TERRENCE T. KIM, M.D.

Board-Certified Orthopaedic Spine Surgeon
444 S. San Vicente Boulevard • Suite 800 • Los Angeles, CA 90048
Office (310) 423-9716 • FAX (310) 248-8712

Thank you for choosing Dr. Terrence T. Kim. Prior to making your appointment, we kindly ask that you complete our New Patient Packet. Dr. Kim's practice is surgical and *not* pain management. To expedite, facilitate, and maximize your time spent with the doctor, we ask that you complete this questionnaire thoroughly. Please note that every patient is evaluated individually, and this summary will assist the doctor in his evaluation.

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

- Email to Maria.Gomez@cshs.org ***or***
- Fax to (310) 248-8712 ***or***
- Mail to: Terrence Kim, MD
  444 S. San Vicente Blvd, Suite 800
  Los Angeles, CA 90048

Please include the following documents when sending back:

- ✓ Dr. Kim's New Patient Questionnaire fully completed (attached)
- ✓ Copy of your insurance card
- ✓ Diagnostic reports (e.g. MRI, CT, EMG/NCV, etc.)
- ✓ Epidural reports, operative reports, and/or procedure reports
- ✓ Any medical records relevant to your spine concerns

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

Thank you for your patience during our review process. We will contact you with appointment details upon receipt and review of your information.

If you have any questions or concerns, please feel free to contact our office at (310) 423-9716.

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.

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Intake Sheet

PATIENT ID

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 #: _____

Preferred Pharmacy

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance

Company: _____ ☐ HMO ☐ PPO ☐ POS

ID #: _____ Group: _____

If you are not the subscriber, please provide subscriber's name: _____

Date of Birth: _____ *Relationship:* _____

Secondary Insurance

Company: _____ ☐ HMO ☐ PPO ☐ POS

ID #: _____ Group: _____

If you are not the subscriber, please provide subscriber's name: _____

Date of Birth: _____ *Relationship:* _____

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

If yes, what is your occupation? _____

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

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

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

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Referral Information

PATIENT ID

Please provide your current physician's information. Write down as much information you can provide (e.g. Name and City), so that we may keep them informed of your progress.

Who can we thank for referring you to us?

Name: _____
(Last, First)

Address: _____
(Street)

_____
(City, State, Zip)

Phone: _____ Fax: _____

INTERNIST / PRIMARY CARE PHYSICIAN

Name: _____
(Last, First)

Address: _____
(Street)

_____
(City, State, Zip)

Phone: _____ Fax: _____

PAIN MANAGEMENT PHYSICIAN / INJECTION SPECIALIST

Name: _____
(Last, First)

Address: _____
(Street)

_____
(City, State, Zip)

Phone: _____ Fax: _____

PHYSICAL THERAPIST

Name: _____
(Last, First)

Address: _____
(Street)

_____
(City, State, Zip)

Phone: _____ Fax: _____

OTHER PHYSICIAN YOU WOULD LIKE TO KEEP UPDATED

Name: _____
(Last, First)

Address: _____
(Street)

_____
(City, State, Zip)

Phone: _____ Fax: _____

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Personal Information

PATIENT ID

Please select the answer to the following questions:

1. I have a problem with my:
   ☐ Cervical spine ☐ Thoracic spine ☐ Lumbar spine ☐ Arm(s) ☐ Leg(s)
2. I have these studies completed:
   ☐ X-rays ☐ MRI ☐ CT scan ☐ Myelogram ☐ SPECT ☐ EMG/NCV
   Imaging facility: _____ I have the CD(s): ☐ Yes ☐ No
3. I have tried physical therapy: ☐ Yes ☐ No
   If yes, for how long? _____
4. I have tried spine injections (epidurals, blocks, cortisone): ☐ Yes ☐ No
   If yes, how long did it help? _____
5. I am looking for a surgical solution: ☐ 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 *(e.g. 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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Medical History

PATIENT ID

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 _____

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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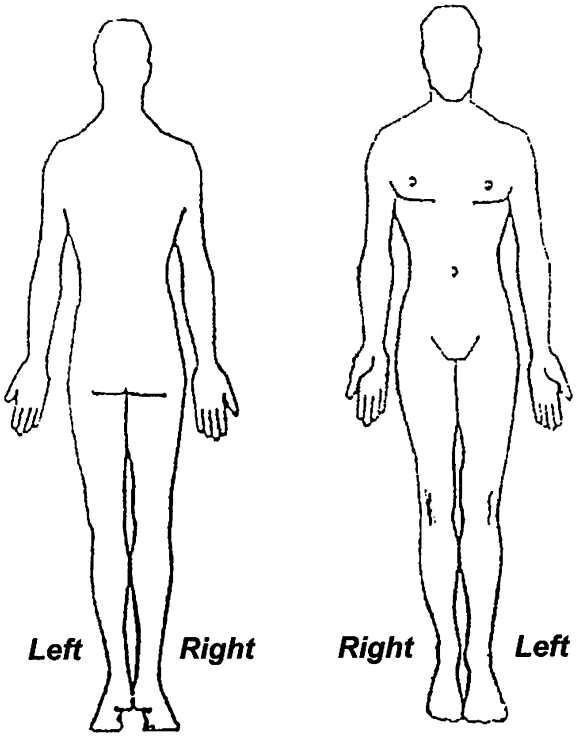
Pain Drawing

PATIENT ID

Where is your pain now?

Mark the areas on the body using the appropriate symbols to describe your symptoms.



TYPE OF PAIN	SYMBOL
Ache	<<<<< <<<<<
Numbness	○○○○○ ○○○○○
Pins & Needles	■■■ ■■■
Burning	xxxxxx xxxxxx
Radiating Pain	////////// //////////

Separate your pain level?

Neck pain _____% vs. Arm pain _____% = 100%

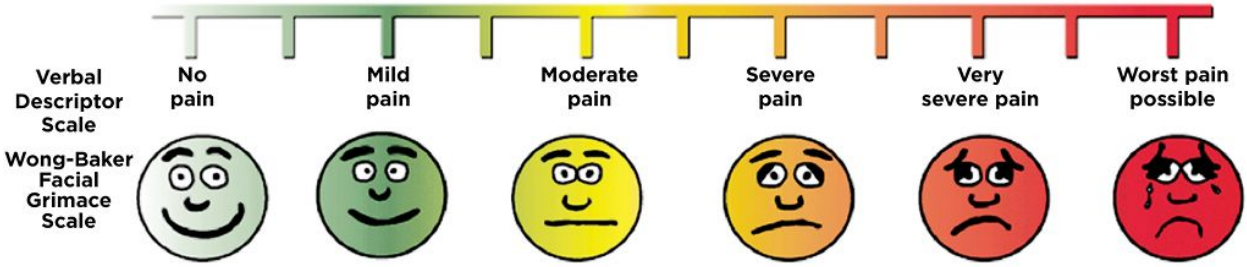
Back pain _____% vs. Leg pain _____% = 100%

Duration of pain?

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

How bad is your pain now?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10



0
No pain

1-3
You feel some pain or discomfort but you can still complete most activities.

4-6
The pain makes it difficult to concentrate and may interfere with your ability to do certain normal activities, such as reading, watching TV, having a phone conversation, etc.

7-9
The pain is quite intense and is causing you to avoid or limit physical activity. Cannot concentrate on anything except pain.

10
Worst pain imaginable.