐NO

IF SO, WHAT WAS THE DIAGNOSIS?

WERE YOU ADMITTED TO THE HOSPITAL? ☐YES ☐NO

HOW LONG DID YOU STAY?_____

WHAT TREATMENT DID YOU RECEIVE?_____

DESCRIBE SYMPTOMS FROM THE DAY FOLLOWING ACCIDENT TO TODAY'S DATE:_____

_____

WHAT RECOMMENDATIONS WERE MADE? SEE OWN DOCTOR: ☐YES ☐NO SEE SPECIALIST DR.?: ☐YES ☐NO

PHYSICAL THERAPY: ☐YES ☐NO

BEFORE THE INJURY WERE YOU CAPABLE OF WORKING ON AN EQUAL BASIS WITH OTHERS YOUR AGE? ☐YES ☐NO

ARE YOUR WORK ACTIVITIES RESTRICTED AS A RESULT OF THIS ACCIDENT? ☐YES ☐NO

ARE YOUR HOME ACTIVITIES RESTRICTED AS A RESULT OF THIS ACCIDENT? ☐YES ☐NO

IF YES GIVE PERCENTAGE OF RESTRICTION: _____%

DO YOU HAVE A COPY OF POLICE REPORT? ☐YES ☐NO IF YES, PLEASE BRING A COPY TO OUR OFFICE.

_____ ____/____/_____

SIGNATURE DATE

Marina del Rey.

D.I.S.C. Sports and Spine Center

310-574-0400 phone
310-574-0403 fax
866.481.DISC toll free

13160 Mindanao Way, Suite 300
Marina del Rey, CA 90292

Please be advised that because West Hills office is a satillite office, there is no direct line. Please call the main number for questions or concerns.