Rochester
BRAIN & SPINE

Welcome to our practice!

You are scheduled to be seen at _____ am / pm on _____ at:

- **400 Red Creek Drive, Suite 120, Rochester NY 14623**
- **2701 Culver Road, Suite C, Rochester NY 14622**

Please arrive around _____ am / pm to check in.

Please be sure to bring your:

- **Insurance card(s).**
- **Photo ID.**
- **Updated/current medication list.**
- **Any applicable copay.**
- **Completed information packet if it has not already been mailed back to us.**
- **Please be sure to bring the imaging CDs we requested you obtain from _____. Failure to obtain the CDs may result in your appointment being rescheduled.**

Please don't hesitate to call the office with any questions:
585-334-5560
We look forward to seeing you!

As a reminder, children under the age of 18 are NOT allowed in the exam rooms and require supervision at all times in the waiting room. Thank you for your cooperation.

Rochester Brain & Spine, Neurosurgery and Pain Management
Patient Registration

Please complete the information below to help us best serve you. You are required to bring any insurance information, driver's license or photo ID, as well as a copy of any imaging studies that have been completed. Failure to bring these items to your appointment will result in rescheduling. If this form has been mailed to you please return in enclosed envelope 5 days prior to your visit so your information may be processed.

Patient_____ Sex_____ Birth Date_____
Race_____ Ethnicity _____ Language _____
Home Address _____ City _____ State_____ Zip_____
Home Phone ( ) _____ Cell Phone ( ) _____
Employer _____ Work Phone ( ) _____
Address _____City _____State _____ Zip _____
Emergency Contact _____ Relationship _____Phone ( ) _____
Address_____ City_____ State_____ Zip _____
Primary Care Physician_____ Phone ( ) _____
Address_____ City _____ State _____ Zip _____
*Have you ever had a Workman's Comp Injury? _____ Have you ever been involved in a MVA? _____

***If YES to either of these questions – please fill out information below.**

Insurance Information is needed for ALL Insurance Carriers

(Please complete Primary or Medical insurance information even if this is a MVA or Work Injury)

Primary Health Insurance

Carrier_____ ID Number_____
Carrier Address_____ City _____ State_____ Zip_____
Subscriber Name _____Subscriber Birth Date _____
Address (If different than patient) _____

Secondary Health Insurance

Carrier_____ ID Number_____
Carrier Address_____ City _____State_____ Zip _____
Subscriber Name _____ Subscriber Birth Date _____
Address (If different than patient) _____

Workman's Compensation/ MVA Information

Workman's Comp_____ _____MVA _____ Date of Injury_____
Carrier _____ Policy Number _____
Carrier Address _____ City _____State_____ Zip_____
WCB#_____ Carrier #_____ Case Worker_____
Employer _____ Phone ( ) _____
Address _____ City _____ State _____ Zip_____

Insurance and Treatment Authorization and Assignment

I hereby authorize Dr. Seth Zeidman and/or his associate to provide treatment as well as furnish information regarding my illness and treatment for insurance authorization. I also authorize the above information to my family physician, referring physician, and or any other medical facility as required. The information that I have provided on this form is true. I understand that I am financially responsible for any co-pay, co-insurance, deductible or office visit balance not covered by my insurance carrier/workman's compensation or no fault. I agree to pay said balance in a timely fashion. If a surgical intervention is required, I will contact my insurance carrier for pre-approval and determine what my financial obligation would be, if any.

Signature _____ Date _____

Patient Questionnaire

NAME: _____ DOB: _____ AGE: _____
PRIMARY CARE PHYSICIAN: _____ REFERRING PROVIDER: _____

REASON FOR VISIT (Circle One):
NEUROSURGERY: **DR.ZEIDMAN** PAIN MANAGEMENT: **DR.TAHIR** PHYSICAL MEDICINE: **DR.AMEDURI**

MEDICAL HISTORY: Diabetes Heart Disease High Blood Pressure Asthma
Blood clots or Clotting Disorder Osteoporosis Cancer (type) _____
Other: _____

PREVENTATIVE MEDICINE:
Last Mammogram [date and where was it performed?] _____
Last Pap test [date and where was it performed?] _____

SURGICAL HISTORY (Type, Year, Surgeon): Tonsillectomy Appendectomy Cholecystectomy Other:
_____

PAST SPINAL/NECK/BRAIN SURGERIES (Type, Year, Surgeon)**:**_____
(SPINAL FUSION, LAMINECTOMY, DISCECTOMY, ETC…)

Have you ever had X-rays, Studies and/or Nerve tests of your Brain or Spine? Yes No
*If so what imaging studies, where are they completed and when?
_____

