Kuether Brain and Spine
Todd Kuether, MD
☐ **19250 SW 65th Avenue, Suite 260 Tualatin, OR 97062**
☐ **501 N. Graham, MOB II #515, Portland, OR 97227**
(503) 489-8111 Phone (503) 908-6800 fax
kuetherbrainandspine.com

Date:_______________ Referring Physician____ Dr. Phone: _________

Primary Care Physician (if different) ____ Dr. Phone: ____________

Patient's Name (last,first,middle): _________________________________ Sex: ____ Birthdate (mo, date, yr)__________ Age: ______

Mailing Address: ____ City: _________________ State: ___________ Zip: _________

☐ Cell#:___________________ Please put an "X" in the box Next to your preferred # SS#: ____________ Employer: _____________________________

☐ Home #: ________________ Work #: ______________________ Email Address: ______________________________________

Spouse's Name (last, middle, first): ____ Cell#: ______________________

Birth (Month, Date, Year): ______________________ Spouse's SS#: ____________________ Work#: ______________________

Spouse's Employer: ____________________

Emergency Contact Name: _______________________________ Relation to Patient: ____

Emergency Contact Cell#: ___________Emergency Contact Work #: _____________ Emergency Contact Home #: ______________

Work Comp Injury? ☐ No ☐ Yes Date: ____________________

Auto Accident? ☐ No ☐ Yes Date ____________ Time ____________
Other Accident? ☐ No ☐ Yes Date ____________ Time ____________

If yes, please fill out additional Workman's Comp or Accident form

**** It is the patient's responsibility to hand carry imaging to appointment or we will need to reschedule the appointment ****
****All patients must provide a copy of a valid insurance card and photo ID****

Primary Insurance: __________________ Phone#: ____________ Secondary Insurance: _________________Phone#: ___________

Policy Holder Name (Last,First):____________________________ Policy Holder Name (Last,First): ___________________________

Policy or ID# or Claim #: ___________Insureds DOB: _________ Policy or ID#: ________________ Insureds DOB: ____________

Group#: __________Group Name: _______Union Local#: ______ Group#: __________Group Name: _______Union Local#: _____

I authorize Kuether Brain and Spine to furnish insurance carriers any information concerning my illness, injury or medical care requested to secure insurance benefits. I also assign medical benefits, including major medical benefits, to Kuether Brain and Spine (tkuether llc) as billed. I understand that should a referral not be secured, I will be financially responsible for this office visit and other costs (such as lab and x-ray) related to this visit. I understand that I am personally responsible for all charges by my medical provider whether or not paid by my insurance and assure payment of the bill within 75 days of receipt.

____
Signature Date

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Date Completed:____________

Name: ______________________________ Age: ___ DOB: _______ Appointment Date:___________

Referring Doctor: _______________________________ Primary Doctor:______________________________

Social History

Living Status: □ alone □ with spouse □ other □ assisted living □ nursing home

Current Occupation:__________________ How Long (yrs) ___ Previous Occupation:___________________
□ Working full-time □ Medical Leave □ Retired □ Disability

Do you use tobacco? □ Yes, use now □ Never used □ Previous user Quit ___ years ago
Cigarerettes: How many per day? _________ How many years? ___________
Cigars: How many per day? _________ How many years? ___________
Smokeless: How much per day? _________ How many years? __________
Nicotine: □ patch □ gum

Do you drink alcoholic beverages? □ Yes, □ No
Beer: How many per day? _________
Wine: How many glasses per day? _________
Other: How much per day? _________

Have you ever had or been treated for a drug or alcohol dependency problem? □Yes □No

CURRENT PAIN MEDICATIONS:

Medication	Dose	Number of pills in 24 hrs	Prescribing Doctor

Unprescribed pain medications:
□ never tried □ marijuana □ alcohol □ cocaine □ someone else's prescribed medication □ other

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Date Completed:____________

NAME: ____________________________ AGE: ___ DOB: _______ Appointment Date:___________

REFFERING DR: _____________________________ PRIMARY DR:____________________________

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Current Occupation:_________________ How Long (yrs) ___ Previous Occupation:___________________
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Do you drink alcoholic beverages? □ Yes, □ No
Beer: How many per day? _________
Wine: How many glasses per day? _________
Other: How much per day? _________

Have you ever had or been treated for a drug or alcohol dependency problem? □Yes □No

CURRENT PAIN MEDICATIONS:

Medication	Dose	Number of pills in 24 hrs	Prescribing Doctor	Started When?

