ATTENTION ADULT PATIENTS

PLEASE DO NOT BRING YOUR CHILDREN TO YOUR APPOINTMENT.

THIS CAUSES TOO MUCH MENTAL EXCITEMENT FOR OUR NEUROLOGICAL PATIENTS.

LOUD NOISES AND STIMULUS CAN HAVE DETREMENTAL AFFECTS ON OUR SEIZURE PATIENTS.

THIS IS WHY WE HAVE SEPARATE ADULT AND PEDIATRIC DAYS.

IF YOU DO BRING YOUR CHILDREN YOU MAY BE ASKED TO HAVE SOMEONE WAIT WITH THEM IN THE HALL UNTIL YOUR APPOINTMENT IS OVER.

THANK YOU!

COVENANT HealthCare

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

PF08139 (R 8/14)

PATIENT HEALTH HISTORY FORM

Covenant Neurosurgery
800 Cooper Ave., Ste. 8
Saginaw, MI 48602
Tel: (989) 752-1177
Fax: (989) 752-2923

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Social Security #: _____

Reason for Visit: _____

Please list all physicians you are under the care of:

Physician's Name: _____ Phone Number: _____

Physician's Name: _____ Phone Number: _____

Physician's Name: _____ Phone Number: _____

A. **This problem is the result of a(n):** *Check all that apply* Date of Injury: _____

☐ Motor Vehicle Accident ☐ Work Accident ☐ Accident

B. **Social History:** *Check all that apply*

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Spouse Name _____

Smoking: ☐ I smoke _____ pack of cigarettes per day for _____ years.

☐ I never smoked. ☐ I don't smoke now, but I smoked _____ packs for _____ years on the past.

(I quit smoking _____ years ago).

☐ I chew tobacco. ☐ I smoke cigars or a pipe.

Alcohol: ☐ I drink _____ (type and amount of alcohol)

☐ Daily ☐ 1 or More Times/Week ☐ 1 or More Times/Month

☐ 1 or More Times/Year

☐ I quit drinking alcohol _____ years ago.

☐ I never drink alcohol.

Illegal Drugs: ☐ I use _____ (type and frequency)

☐ I used _____ (type and frequency) in the past

☐ I never used illegal drugs.

C. **List Drug or Medication Allergies with type of Reaction** (Rash, Stop Breathing, Etc.)

☐ No known allergies

Medication	Reaction	Medication	Reaction

Have you had skin or other reactions to: *Check all that apply*

☐ Novocaine ☐ Tetanus Antitoxin ☐ Iodine

☐ IVP Dye ☐ Latex Rubber ☐ Shellfish

D. MAJOR ILLNESSES AND INJURIES ☐ **None**

E. Do you have any of the following medical problems? *Check all that apply*

	How Long?
☐ Cholesterol	
☐ Diabetes	
☐ High Blood Pressure	
☐ Cancer Where?_____	
☐ Stroke	
☐ Heart Trouble	
☐ Convulsions/Seizures/Epilepsy	
☐ MS	
☐ Parkinsons	
☐ Memory Loss	
☐ Headache	
☐ Dizziness	
☐ Other_____	

☐ **None of the Above**

F. SURGERIES/HOSPITALIZATIONS **YEAR** **COMPLICATIONS**

Have you ever had problems with anesthesia? ☐ Yes ☐ No

☐ **None**

G. Family Medical History:

Family Member	Alive/Dead	Age	Illnesses/Cause of Death
Father	☐ / ☐		
Mother	☐ / ☐		
Sister(s)	☐ / ☐		
	☐ / ☐		
Brother(s)	☐ / ☐		
	☐ / ☐		

H. CURRENT MEDICATIONS **DOSE** **HOW OFTEN**

Are any of your medications blood thinners? ☐ Yes ☐ No

☐ **I do not take any prescription/over the counter medications.**

I. Do you have any of the following? *Check all that apply*

GENERAL

- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Night Sweats
- ☐ **None**

EYES

- ☐ Wear Glasses/Contacts
- ☐ Eye Infections
- ☐ Eye Injuries
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ **None**

EARS/NOSE/THROAT/MOUTH

- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Ear Pain
- ☐ Wearing Hearing Aides
- ☐ Ear Infections
- ☐ Balance Problems
- ☐ Sinus Infections
- ☐ Nose Bleeds
- ☐ Inability to Smell
- ☐ Sinus Headaches
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath
- ☐ Bad Taste in Mouth
- ☐ Sore Throat
- ☐ Voice Change
- ☐ Swollen Glands in Neck
- ☐ **None**

