



The Spine Clinic of Los Angeles

1245 Wilshire Boulevard, Suite # 717
Los Angeles, California 90017

213.481.8500 (o) 213.481.8555 (f)
www.laspineclinic.com
patients@laspineclinic.com

Dear Esteemed Patient:

Thank you for choosing to make an appointment at The Spine Clinic of Los Angeles located at 1245 – Wilshire Blvd., Suite 717 in Los Angeles

Please be sure to bring the following to your appointment:

- Your most current diagnostic films and reports** (e.g. MRI, CT, plain x-rays; SSEP or EMG reports; Physical Therapy reports; Pain Medicine reports, etc.) pertaining to your current medical condition. **(PLEASE NOTE: If your Films were done within the Good Samaritan system at Santa Monica or Westwood, our office will make sure that they are here for your visit and you do not need to pick up these films. However, if you had films done outside of UCLA, you do need to bring these with you).**
- Prior medical records and consultations** from your referring physician and any other specialist you've seen for your current condition. To help expedite your visit, please hand carry your reports to this office. Do not send them prior to your appointment.
- Your medical insurance card (s)**
- If you have HMO Insurance: **Please be sure to bring your "Letter of Authorization: from your HMO.** If you do not bring your authorization letter and we do not have written authorization on file, you will be financially responsible and will be asked to pay the consultation fee on the day of your appointment.
- If you have HMO or PPO Insurance: **Please be sure to bring your co-payment with you.** We accept cash, check, or Visa/ Mastercard / American Express.

Attached you will find a questionnaire and a map with directions to our location. Please bring in the completed paperwork to your appointment. If you have any questions, please feel free to contact The Spine Clinic of Los Angeles at (213) 481-8500. We look forward to seeing you.

PLEASE NOTIFY US OF ANY CANCELLATIONS AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT

On your initial visit, Larry Khoo, MD, Director of The Spine Clinic located in Los Angeles and Spinal Neurosurgeon, will see you. He will, with or without a Physician's Assistant and / or Spine Fellow and / Medical Student, obtain a medical history and perform a physical examination. The Spine Clinic of Los Angeles advocates a multi-disciplinary approach to strive and attain the best possible healing and recovery for every patient. Because every patient is unique, we prescribe treatment based on a thorough evaluation, which we perform utilizing the latest technological advancements available. We believe in evaluating patients promptly and educating them on their diagnosis, so they can play an active role in the decision-making and treatment process. Our physician; clinical experience has shown us that patients who participate in their own health care decisions are far more likely to achieve an optimal level of healing and recovery.

Sincerely,

The Spine Clinic of Los Angeles Team

Referring Physicians, Other Physicians involved in Medical Care

| |
|-----------------|
| Physician Name: |
| Specialty: |
| Address |
| |
| |
| |
| |
| Phone Number: |
| FAX Number |

| |
|-----------------|
| Physician Name: |
| Specialty: |
| Address |
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| Phone Number: |
| FAX Number |

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|-----------------|
| Physician Name: |
| Specialty: |
| Address |
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| |
| Phone Number: |
| FAX Number |

Please tell us about surgical procedures you have had before.

| Previous operations | Dates | Any Problems (y/n?) |
|---------------------|-------|---------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please tell us about any other medical problems you may have (examples: hypertension, diabetes, stroke, cancer, etc.)

| Medical Issue | How Long | Any Treatment? When? |
|---------------|----------|----------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Do you smoke? Y / N How many packs per day? _____ For how many years? _____
Do you drink? Y / N What do you drink? _____ How often? _____

| | | |
|-----------------------------|--------------------------------|-------------------------|
| { Y / N } Osteoporosis | { Y / N } Rheumatoid Arthritis | { Y / N } Cancer |
| { Y / N } Recent Infections | { Y / N } HIV/AIDS | { Y / N } Hepatitis |
| { Y / N } Heart Attacks | { Y / N } Chest Pain | { Y / N } Lung Problems |

