1120 West Avenue M-4, Palmdale, CA. 93551 Phone 661.480.2377 Fax 661.480.2378
16311 Ventura Blvd. Suite 1080P Encino, CA. 91436 Phone 661.480.2377 Fax 661.480.2378
8920 Wilshire Blvd. Suite 301 Beverly Hills, CA. 90211 Phone 661.480.2377 Fax 661.480.2378

Patient: Last________________________________First:____MI: ______

Birth Date: /___/______Sex: M / F Soc. Security Number: ____

Address:____City:________________Zip Code: ________

Cell Phone Number:_____________________________________Home Phone Number: ____________________

Email Address:____CDL No: ________________________________

Primary Care Provider:
Name:____Office: __________________________________

Address:____City:________________Zip Code: ________

Telephone Number:_____________________________________Fax Number: ____________________________

Emergency Contact's Name:____
Address:____City:________________Zip Code: ________

Telephone number to best reach them:______________________Relationship: ____________________________

Insurance Information: Name of Insurance: ____

Primary Holder of Insurance: ____

Insurance ID #:____Group #: ________________________

Address:____City:________________Zip Code: ________

Telephone Number:_____________________________________Fax Number: ____________________________

The Above information is true to the best of my knowledge. I authorize my Insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize NeuroSpine Institute or insurance company to release any information required to process my claims. I acknowledge I have received NeuroSpine notice of privacy practices.

Patient/Guarantor Signature: ____

New Patient Intake Questionnaire

Please fill out this form in its entirety and fill in the bubbles completely.

PATIENT INFORMATION		
Patient Name:		**Date:**
Date of Birth:	**Insurance:**	**Dr.**
Gender:	**Date of Injury if Applicable:**	

1. Chief complaint: O Neck Pain O Back Pain O Brain Disorder
2. Does the symptoms radiate? O Yes O No O Sometines

   If Yes Where? ____________________________

3. How would you describe your symptoms?

   O Sharp O Aching O Tingling O Burning

   O Cramping O Electric Like O Numbing O Other:__________

4. What is the intensity of the range of your pain symptoms? E.g.: 4-7 Out of 10

   [/10] Good Day [/10] Worst Day

5. Are the focal symptoms worse or the radiating symtoms?

   [ ] % Focal [ ] % Radiating

6. When did the symptoms begin?____

7. Have the symptoms been?

   O Worsening O Staying the sme O Improving Since they began

8. What do you do that worsens your symptoms?_________________________________

9. Associated Symptoms:

   O Headaches O Leg Gives Out O Bladder Incontinence

   O Drop Object from Hands O Bowel Incontinence O Frequent Falls

10. Prior treatments?

    Anti-Inflammatory Agents O Yes O No

    Physical Therapy O Yes O No

    Injections O Yes O No

    How many injections in the last 12 months?________________ Date of the most recent injection:____________

    Did you get any relief from the injections ? O Yes O No

    Prior surgeries on the spine or/and brain? O Yes O No

    Acupunture O Yes O No

11. Have you had any testing ? O MRI O CT-Scan O EMG/NCS O X-Ray

12. Have you had any surgeries/trauma to your brain/spine in the past? O Yes O No

13. Limitations that chief complaint has placed:

O Sleeping O Performing Daily Chores O Placed into Disability

O Exercising O Bathing O Feeding

O Performing Effectively at Occupation O Spending time with family and Friends

13. Has the chief complaint symptoms caused you to go into depression? O Yes O No

Medical History

Do you have or have you had:	**Yes**	**No**		**Yes**	**No**
Asthma/COPD	O	O	Cancer	O	O
Diabetes	O	O	High Blood Pressure	O	O
Acid Reflux Disease	O	O	Heart Attack	O	O
Osteoporosis	O	O	Hypertension	O	O
Emphysema	O	O	Seizures	O	O
Stroke	O	O	Arthritis	O	O
Gout	O	O	Thyroid Disease	O	O
Kidney Problems	O	O	Blood Clots	O	O

Social History

Marital status:	O	Single	O	Married	O	Widowed	O	Divorced
Do you smoke?			O	Yes	O	No	O	Have Previously
If yes,								
How many packs/ day?			O	<1	O	1-2	O	>2
How many years have you smoked?			O	1-4	O	5-10	O	>11
Do you consume alcohol?			O	Yes	O	No		
In the past did you consume alcohol?			O	Yes	O	No		
How often do you consume alcohol?			O	Daily	O	Social	O	Never
Do you exercise regularly?			O	Yes	O	No		

