THE STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION Today's Date_______________________________

Patient Name ____
Last First (Legal) Middle Initial Nickname

Date of Birth _______________ Age_________ SS# _______________________ Sex M ☐ F☐

Race_______________Ethnicity______________________Language_____________________________

Cell Phone __________________ Work Phone _________________ Home phone _________________

Permanent mailing address ____

City ______________________________State _________________ Zip__________________

Email address _____________________________ Occupation _____________________________

Marital Status __________Spouses Full Name _______________________ Phone _________________

Contact In Case of Emergency ____

Relationship ___________________________ Phone _______________________________________

Primary Physician _____________________________ Phone _________________________________

Address ___________________________ City ________________ State ___________ Zip ___________

How were you referred to us?

Medical Professional ☐ Family / Friend ☐ Internet/Website ☐ Other ☐ ________________________

Referral Name ____________________________________ City / State / Zip _______________________

INJURY INFORMATION

Date of injury __________________ Work Related: NO ☐ YES☐ Auto Accident: NO☐ YES ☐

What is injured? ____

Describe Injury ____

____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

Carrier________________________________ Address ____

City____________________ State________________ Zip______________ Phone ___________________

Policy ID Number______________________________ Group ____________________________________

Name of the Policy Holder________________________ Relationship ______________________________

Address____________________________ City________________ State_______________ Zip __________

Date of Birth_______________ Social Security Number ______________________ Sex M F

Employer____ Occupation ___________________________

SECONDARY INSURANCE COMPANY:

Carrier________________________________ Address_____________________________

City____________________ State________________ Zip______________ Phone ___________________

Policy ID Number______________________________ Group ____________________________________

Name of the Policy Holder________________________ Relationship ______________________________

Address_____________________________ City_______________ State______________ Zip ___________

Date of Birth________________ Social Security Number _____________________ Sex M F

Employer____ Occupation ___________________________

WORKMAN'S COMPENSATION INSURANCE:

Carrier________________________________ Address _________________

City____________________ State________________ Zip______________ Phone ___________________

Claim Number___________________________________ Case Worker's Name _______________________

Case Worker's Phone Number_____________________________ Fax ______________________________

Employer at Time of Injury ____

Address ____

Patient ____ Date ____________________

Responsible Party ____ Date ___________________

UNACCOMPANIED MINOR WAIVER

This section is required to be signed by a parent or legal guardian in order for an unaccompanied minor to be seen by any physician or clinical staff at The Steadman Clinic. By signing, you (parent/guardian) agree that The Steadman Clinic may evaluate and treat the unaccompanied minor in whatever way is medically necessary.

Parent/Guardian Signature: ____ ***Date:*** ______________

Nondiscrimination

The Steadman Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

This information available in Spanish upon request. Solicite la versión en español de esta información.

Dr. Evans' Patient History

Date: ____/____/_______

Please fill out completely.

Shade like this: ■

Med Record # ____________________

Name: ____ Age ___________yrs. DOB______________________

Height: _____ft _____in **Weight:** _____lbs **Sex:** Male Female **Are you or could you be pregnant?** Yes No

History of Current Spine/ Joint Problems

Date of Injury:____

List your chief complaints or main problems with the most severe first:

1.____

2.____

3.____

Describe all details of any accident, incident or the way these problems began:

____

____

____

Current Symptoms

What time of the day is your pain at its worst? Morning Afternoon Evening Night Not Applicable

Does the pain wake you up at night? Yes No

In the past six months have you experienced: Fever Weight Loss__________lbs Chills Night Sweats

How would you describe you pain? Constant Constant, but worse with activity Intermittent (comes and goes) Intermittent, but worse with activity

Do you have full control for your bladder? Yes No

Do you have full control of your bowels? Yes No

What Treatments have you tried for this condition?

Nothing Decrease Activity Exercise Bracing Ice Heat

Physical Therapy (Date Started):_______________(Stopped/ Last Visit Date:) ____________Facility:______________________________

Chiropractor (Date Started): _____________________________ Acupuncture (Date Started) :___________________________________

Other:____

What medications have you tried for this condition? (OTC, Rx) : ____

____

Have you seen another physician for this problem/injury? (who/when) ____

____

INJECTIONS

Have you ever had a spinal injections (epidurals, facet injections, rhizotomies, etc) Yes No

If so, what types of injections have you had and at what level(s)? ____

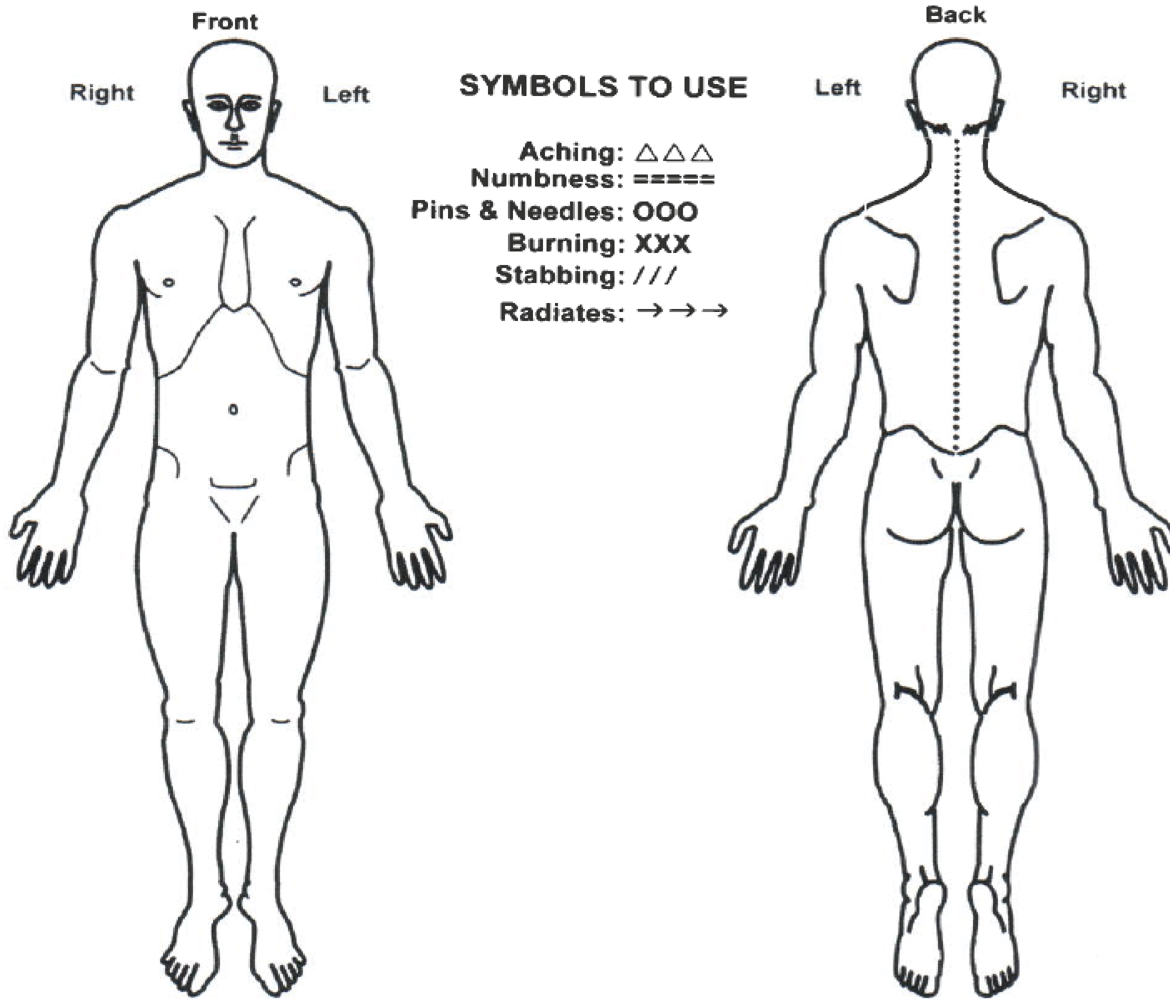
What type of injection and when was your last spinal injection(s)? ____

What % of relief did it provide you for the FIRST 3 HOURS? ____

How long did the relief last after that? ____

Patient Pain Drawing

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, include all affected areas.