HEART/CARDIOVASCULAR

- ☐ Chest Pain or Angina
- ☐ Irregular Pulse or Palpitations
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Swelling of Hands
- ☐ Swelling of Feet or Ankles
- ☐ Shortness of Breath with Walking/Lying Flat
- ☐ Leg Pain with Walking
- ☐ **None**

BREATHING/RESPIRATORY

- ☐ **None**
- ☐ Frequent Cough
- ☐ Chronic Cough
- ☐ Spitting up Blood
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Wheezing

STOMACH/BOWELS/GASTROINTESTINAL

- ☐ Loss of Appetite
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Heartburn
- ☐ Ulcer
- ☐ Gastritis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Pain with Bowel Movement
- ☐ **None**
- ☐ Liver Disease
- ☐ Rectal Bleeding or Blood in Stool
- ☐ Jaundice

GENITOURINARY

- ☐ Frequent Urination
- ☐ Burning with Urination
- ☐ Pain with Urination
- ☐ Blood in Urine
- ☐ Change of force of Stream with Urinating
- ☐ Kidney Stones
- ☐ Incontinence or Dribbling
- ☐ Sexual Difficulty
- ☐ Urinary Tract Infections

Males

- ☐ Testicle Pain
- ☐ Prostate Problems

Females

- ☐ Pain with Periods
- ☐ Irregular Periods
- ☐ Vaginal Discharge
- # of Pregnancies_____
- # of Miscarriages_____
- ☐ Currently Pregnant
- Date of last Menstrual Period_____
- ☐ **None**

MUSCLES AND BONES/MUSCULOSKELETAL

- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Weakness of Muscles
- ☐ Weakness of Joints
- ☐ Muscle Pain
- ☐ Back Pain
- ☐ Muscle Spasms or Cramps
- ☐ Difficulty Walking
- ☐ Coldness in Arms or Legs
- ☐ **None**

SKIN/BREAST/INTEGUMENTARY

- ☐ Rash
- ☐ Itching
- ☐ Varicose Veins
- ☐ Change in Skin Color
- ☐ Change in Hair or Nails
- ☐ **None**
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge

NEUROLOGICAL

- ☐ Frequent Headaches
- ☐ Convulsions/Seizures
- ☐ Paralysis
- ☐ Speech Problems
- ☐ Lightheaded or Dizzy
- ☐ Numbness
- ☐ Stroke
- ☐ Coordination Problems
- ☐ Tremors
- ☐ Tingling
- ☐ Head Injury
- ☐ Face Weakness
- ☐ **None**

MENTAL/PSYCHIATRIC

- ☐ Confusion
- ☐ Depression
- ☐ Memory Loss
- ☐ Insomnia
- ☐ Nervousness
- ☐ **None**

GLANDS/ENDOCRINE

- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Heat or Cold Intolerance
- ☐ Thyroid Disease
- ☐ Excessive Urination
- ☐ Change in Hat or Glove Size
- ☐ Hormone Problems
- ☐ Skin becoming Dryer
- ☐ **None**

BLOOD/INFECTION HEMATOLOGIC/LYMPHATIC

- ☐ Slow to Heal after Cuts
- ☐ Anemia
- ☐ Persistent Swollen Glands
- ☐ Bleeding Tendencies
- ☐ Plebitis
- ☐ Bruises Easily
- ☐ Past Transfusions
- ☐ **None**

ALLERGIC/IMMUNOLOGIC

☐ Cancer Where _____ Treatment _____

List Food Allergies _____

List Environmental Allergies _____

(Dust, Pollen, Molds, Etc.)_____

☐ None

I certify that the above information is complete and correct to the best of my knowledge:

_____ _____

Name of Person Completing Form | Relationship to Patient

_____ _____

Signature of Person Completing Form | Date

Note: This is a confidential record and will be kept in our office. Information contained here will not be released to anyone other than your doctor without your authorization.