FAMILY HISTORY: *PLEASE LIST WHICH FAMILY MEMBER*
Diabetes Heart Disease Cancer (Type) Hypertension Stroke
Other: _____

Most recent occupation held: _____ CURRENTLY WORKING: YES NO
REASON: Retired Disabled Other Last Date Worked _____

SOCIAL HISTORY
LIVES WITH: Alone Spouse Significant Other Friend Children (#)_____

NICOTINE USE: Current Quit Never Packs Per Day _____ Years _____ Quit/When_____
ALCOHOL: Yes No Former Drinks per Day _____
DRUG USE: Yes No Former Substance _____

DRUG ALLERGIES: YES NO Please list _____
OTHER ALLERGIES: YES NO Please list _____
LATEX ALLERGY: YES NO

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	REASON FOR TAKING	PRESCRIBING PHYSICIAN

CONSTITUTIONAL	GASTROINTESTINAL	NEUROLOGICAL
○ Fatigue	○ Constipation	○ Numbness/Tingling
○ Fever	○ Ulcers and Gastritis	○ Seizures
○ Chills	○ Nausea	○ Muscular Weakness
○ Night Sweats	○ Diarrhea	○ Memory Difficulty
○ Weight Gain	○ Abdominal Pain	○ Speech Difficulty
○ Weight Loss	○ Reflux/Indigestion	○ Difficulty Concentrating
○ Loss of Appetite	○ Incontinence of Stool	○ Headaches/Migraines
HEENT	**RESPIRATORY**	**MUSCULOSKELETAL**
○ Thyroid Lump	○ Shortness of Breath	○ Joint Pain
○ Difficulty Swallowing	○ Chronic Cough	○ Back Pain
○ Hearing Loss	○ Spitting up Blood	○ Muscular Weakness
○ Ear Pain	○ Wheezing	○ Weakness in Arms or Legs
○ Ringing in Ears	○ Bronchitis	○ Difficulty with Mobility
○ Sinus Pain	○ Pneumonia	○ Balance Disturbance
ALLERGY/IMMUNOLOGY	**SKIN**	**ENDOCRINE**
○ Environmental Allergies	○ Rash	○ Excessive Sweating
○ Food Allergies	○ Dryness	○ Diabetes (Type 1 or 2)
○ Latex	○ Skin Lesions	○ Abnormal Hair Growth
○ Drug Allergies	○ Eczema	○ Thyroid Disease
CARDIOVASCULAR	**GENITOURINARY**	**PSYCHIATRIC**
○ Leg Pain with Walking	○ Urgency of Urination	○ Anxiety
○ Swollen Hand and Feet	○ Pain with Urination	○ Depression
○ High Cholesterol	○ Night Time Urination	○ Other Psychiatric Disorder
○ Chest Pain	○ Urinary Tract Infection	○ Difficulty Sleeping
○ Irregular Heart Beat	○ Painful Urination	○ Suicidal Thoughts
○ Varicose Veins	○ Kidney Stones	○ Homicidal Thoughts
○ Leg Swelling	○ Blood in Urine	○ Mood Swings
○ High Blood Pressure	○ Frequency of Urination	
○ Irregular Pulse	○ Incontinence of Urine	
○ Heart Murmur	○ Sexual Dysfunction	
EYES	**HEMATOLOGIC**	
○ Double Vision	○ Bruises: Frequent or Easily	
○ Vision Changes	○ Cuts That Bleed Easily	
○ Cataracts	○ Enlarged Lymph Nodes	
○ Blurred Vision	○ Anemia	
○ Glaucoma	○ Blood Clots	

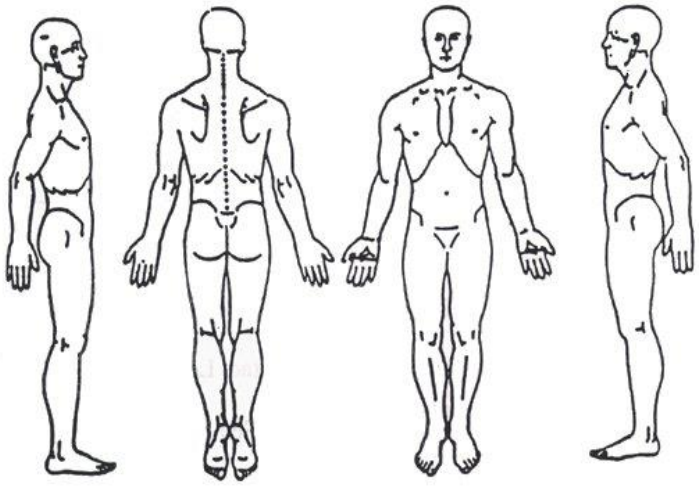
REVIEW OF PAIN

Circle your AVERAGE severity of pain on a scale of 0 (NO pain) to 10 (Severe Pain).
0 1 2 3 4 5 6 7 8 9 10

Describe the type of pain you are experiencing
(Circle all that Apply)

Aching	Cramp
Numbness	Shooting
Stiffness	Throbbing
Burning	Dull
Sharp	Stabbing
Swelling	Tingling

Other:_____



Please shade in the areas where your current pain is located.