For each area of your body, please mark where your symptoms (pain, numbness, weakness, etc.) exist on "average" and at the "worst." ZERO is no symptoms - > TEN is the worst pain of your life

Current **NECK** pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Current **Low Back** pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Current **SHOULDER** pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Current **SI** pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Current **ARM** pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Current **Buttock** pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Current **MID BACK** pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Current **Groin** pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
	Current **Leg** Pain **Average** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Worst** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Dr. Evans' <u>MIGRAINE</u> history

Please complete if you are seeing Dr. Evans' for evaluation

☐ ***<u>NONE: If no history of migraines/headaches, skip this page</u>***

How long have you had migraines/headaches? ______________________________

How many headaches do you get per month? ______________________________

How many hours do your headaches typically last? ______________________________

Where do you get your headaches? ______________________________

What is the intensity of your headaches? Pain scale 0-10/10: ______________________________

What do you do when you have a headache? ______________________________

What other symptoms do you get with your headaches (nausea, aura, etc)?
____

What medications do you take NOW for your headaches (list any/all)?
____

What medications have you taken in the past that do not work now?______________________________

Have you tried ANY of the following medications or others like them? (please circle)

Rescue Medications/Triptans: Imitrex, Frova, Maxalt, Relpax, Treximet, Zomig, Rizatriptan, Amerge
Date Started: ____________________ Ended:__________________

Angiotensin-converting enzyme inhibitors/angiotensin II receptor blockers: Losartan, Valsartan, Lisinopril
Date Started: ____________________ Ended:__________________

Anti-depressants: Amitriptyline, Nortryptiline, Effexor, Paxil, Prozac
Date Started: ____________________ Ended:__________________

Anti-epileptics: Gabapentin, Lyrica, Topiramate, Valproic Acid, Depakote
Date Started: ____________________ Ended:__________________

Beta Blockers: Atenolol, Metoprolol/Lopressor, Propanolol/Inderal, Timolol
Date Started: ____________________ Ended:__________________

Calcium Channel Blockers: Diltiazem, Nifedipine, Verapamil
Date Started: ____________________ Ended:__________________

Others: Excedrin, Fioricet, Fiorinal, Stadol, Midrin, Cafergot, Butalbital
Date Started: ____________________ Ended:__________________

Muscle Relaxers
Date Started: ____________________ Ended:__________________

NSAIDs: Advil, Ibuprofen, Aleve
Date Started: ____________________ Ended:__________________

Injections: Botox injections, Aimovig injections
Last Treatment Date:______________________________

Others*:* ______________________________

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Directions – The Steadman Clinic Vail Location
181 West Meadow Drive, Suite 400
Vail, CO 81657
Phone: (970) 476-1100

<u>From Denver (East) to Vail (West)</u>

Exit the Denver International Airport and take Pena Boulevard to Interstate 70 heading West. Follow Interstate 70 West approximately 120 miles to Vail, Exit 176. Follow the roundabout half-way around and exit in the direction of Vail Village (under the Interstate). Enter the second roundabout and exit at the second right headed towards Vail Road. At the three-way stop sign take a right onto West Meadow Drive. Turn right into the parking area for the Steadman Clinic and Vail Valley Medical Center. Parking attendants are available for drop-off assistance and valet parking upon request. The Steadman Clinic is located on the 4th floor of Vail Valley Medical Center. Elevators to the clinic are located on the 1st floor lobby on the far West side of the building.

<u>From Eagle (West) to Vail (East)</u>

Exit the Eagle County Airport onto Cooley Mesa Road going East. At the stop light turn right (East) on Highway 6. Follow the signs to Interstate 70 East. Take Interstate 70 East approximately 30 miles to Vail, Exit 176. Enter the roundabout and exit at the second right headed towards Vail Road. At the three-way stop sign take a right onto West Meadow Drive. Turn right into the parking area for the Steadman Clinic and Vail Valley Medical Center. Parking attendants are available for drop-off assistance and valet parking upon request. The Steadman Clinic is located on the 4th floor of Vail Valley Medical Center. Elevators to the clinic are located on the 1st floor lobby on the far West side of the building.