COVENANT HealthCare

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

CONSENT/PATIENT INFORMATION

PF02996 (2/11)

PATIENT I.D. _____

Patient Full Legal Name: _____ Photo ID: y/n _____

Date of Birth: _____ Soc Sec #: _____ Patient Sex: _____ Male _____ Female

Address: _____ Marital Status: S / M / D / W

City, State, Zip: _____ Ethnicity: _____

Telephone: _____ Preferred Language: _____

Cell Phone#:(_____) _____ Race: White / Black / Hispanic / Asian / Other

Email Address: _____

Contact Person Other than Home: _____ Telephone #: (_____) _____ - _____

Patient Employer: _____ Employer Telephone: _____

Employer Address: _____ Date of Retirement: _____

Student:Full Time: _____ Part Time: _____ Parent/Guardian: _____

Family Doctor: _____ ReferringDoctor: _____

Pharmacy _____ Location: _____

BILL TO:Self___Parent/Guardian___Work comp___Auto___Insured Name & Date of Birth _____

Primary Insurance: _____ Secondary Insurance: _____

Spouse Name: _____ Spouse Employer: _____

Spouse Date of Birth: _____ Employer Address: _____

Spouse Soc. Sec. #: _____ - _____ - _____ Date of Retirement: _____

AUTHORIZATION FOR MEDICAL INSURANCE BENEFITS

1) I assign payment to be made on my behalf to Covenant Healthcare.
2) I also authorize Covenant Healthcare to furnish information necessary for claims processing to any insurance carrier concerning my illness and treatments.
3) A universal claim form will be completed to help expedite insurance carrier payment.
4) I understand that all professional services will be charged to the patient for insurance other than our participating carriers.
5) Payment of the account is the patientís direct responsibility and I am responsible for any non-paid services.
6) Payment for services are due when rendered unless other arrangements have been made in advance with our billing staff.

_____ _____

Date Patient Signature/Guardian

COVENANT HealthCare

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

PF08203 (R 12/04)

ACKNOWLEDGMENT/ RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT I.D.

I acknowledge, by signing below, that I have received a copy of the Covenant HealthCare **Notice of Privacy Practices**.

_____
Name

_____
Signature

Date:____/____/____

Covenant HealthCare Staff Use Only

Acknowledgment Received:_____/_____/_____

Reason Acknowledgment **was not** Received:

☐ I have previously received the Notice of Privacy Practices.

☐ Other, explain:

_____

_____

_____

Covenant HealthCare Staff _____
(Signature)

COVENANT
Neurosurgery

Authorization for Release of Information

This may include your spouse, children, siblings, caregiver, etc

Date:_____

I, _____, give Covenant Neurosurgery permission to release and/or discuss my medical information with the following people:

Name:_____

Relationship:_____Phone:_____

Name:_____

Relationship:_____Phone:_____

Name:_____

Relationship:_____Phone:_____

I, _____, give consent to the office listed above to identify themselves and leave messages on the answering machines/voice mails attached to the phone numbers I have listed as my contact numbers. I understand that the messages may include information on dates of future appointments and/or test results.

_____ _____ _____

Patient Signature * Date of Birth Date

_____ _____

Witness Date

COVENANT HealthCare

MSSIC Data Registry
Lumbar Baseline
Patient Questionnaire

MICHIGAN SPINE SURGERY IMPROVEMENT COLLABORATIVE

Patient Name (please print): _____ **Date of Birth:** _____

Date of Questionnaire: _____

We ask that you please complete this form as fully and accurately as possible. Some questions may be difficult, but we ask that you answer them to the best of your ability. Please be sure to follow the directions in each section. Clearly print responses and mark boxes where needed.

Thank you for your time filling out this questionnaire, your answers will help us to provide the best possible spine care.

Back & Leg Pain Scale

Please describe your back and leg pain when off your pain medication. Please rate your back pain and leg pain on a scale of 0 to 10, where zero (0) would mean "no pain" and a ten (10) would mean "worst pain imaginable."

For example, describe your pain when you are off your medication, after your pain medication has worn off, when you are due to take your next pill, that is please describe how your pain would feel if you were not on pain medication.

Please rate your back pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

Now, please rate your leg pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

Oswestry Disability Index (ODI)

This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life.

Please answer every section. Mark one box only in each section that most closely describes you today.

Section 1 - Pain intensity

0 ☐ I have no pain at the moment
1 ☐ The pain is very mild at the moment
2 ☐ The pain is moderate at the moment
3 ☐ The pain is fairly severe at the moment
4 ☐ The pain is very severe at the moment
5 ☐ The pain is the worst imaginable at the moment

Section 2 - Personal care (washing, dressing, etc.)