Review of Systems

Neurological				
Migraine Headaches	O	Yes	O	No
Numbness/ Tingling	O	Yes	O	No
Seizures	O	Yes	O	No
Dizziness	O	Yes	O	No
Coordination Problems	O	Yes	O	No
Neck Pain	O	Yes	O	No
Respiratory				
Chest Pain	O	Yes	O	No
Trouble Breathing	O	Yes	O	No

Shortness of Breath O Yes O No

Constitutional

Fatigue O Yes O No

Weight change O Yes O No

Fever O Yes O No

Allergies

Are you allergic to any medications? O Yes O No

If yes, please list: ____________________

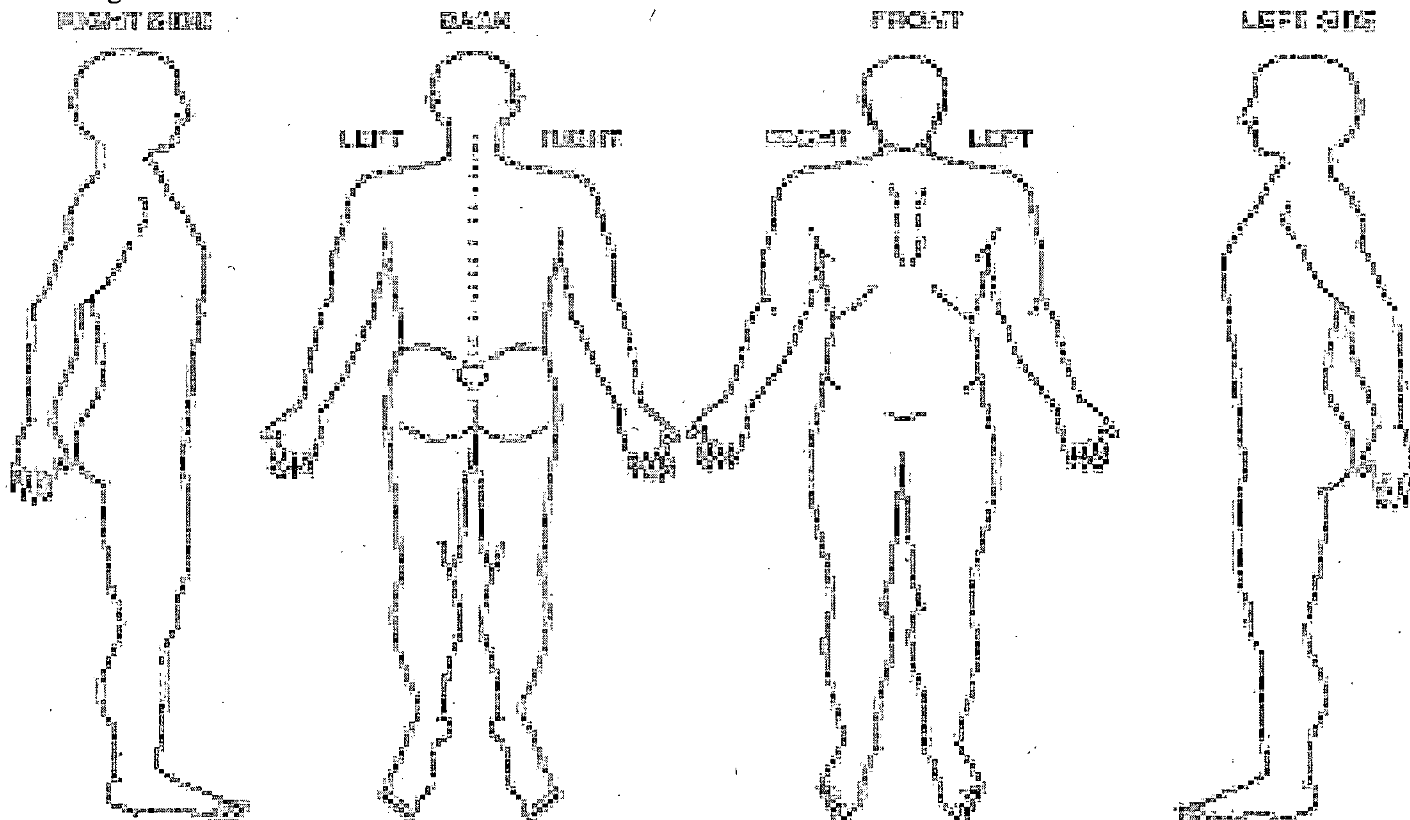
Are you allergic to food or environmental substances? O Yes O No

If yes, please list: ____________________

Do we have your permission to run your Prescription Eligibility? O Yes O No

Medications (Please list name of medication and dosage)

Pain Diagram



Patient Signature ____________________ Date ____________________

Patient's Name________________________________ Number____________ Date________________

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

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 causes extra pain.
- ☐ 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 self care.
- ☐ I do not get dressed, I 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, for example 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 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 one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick 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 only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = ____________ %ADL

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 extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives 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. dancing.
- ☐ 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 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments________________________________

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient Signature:____________________

Patient's Name____________________ Number__________ Date__________

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

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 causes extra pain.
- ☐ 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 self care.
- ☐ I do not get dressed, I 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, for example 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 very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = __________ %ADL_____

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments__________________ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient Signature:__________________

DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE

AGREEMENT AS TO RESOLUTION OF CONCERNS OF DISSATISFACTION
READ CAREFULLY

We take pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We therefore recognize and respect a patient right to pursue legal action if he/ she feels we have been negligent in some way. While some health care legal claims are justified, there are also frivolous legal claims filed in our country, which drive up insurance rates and adversely impact court decisions for patients who deserve compensation. As such, we believe that an agreement early in the treatment process regarding the use of board-certified experts may help expedite resolution of concerns.

OUR COMMITMENT TO YOU: We commit to using only American Osteopathic Board of Surgeons, American Board of Medical Specialties, board certified expert witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics. We demonstrate this commitment to you with our signature on this form (which you may receive a copy of at any time after such signature is affixed) **WHAT WE ARE ASKING YOU TO DO**: We are asking you or any representative to commit to a process also, by using only American Osteopathic Board of Surgeons, American Board of Medical Specialties, board- certified physician expert medical witness(es) if you are dissatisfied with your medical care and decide on legal action. I understand that I am entering into a contractual relationship with the DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE for professional services. I further understand that claims that are without merit or are frivolous have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided me by DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE claims of medical malpractice against the providers within the DR. KAMRAN PARSA. DBA NEUROSPINE INSTITUTE should I initiate or pursue a medical malpractice claim against a provider within the DR. KAMRAN PARSA. DBA NEUROSPINE INSTITUTE, I agree to use as expert witness only physicians who are board certified by the American Osteopathic Board of Surgeons, , American Board of Medical Specialties in the same or similar specialty as the provider against whom the claim is being made. Further I agree that these physicians retained by me or on my behalf to be an expert witness will be a member in good standing of the medical specialty society to which the provider belongs. I agree an expert will be obligated to adhere to the guidelines or code of conduct defined by that physicians or providers specialty society. I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE also agree to exactly the same above referenced stipulations.

Each party agrees that his/her counsel shall have the right and be free to depose the other partys expert witness(es) at least 120 days before any scheduled trial date.

Each party agrees that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other defendants.

Each party agrees that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

PRINT PATIENT NAME____

PATIENT SIGNATURE______________________________________ Date______________

PHYSICIAN SIGNATURE____________________________________ Date______________

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient Information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient Files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restriction in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____________________________ date______________ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature:____

Patient Record of Disclosures of Protected Health Information (PHI)

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

- ☐ Appointment Dates/Times
- ☐ Diagnosis
- ☐ Imaging Results
- ☐ Medications
- ☐ Lab Tests/Results
- ☐ Medical Records
- ☐ Care Plan
- ☐ Other (specify)

Indicate Confidential Information:____

____

Patient Name: ____

Date of Birth: ________________ Email Address:________________________

Informed to be released to: __________________________________

Name: ______________________________

Relationship: __________________________

Address: _____________________________

Phone: ______________________________

This authorization shall remain in effect from the date signed below until

(please check one):

☐ ____________________ (Specify expiration date or event)

☐ NO EXPIRATION

Signature: ________________________________ Date: ________________

Relationship to Patient (If signed by personal representative of Patient): _______________