Family History: Parents, Grandparents, Siblings (alive or deceased; list age at date of death and cause)

| |
|-------|
| _____ |
| _____ |
| _____ |

Please tell us ALL medications , pain pills, aspirins, or supplements you are taking or have recently taken.

| Medication | Strength/Amount | How many pills and times per day? |
|------------|-----------------|-----------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| | |
|--------------------------|-----------------|
| Allergies to medications | Other allergies |
| _____ | _____ |
| _____ | _____ |

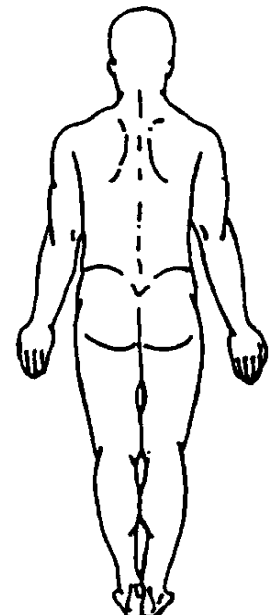
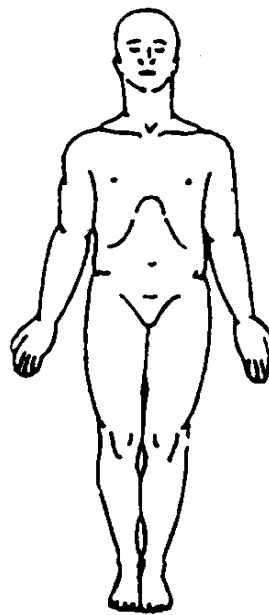
Please list all recent X-rays, CTs, MRIs, or other studies you have had for your problem. (dates/where)

| |
|-------|
| _____ |
| _____ |
| _____ |

Are you claustrophobic to scans? Y/ N Have you required sedation in the past? Y/ N

Implants (i.e. stimulators, medication pumps, metal (titanium or steel), include location of implant)

| |
|-------|
| _____ |
|-------|



Please help us better understand the pain that you are experiencing.

Indicate the locations of your pain by shading in the painful areas on these figures >>

1. Please indicate the **current** intensity of your pain by making an X anywhere on the line below:

NO PAIN

THE MOST INTENSE PAIN IMAGINABLE

2. Please indicate the **worst** intensity of your pain over **the past month** by making an X anywhere on the line below:

NO PAIN

THE MOST INTENSE PAIN IMAGINABLE

3. Please indicate your **mood** over **the past month** by making an X anywhere on the line below:

EXTREMELY GOOD MOOD

EXTREMELY BAD MOOD

4. Please rate how **often** your pain problem **stopped you** from doing what you wanted to do over **the past month**:

DID NOT STOP ME

COMPLETELY STOPPED ME

5. Please indicate how many **days per week** you have had **adequate** relief of your pain over **the past month** (by circling a number):

0 1 2 3 4 5 6 7

6. If you are taking pain medications, please indicate the **amount of relief** you receive after taking your medication by making an X anywhere on the line below:

NO RELIEF

COMPLETE RELIEF

7. Overall, how satisfied are you with the results of your pain treatment? (circle your response)

| | | | | | | | |
|---------------------|----------------|--------------------|-------|-----------------------|-------------------|------------------------|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| extremely satisfied | very satisfied | somewhat satisfied | mixed | somewhat dissatisfied | very dissatisfied | extremely dissatisfied | |

8. Circle all the words that describe your pain this month:

| | | | | | | | |
|--------|-----------|------------|-----------|-----------|-----------|----------|--------|
| Aching | Throbbing | Shooting | Stabbing | Gnawing | Fearful | Sharp | Tender |
| Heavy | Burning | Exhausting | Splitting | Punishing | Sickening | Cramping | |

REVIEW OF SYSTEMS



Please tell us if you are experiencing any of the following:

