**Terrence T. Kim, M.D.**
*Orthopaedic Spine Surgeon*
444 S. San Vicente Blvd, Suite 800
Los Angeles, CA 90048
Phone: (310) 423l 9716 Fax: (310) 248l 8712
www.tkspine.com

## SUMMARY OF CARE QUESTIONNAIRE

Please **select** the answer to the following questions.

1. I have a problem with my:
   ☐ **Cervical** ☐ **Thoracic** ☐ **Lumbar** ☐ **Arm pain** ☐ **Leg pain**

2. I have symptoms in my:
   ☐ **Arms** ☐ **Hands** ☐ **Legs** ☐ **Feet**

3. I have had the following diagnostic studies:
   ☐ **MRI's** ☐ **CT scans** ☐ **Myelogram** ☐ **X-ray's** ☐ **Bone scan** ☐ **EMG's**
   I have the studies with me and can bring them: ☐ **Yes** ☐ **No**
   Imaging Facility: ______________________________

4. I have had injections:
   ☐ **Epidurals** ☐ **Nerve blocks** ☐ **Facet blocks** ☐ **Trigger point** ☐ **Cortisone**
   Did the injections help? ☐**Yes** ☐**No** **For how long?** ______________
   Physician: ______________________ Phone: ______________________

5. I have had physical therapy:
   ☐ **Yes** ☐ **No** **For how long?** ______________________

6. I have been seen by the following specialist:
   ☐ **Pain management** ☐ **Neurologist** ☐ **Other spine surgeons**

7. I am looking for a surgical solution to my problem:
   ☐ **Yes** ☐ **No**

8. I am looking for conservative treatment (no surgery):
   ☐ **Yes** ☐ **No**

*Please note: Dr. Kim's practice is **surgical** and not pain management. To expedite/facilitate your visit and maximize your time spent with the doctor we ask that you complete our questionnaire. Please note that every patient is evaluated individually and this summary will assist the doctor in his evaluation.*

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# Demographic Intake Sheet for Consultation

## Patient Information

Last Name: ____________________ First Name: ____________________

Date of Birth: __________ Social Security #: __________ Gender: ☐ Female ☐ Male

Address: ____________________ City: __________ State: ______ Zip: ______

Home Phone #: __________ Work Phone #: __________ Cell Phone #: __________

Email: ____________________ Preferred Method of Contact: ☐ Email or Call: ☐ Home ☐ Work ☐ Cell

Emergency Contact: __________ Relationship __________ Phone #: __________

## Employer Information ☐ Retired ☐ Student ☐ Disability ☐ Unemployed

Name: ____________________ Occupation: ____________________

Address: ____________________ City: __________ State: ______ Zip: ______

## Insurance Information

*If Medicare, please provide:*

Medicare #: __________ Effective Date: __________ ☐ A ☐ B ☐ A&B

**Primary Insurance** ☐ HMO ☐ PPO ☐ POS

Company: ____________________ Phone: ____________________

Address: ____________________ City: __________ State: ______ Zip: ______

Group: ____________________ ID #: ____________________

*If patient is not the subscriber, please provide:*

Subscriber's Name: ____________________ Relationship: ____________________

Date of Birth: __________ Social Security #: __________ Gender: ☐ Female ☐ Male

**Secondary Insurance** ☐ HMO ☐ PPO ☐ POS

Company: ____________________ Phone: ____________________

Address: ____________________ City: __________ State: ______ Zip: ______

Group: ____________________ ID #: ____________________

*If patient is not the subscriber, please provide:*

Subscriber's Name: ____________________ Relationship: ____________________

Date of Birth: __________ Social Security #: __________ Gender: ☐ Female ☐ Male

## Preferred Pharmacy

Name: ____________________ Phone: ____________________

Address: ____________________ City: __________ State: ______ Zip: ______

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# PHYSICIAN INFORMATION

PATIENT ID

Please provide your current 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.

## Who can we thank for referring you to us?

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

______________________________
(City, State, Zip Code)

Phone: (____) ______________________ Fax: (____) ______________________

## INTERNIST / PRIMARY CARE PHYSICIAN

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

______________________________
(City, State, Zip Code)

Phone: (____) ______________________ Fax: (____) ______________________

## PAIN MANAGEMENT PHYSICIAN

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

______________________________
(City, State, Zip Code)

Phone: (____) ______________________ Fax: (____) ______________________

## OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

______________________________
(City, State, Zip Code)

Phone: (____) ______________________ Fax: (____) ______________________

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**Personal Information**

Last Name: ______________________ First Name: ______________________

Age: ________ Date of birth: ______________ Occupation: ______________ ☐ Not working

**Social History**

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you live alone? ☐ Yes ☐ No

How many children do you have? ____________ ☐ None

Will you have a caregiver to assist you if surgery is needed? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No