What side is your pain on? Left Right Middle

When did it start?

Please describe what happened:

Is it constant or intermittent?

Does anything bring on the pain? _____

Does pain interfere with : Work Sleep Daily Routine Recreation
Other:_____

Does your pain radiate? Right or Left? _____

Activities that exacerbate your pain: Sitting Standing Walking Bending Lying Down
Other:_____

What makes your pain better?_____

Is there anything else you would like to discuss today? _____

Patients Signature: _____ Date: _____

Functional Ability Evaluation

Name_____DOB_____

Do you ever use the following (Please circle)

Cane Walker Wheelchair Crutches Brace

Difficulty with

Standing >2 hours	Yes	No	Sitting >2 hours	Yes	No
Walking >2 hours	Yes	No	Stairs	Yes	No
Uneven terrain	Yes	No	Ramps	Yes	No
Getting on Exam Table	Yes	No	Changing Positions	Yes	No

Bladder or Bowel Dysfunction Yes No

Sexual Dysfunction Yes No

Trouble dressing/disrobing Yes No

Daily Living Assistance (Do you need anyone to help you around the house) Yes No

If **YES** then please explain:

Shopping Cooking Cleaning Laundry

Other:

Driving Yes No Limited (explain):

Date Previous Worked:

Frequently miss work because of injury/illness Yes No

If **Yes**, explain:

Working Yes No **Hours/Day:** **Restrictions:**

Full time	Yes	No		Yes	No
Part time	Yes	No		Yes	No
Retired	Yes	No	Date Retired: _____		

If any, what are your **restrictions**:

_____

Date:_____

Cervical Conservative Treatments
Last 12 months

Name: _____ DOB:_____

Physical Therapy: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

Injections: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

Chiropractic treatment: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

TENS UNIT: Yes No **Did this make your pain:** Better Worse No Change

ACUPUNCTURE: Yes No **Did this make your pain:** Better Worse No Change

BRACE: Yes No **Did this make your pain:** Better Worse No Change

TRACTION UNIT: Yes No **Did this make your pain:** Better Worse No Change

ANTI-INFLAMMATORIES: Yes No **Did this make your pain:** Better Worse No Change

PAIN MEDICATION (please list below):

Today's Date: _____

Thoracic Conservative Treatments
Last 12 months

Name: _____ DOB:_____

Physical Therapy: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

Injections: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

Chiropractic treatment: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

TENS UNIT: Yes No **Did this make your pain:** Better Worse No Change

ACUPUNCTURE: Yes No **Did this make your pain:** Better Worse No Change

BRACE: Yes No **Did this make your pain:** Better Worse No Change

TRACTION UNIT: Yes No **Did this make your pain:** Better Worse No Change

ANTI-INFLAMMATORIES: Yes No **Did this make your pain:** Better Worse No Change

PAIN MEDICATION (please list below):

Today's Date: _____

Lumbar Conservative Treatments
Last 12 months

Name: _____ DOB:_____

Physical Therapy: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

Injections: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

Chiropractic treatment: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

TENS UNIT: Yes No **Did this make your pain:** Better Worse No Change

ACUPUNCTURE: Yes No **Did this make your pain:** Better Worse No Change

BRACE: Yes No **Did this make your pain:** Better Worse No Change

TRACTION UNIT: Yes No **Did this make your pain:** Better Worse No Change

ANTI-INFLAMMATORIES: Yes No **Did this make your pain:** Better Worse No Change

PAIN MEDICATION (please list below):

Today's Date: _____

Carpal Tunnel Syndrome Conservative Treatments
Last 12 months

Name: _____ DOB:_____

Physical Therapy: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

Injections: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

Chiropractic treatment: Yes No

Where: _____ Phone:

Date Started: Last Visit: How many total sessions:

Did this make your symptoms: Better No Change Worse

TENS UNIT: Yes No **Did this make your pain:** Better Worse No Change

ACUPUNCTURE: Yes No **Did this make your pain:** Better Worse No Change

BRACE: Yes No **Did this make your pain:** Better Worse No Change

TRACTION UNIT: Yes No **Did this make your pain:** Better Worse No Change

ANTI-INFLAMMATORIES: Yes No **Did this make your pain:** Better Worse No Change

PAIN MEDICATION (please list below):

Today's Date: _____