Allergies

- } Asthma
- } Hay Fever
- } Skin eruptions

Cardiovascular

- } Chest Pain
- } Irregular heart beat
- } High/low blood pressure
- } Poor circulation
- } Rapid heart beat
- } Swelling of ankles
- } Varicose veins

Constitutional

- } Chills/sweats/fever
- } Fainting
- } Forgetfulness
- } Headache
- } Loss of sleep
- } Nervousness
- } Weight loss

Ears, Nose, Mouth, Throat

- } Bleeding gums
- } Difficulty swallowing
- } Earache
- } Ear discharge
- } Hearing loss
- } Hoarseness
- } Nosebleeds
- } Persistent cough
- } Ringing in ears
- } Sinus problems

Endocrine

- } Spontaneous nipple discharge
- } Intolerance to warm room
- } Multiple broken bones
- } Cessation of menstrual period
- } Excessive hunger/thirst
- } Loss of libido

Eyes

- } Blurred vision
- } Crossed eyes
- } Double vision
- } Vision flashes or halos

Genitourinary

- } Blood in urine
- } Lack of bladder control
- } Painful urination

Gastrointestinal

- } Bloating
- } Bowel changes
- } Constipation
- } Diarrhea
- } Gas
- } Hemorrhoids
- } Indigestion
- } Nausea
- } Poor appetite
- } Rectal bleeding
- } Stomach pain

Hematologic/Lymphatic

- } Swollen lymph nodes
- } Easy skin bruising
- } Prolonged bleeding

Integumentary

- } Skin rashes or eruptions
- } Chronic skin itching

Men

- } Breast lump
- } Lump in testicle
- } Penis discharge
- } Sore on penis

Musculoskeletal

- } Pain, weakness numbness, swelling in:
} Hands, wrists, hips, knees, or joints

Neurological

- } Fainting
- } Headache
- } Numbness of arms or legs
- } Seizures
- } Tingling of hands, feet
} arms or legs

Psychiatric

- } Anxiety
- } Depression
- } Panic attacks
- } Restlessness

Respiratory

- } Blood
- } Cough
- } Dizziness
- } Shortness of breath

Women

- } Abnormal pap smear
- } Bleeding between periods
- } Breast lump
- } Extreme menstrual pain
- } Hot flashes
- } Nipple discharge
- } Painful intercourse

Last period _____

Last pap smear _____

Last mammogram _____

Are you pregnant? _____

of children (ages) _____

Signature _____



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How long have you had back/neck pain? _____ years _____ months _____ weeks
How long have you had leg/arm pain? _____ years _____ months _____ weeks

Please help us understand about the activity of your life right now: We realize you may consider that two of the statements in any one section relate to you, but please mark only the box that most closely describes your problem. Do not skip any sections. Once completed – PLEASE RETURN TO SCLA VIA FAX, MAIL, EMAIL.

Section 1: Pain intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

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

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

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift only very light weights
- I cannot lift or carry anything at all

Section 4: Walking

- Pain does not prevent me from walking any distance
- Pain prevents me from walking more than one mile
- Pain prevents me from walking more than a quarter of a mile
- Pain prevents me from walking more than 100 yards
- I can only walk using a cane or crutches
- I am in bed most of the time and have to crawl to the toilet

Section 5: Sitting

- I can sit in any chair as long as I like
- I can sit in my favorite chair as long as I like
- Pain prevents me from sitting for more than 1 hour
- Pain prevents me from sitting for more than half an hour
- Pain prevents me from sitting for more than 10 minutes
- Pain prevents me from sitting at all

Please help us understand about the activity of your life right now: We realize you may consider that two of the statements in any one section relate to you, but please mark only the box that most closely describes your problem. Please do not skip any sections.

Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than half an hour
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7: Sleeping

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

Section 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9: Social Life

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

Section 10: Traveling

- I can travel anywhere without pain
- I can travel anywhere but it causes extra pain
- Pain is bad but I manage journeys over 2 hours
- Pain restricts me to journeys of less than 1 hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment