The Comprehensive Spine Center is located at Vanderbilt Health One Hundred Oaks, 719 Thompson Lane, Ste 23108, Nashville, TN 37204

Please do not hesitate to contact us at (615) 875-5100 if we can be of further assistance.

Thank you for allowing us to participate in your care. We are including this letter to help inform you about certain policies for our office. The following are some basic guidelines for our practice.

Please be prepared to spend approximately two to three hours for your clinic visit, which will include your examination and possible testing. If the physician determines that surgery needs to be scheduled, please be prepared to stay longer. This will allow time necessary for your pre-operative evaluation, the pre-admission process, and any other tests or evaluations needed to properly prepare you for surgery.

Enclosed is a Health Assessment Form. It is very important that you take the time to complete this form. You may have a family member assist you if necessary. Please bring the form to the clinic on the date of your visit (PLEASE DO NOT SEND BY MAIL). There may be a delay in your appointment if this information is not provided at the time of check-in.

All patients must contact their referring doctor/facility and request that the physician send/fax their latest imaging reports and latest clinic notes related to their existing condition to the Comprehensive Spine Center.

You are required to bring in your radiology images (CD, DVD, Films and radiology reports if done at an outside facility)

These images should ONLY include: The first image taken for your existing condition and your most recent film taken. We prefer MRI but will also review PET, CT, and X-ray. NO other films are needed unless requested. Unfortunately, if we do not have your images, your appointment will be cancelled and need to be rescheduled.

Our office does not handle pain management. This means that we DO NOT refill any narcotic or other pain medication prescribed by another doctor. If you are currently taking pain medication you will need to see the doctor who prescribed the medication or a pain management specialist. In only rare cases will we prescribe narcotic or other pain medication, and these cases are solely related to those patients who we have already determined will need surgery.

Please do not forget to bring your Insurance card(s), Insurance referral (if applicable), and Insurance co-payment (if-applicable. If your insurance requires a co-payment, you MUST pay this at the time of check-in. Your insurance information should be verified by Vanderbilt’s Central Registration at (615) 322-2971 or (888) 567-5255 to ensure proper insurance filing at least two weeks before your scheduled appointment.

If a referral is required by your insurance company, please make sure that your referring physician sends us an approved referral 2 weeks before your appointment. Patients who need to be seen without a referral must agree to take financial responsibility for their clinic visit. Failure to obtain a referral may result in cancellation of your appointment.

Your cooperation will assist us in providing you with the best possible care.
Please visit the website for more information.  www.VanderbiltSpine.com
Orthopaedics

Name: ______________________________
Age: _______ Sex: _______ Height: _______ Weight: _______
Referring physician: __________________

Chief Complaint: Do you have? (circle):
Back Pain: Yes / No    Neck Pain: Yes / No
Leg Pain: Yes / No    Arm Pain: Yes / No
Which is worse? Back / Leg    Neck / Arm
Describe pain: _______________________________________

Pain Diagram
Mark the area where you now feel your typical pain

Rate your pain on a scale from 1-10 (10 being the most severe) ______

How long have you had these symptoms? ______________

How did it happen? _________________________________

What makes it worse? _______________________________

What makes it better? _______________________________

Is this problem resulting from: Work Injury- Yes/ No    Car Crash- Yes/No

Do you have an attorney for your problem? Yes / No

Have you had back/neck surgery before? Yes / No

Year: _______________ Operation: _______________________

Did your symptoms improve after surgery? Yes / No
If so, how long? ___________________________________

What other surgeries have you had? _______________________________

Any problems with anesthesia or bleeding problems? _______________________________

Diagnostic Studies: Most Recent Dates of studies performed:
MRI ____________________________    CT MYELOGRAM ____________________________
EMG ____________________________    DISCOGRAM ____________________________

Previous Treatment

Physical Therapy Yes / No    Did it help? Yes/ No /Temporarily
Chiropractor Yes / No    Did it help? Yes/ No / Temporarily
Epidural Steroid Injections Yes / No    Did it help? Yes/ No / Temporarily   How many? ______
Acupuncture Yes / No    Did it help? Yes/No/ Temporarily
Trigger point injections Yes/ No    Did it help? Yes/No/Temporarily
Pain management clinic Yes/No    Name of pain physician _____________________
Medical History

Have you ever been diagnosed with the following: (check all that apply)

☐ Diabetes  ☐ Fatigue Syndrome
☐ Asthma    ☐ Cancer
☐ Heart Attack ☐ Arthritis
☐ Blood Clots ☐ Thyroid nodule
☐ Stroke    ☐ Kidney infection
☐ Ulcers    ☐ Migraine Headaches
☐ Hypertension ☐ Depression

Family History (check all that apply)

☐ Spine Problem
☐ Bleeding Disorder
☐ Diabetes
☐ Heart Disease
☐ Cancer (what type)________________

Social History (check all that apply)

Level of Education ☐ High School ☐ College
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Work Status: ☐ Working ☐ Not working ☐ Disabled ☐ Retired
Occupation: ____________________________

Do you Smoke Cigarettes/Chew? _____ How much? ____
Amount of beer/alcohol consumed in a week: ____________
How often do you exercise each week? ________________

Review of Symptoms (circle all that apply)

Constitutional
Weight loss ☐ Y ☐ N
Fever ☐ Y ☐ N

Allergy/Immune
Drug Allergy ☐ Y ☐ N
Food Allergy ☐ Y ☐ N

Musculoskeletal
Stiffness/Swelling ☐ Y ☐ N
Fractures ☐ Y ☐ N

Hematologic
Anemia ☐ Y ☐ N
Excessive Bleeding ☐ Y ☐ N

Gastrointestinal
Constipation ☐ Y ☐ N
Diarrhea ☐ Y ☐ N

Endocrine
Menopause ☐ Y ☐ N
Obesity ☐ Y ☐ N

Skin
Rash ☐ Y ☐ N
Eczema ☐ Y ☐ N

Genitourinary
Sexual Difficulties ☐ Y ☐ N
Pain Urinating ☐ Y ☐ N

Neurologic
Paralysis ☐ Y ☐ N
Seizures ☐ Y ☐ N

Respiratory/CV
Shortness of Breath ☐ Y ☐ N
Irregular Heartbeat ☐ Y ☐ N

HEENT
Swallowing difficulty ☐ Y ☐ N
Hoarseness of throat ☐ Y ☐ N

Psychiatric
Depression ☐ Y ☐ N
Anxiety ☐ Y ☐ N

Allergies (list drug allergies)
______________________________
______________________________
______________________________

Medications (list current medications/doses)
______________________________
______________________________
______________________________

Patient signature ____________________________

This information was reviewed and confirmed with the patient.

MD/NP signature ____________________________ DATE: __________________________
MD/NP signature ____________________________
RESIDENT signature ____________________________