Have you lost work due to your back problem? ☐ Yes ☐ No

Do you have stairs in your home? ☐ Yes ☐ No

Do you think you are at risk for a fall? ☐ Yes ☐ No

Date symptoms began: ____________________

**Current Problems**

Chief complaint or reason for visit: ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Cause of present problem (*e.g. work related injury, auto accident, slip-and-fall, etc.*):

______________________________________________________________________________

What favorite activities does your pain prevent? __________________________________

______________________________________________________________________________

______________________________________________________________________________

Can you care for yourself *(i.e. dressing, eating, toileting, standing up, etc.)*? ______________

______________________________________________________________________________

Other difficult functions include: ______________________________________________

______________________________________________________________________________

**Past History**

Past or ongoing medical problems (e.g. high blood pressure, stroke, diabetes, heart condition, cancer, etc.):

(*If more space is needed, please attach on a separate sheet.)*

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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**Previous Surgeries**

Name of operation: Date:

______________________ ______________
______________________ ______________
______________________ ______________

**Other Information**

Do you smoke? ☐ Yes ☐ No Number of cigarettes per day ________

Do you drink alcohol? ☐ Yes ☐ No Number of drinks per day ________

Have you had imaging in the last 3 months?

☐ No ☐ Yes ☐ MRI ☐ CT scan ☐ X-rays

**Allergies**

Please list all allergies and response, such as rash, itching, difficulty breathing, or unknown:

| Drug name | Reaction |
|---|---|
| | |
| | |
| | |

**Medications**

Please list all current medications, over-the-counter drugs, vitamins, and herbals.

Please give us the total number of "as needed" medication taken in a 24-hour period.

| Name | Dosage / Amount | Time of day | Total taken in 24 hours |
|---|---|---|---|
| | | | |
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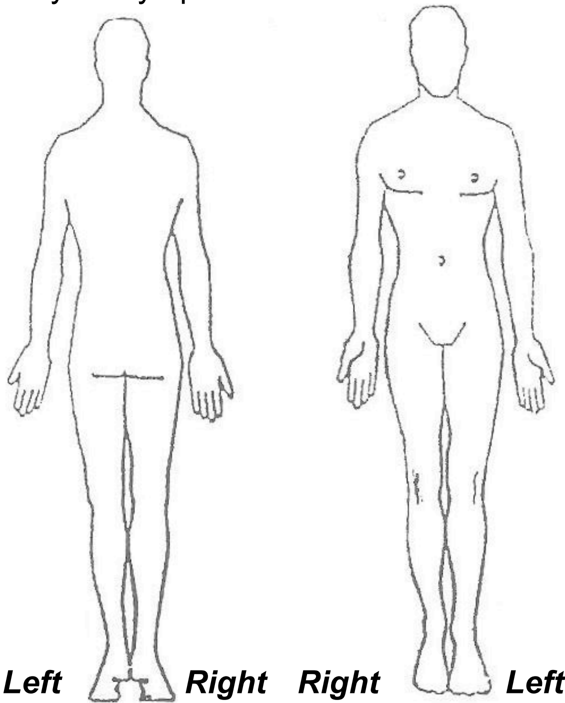
# PAIN DRAWING

PATIENT ID

**1. How much pain, in general, can you tolerate**

☐ 0 No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Worst pain imaginable

**2. Where is your pain now?**
Mark the areas on your body using the appropriate symbols to describe your symptoms.




| TYPE OF PAIN | SYMBOL |
| --- | --- |
| Ache | <<<<< <<<<< |
| Numbness | OOOOO OOOOO |
| Pins & Needles | ##### ##### |
| Burning | XXXXXX XXXXXX |
| Radiating Pain | ////////// ////////// |

**3. How bad is your pain?**

Neck pain ________ %

Arm pain ________ %

Total 100%

Back pain ________ %

Leg pain ________ %

Total 100%

**4. How bad is your pain now?**

☐ 0 No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Worst pain imaginable

**5. The duration of pain:**

☐Continuous ☐Positional ☐Intermittent (On/Off) ☐Unable to Rate

**6. Have you taken pain medication in the past 24 hours?**

☐Yes ☐No

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Once your information is complete, please forward your New Patient Packet to us in one of the following ways:

- Click here to email the completed form ***or***
- Save/scan and email to Nicole.Lum@cshs.org ***or***
- Print and fax to (310) 248-8712 ***or***
- Print and send through standard mail to our office:

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Please be prepared to BRING ALL FILMS/CDs with you on the day of your appointment.

We will contact you with appointment details upon receipt and review of your information.

Thank you for your patience during our review process.

Missed Appointment and Late Policy

We understand that situations arise in which you must cancel your appointment. In these cases, we ask that you kindly contact our office 48 hours prior to your appointment to cancel or reschedule. Patients who do not give our office notice within this time period will be subject to a $50.00 cancellation/no show fee.

In the case that you feel you are unable to make your appointment time and are running late, please contact our office to inform us of your delay. Patients who do not call and are more than 15 minutes late will be considered a “missed appointment” and will be rescheduled.