0 ☐ I can look after myself normally without causing extra pain
1 ☐ I can look after myself normally but it is very painful
2 ☐ It is painful to look after myself and I am slow and careful
3 ☐ I need some help but manage most of my personal care
4 ☐ I need help every day in most aspects of self-care
5 ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting

0 ☐ I can lift heavy weights without extra pain

1 ☐ I can lift heavy weights but it gives extra pain

2 ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table

3 ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned

4 ☐ I can lift only very light weights

5 ☐ I cannot lift or carry anything at all

Section 4 - Walking

0 ☐ Pain does not prevent me walking any distance

1 ☐ Pain prevents me walking more than one mile

2 ☐ Pain prevents me walking more than a quarter of a mile

3 ☐ Pain prevents me walking more than 100 yards

4 ☐ I can only walk using a stick or crutches

5 ☐ I am in bed most of the time and have to crawl to the toilet

Section 5 - Sitting

0 ☐ I can sit in any chair as long as I like

1 ☐ I can sit in my favorite chair as long as I like

2 ☐ Pain prevents me from sitting for more than 1 hour

3 ☐ Pain prevents me from sitting for more than half an hour

4 ☐ Pain prevents me from sitting for more than 10 minutes

5 ☐ Pain prevents me from sitting at all

Section 6 - Standing

0 ☐ I can stand as long as I want without extra pain

1 ☐ I can stand as long as I want but it gives me extra pain

2 ☐ Pain prevents me from standing for more than 1 hour

3 ☐ Pain prevents me from standing for more than half an hour

4 ☐ Pain prevents me from standing for more than 10 minutes

5 ☐ Pain prevents me from standing at all

Section 7 – Sleeping

0 ☐ My sleep is never disturbed by pain
1 ☐ My sleep is occasionally disturbed by pain
2 ☐ Because of pain I have less than 6 hours sleep
3 ☐ Because of pain I have less than 4 hours sleep
4 ☐ Because of pain I have less than 2 hours sleep
5 ☐ Pain prevents me from sleeping at all

Section 8 - Sex life (if applicable)

0 ☐ My sex life is normal and causes no extra pain
1 ☐ My sex life is normal but causes some extra pain
2 ☐ My sex life is nearly normal but it is very painful
3 ☐ My sex life is severely restricted by pain
4 ☐ My sex life is nearly absent because of pain
5 ☐ Pain prevents any sex life at all

Section 9 - Social life

0 ☐ My social life is normal and causes me no extra pain
1 ☐ My social life is normal but increases the degree of pain
2 ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc.
3 ☐ Pain has restricted my social life and I do not go out as often
4 ☐ Pain has restricted social life to my home
5 ☐ I have no social life because of pain

Section 10 - Traveling

0 ☐ I can travel anywhere without pain
1 ☐ I can travel anywhere but it gives extra pain
2 ☐ Pain is bad but I manage journeys over two hours
3 ☐ Pain restricts me to journeys of less than one hour
4 ☐ Pain restricts me to short necessary journeys under 30 minutes
5 ☐ Pain prevents me from traveling except to receive treatment

****

FOR OFFICE USE

Date _____ / _____ / _____

Score _____ / _____ X 100 = _____%

Name:_____ Date of Birth:_____

Quality of Life (EQ-5D)

By marking one box in each group below, please indicate which statements best describe your own health state today.

Mobility

- ☐ I have no problems in walking about
- ☐ I have some problems in walking about
- ☐ I am confined to bed

Self-Care

- ☐ I have no problems with self-care
- ☐ I have some problems washing or dressing myself
- ☐ I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- ☐ I have no problems with performing my usual activities
- ☐ I have some problems with performing my usual activities
- ☐ I am unable to perform my usual activities

Pain/Discomfort

- ☐ I have no pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have extreme pain or discomfort

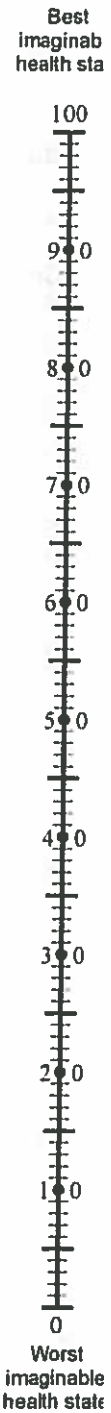
Anxiety/Depression

- ☐ I am not anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am extremely anxious or depressed

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by choosing a number on the scale to indicate how your health is TODAY.

Now, please enter the number you chose on the scale in the box provided (0 through 100): _____



Do you participate in activities outside the home (i.e. gardening, golf, walking, cycling, volunteering)?

☐ Yes ☐ No

If "Yes":

Would you describe your activity as....

☐ Sedentary or Light ☐ Moderate ☐ Strenuous

Do you participate in activities inside the home (vacuuming, cooking, general housework)?

☐ Yes ☐ No

If "Yes":

Would you describe your activity as...

☐ Sedentary or Light ☐ Moderate ☐ Strenuous

Do you plan on returning to your previous activity?

☐ Yes ☐ No

On a daily basis, do you generally walk...

☐ Independently
☐ With an assistive device (cane or walker)
☐ Do not walk (wheelchair bound)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
   ☐ Not at all
   ☐ Several days
   ☐ More than half the days
   ☐ Nearly every day

2. Feeling down, depressed, or hopeless
   ☐ Not at all
   ☐ Several days
   ☐ More than half the days
   ☐ Nearly every day

Do you have a history of....

Smoking

- ☐ Current every day smoker
- ☐ Current some days smoker
- ☐ Former smoker
- ☐ Never smoked
- ☐ Prefer not to answer

Diabetes

- ☐ No
- ☐ Yes, Type I
- ☐ Yes, Type II - Insulin dependent
- ☐ Yes, Type II - Non-insulin dependent

Coronary Artery Disease (CAD)

☐ Yes ☐ No

Osteoporosis

☐ Yes ☐ No

Anxiety Disorder

☐ Yes ☐ No

Depression Disorder

☐ Yes ☐ No

Did you ever have a blood clot (deep venous thrombosis)?

☐ Yes ☐ No

Has your doctor ever told you that you have a tendency to form blood clots?

☐ Yes ☐ No

Do you take opioid painkillers ***daily*** to control your pain? (prescription medications such as Vicodin, Lortab, Norco, hydrocodone, codeine, Tylenol #3 or #4, fentanyl, Duragesic, MS Contin, Percocet, Tylox, OxyContin, oxycodone, methadone, tramadol, Ultram, Dilaudid)

☐ Yes ☐ No

If "Yes":

How long have you been using opioid painkillers on a daily basis?

- ☐ Less than 3 weeks
- ☐ 3 weeks but less than 6 weeks
- ☐ 6 weeks but less than 3 months
- ☐ 3 months but less than 6 months
- ☐ 6 months or greater

Is this spinal injury related to...

Was your spinal injury caused by a motor vehicle injury?

☐ Yes ☐ No ☐ Unknown

Workers Compensation Claim

☐ Yes ☐ No ☐ Undecided ☐ Prefer not to answer

Liability or Disability Insurance Claim

☐ Yes ☐ No ☐ Undecided ☐ Prefer not to answer

Are you working?

☐ Yes - Full-time
☐ Yes - Part-time
☐ No
☐ Retired
☐ Volunteering
☐ On disability

If "Yes - Part-time"

Is the part-time status because of your neck or back problems?

☐ Yes ☐ No

If "Yes" Either "Full-time" or "Part-time":

Would you say your job was...

☐ Sedentary
☐ Light
☐ Medium
☐ Heavy

Does your job require you to stand up to 6 hours per day?

☐ Yes ☐ No

Does your job require you to lift ...

☐ Frequently more than 50 pounds
☐ Frequently more than 25 pounds and occasionally 50 pounds
☐ Frequently 10 pounds and occasionally 25 pounds
☐ Occasionally up to 10 pounds

Regardless of your current work status, do you plan to return to work after your surgery?

☐ Yes ☐ No ☐ Unknown

*If "Are you working?" is "**Retired**":*

Are you retired because of your back or neck problems?

☐ Yes ☐ No

*If "Are you working?" is "**No**":*

Are you not working because of your back or neck problems?

☐ Yes ☐ No

Additional Information...

Race/Ethnicity

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ American Indian
- ☐ Unknown/Refused
- ☐ Other

Level of Education

- ☐ Less than High School
- ☐ High School Diploma or GED
- ☐ Two-Year College Degree
- ☐ Four-Year College Degree
- ☐ Post-College

What is your preference for future contact for this study?

- ☐ E-mails with access to web-based questionnaires

  E-mail address: _____
- ☐ Telephone calls with questionnaires by interview process

  Phone number: _____
- ☐ Mailings with paper questionnaires to be returned