Unprescribed pain medications:
□ never tried □ marijuana □ alcohol □ cocaine □ someone else's prescribed medication □ other

CURRENT NON-PAIN MEDICATIONS:

Medication	Amount	How Often?	Start Date?

Are you currently taking □ Aspirin, □ Motrin, □ Aleve, □ or any other anti-inflammatory? ___________________
Are you taking □ Coumadin □ Plavix □Aggrenox

DRUG ALLERGIES: □ **NONE**

Medications

1.	5.
2.	6.
3.	7.
4.	8.

Are you allergic to iodine □ Yes □ No
Are you allergic to tape □ Yes □ No
Do you have any skin reactions to jewelry or metals? □ Yes □ No

Please list any doctors that you have seen for this spine problem:
1.______________________________________ 4. ____
2.______________________________________ 5. ____
3.______________________________________ 6. ____

Physical Therapy □ never tried □ yes Last appointment ____________________________
Where____
Start Date:___________________________________

What treatment was performed?
□ exercises □ stretching □ TENS unit □ ultrasound □massage
□ helpful □ not helpful

Spine Injections

Type of Injection	Date	Doctor	Helpful
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No

Acupuncture □ never tried □ yes □ helpful □ not helpful
Last treatment ________________ Where____

Chiropractics □ never tried □ yes □ helpful □ not helpful
Last treatment ________________ Where____

Naturopath □ never tried □ yes □ helpful □ not helpful
Last treatment ________________ Where____

Neurosurgical History:

Type of Surgery	Date	Surgeon	Helpful
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No

Please list all other operations:

Type of Surgery	Date

Blood Products / Transfusions:
□ YES, if necessary I am able to be transfused with blood products
□ NO, if necessary I am not able to be transfused with blood products

Family History

Relative	Alive	Deceased	Health Problems
Father	□	□	
Mother	□	□	
Sibling 1	□	□	
Sibling 2	□	□	
Sibling 3	□	□	
Sibling 4	□	□	
Sibling 5	□	□	
Sibling 6	□	□	

Please check the box if anyone in your immediate family has had any of the following conditions:

□ High Blood Pressure
□ Heart Attack
□ Chemical Dependency
□ Heart Disease
□ Diabetes
□ Epilepsy
□ Kidney Disease
□ Arthritis
□ Thyroid Disease
□ Stroke
□ Asthma
□ Blood Disorder
□ Gout
□ Cancer Type:____________

Does anyone in your family have a spine problem? □ yes □ no

Review of Systems

Height: __________________ Weight: _________________________

General

□weight gain □weight loss □history of falls □dizziness
□fever □sweats □chills □snoring
□insomnia □hypersomnia(sleep a lot)

Skin

□rash □change in mole □lumps □easy bruising
□itching □change in nails □dryness

Eyes

□glasses □double vision □glaucoma □cataracts
□pain □discharge

Ears

□pain □hearing loss □hearing aid □deafness
□tinnitus (ringing) □discharge

Nose

□runny nose □discharge □nose bleeds

Mouth / Throat

□difficulty swallowing □hoarseness □dentures □mouth sores
□dry mouth □bleeding

Respiratory

□dry cough	□productive cough	□bloody cough	□tuberculosis
□shortness of breath	□pain with breathing	□wheezing	□pulmonary embolism

Heart/ Blood Vessel

□heart attack	□angina	□high blood pressure	□murmur
□leg / foot swelling	□varicose veins	□rheumatic fever	□blood clots

Gastrointestinal

□abdominal pain	□change in appetite	□hepatitis	□heartburn
□indigestion	□nausea	□vomiting	□constipation
□diarrhea	□change in bowel movements	□hemorrhoids	

Urology

□painful urination	□frequent urination	□blood in urine	□night time urination
□urgency	□bladder infections	□genital / STD infection	□bladder control probs.

Hematologic

□anemia	□bleeding problem	□transfusions	□transfusion reaction

Allergic / Endocrine

□food allergies	□hay fever

Neurologic/Psychiatric

□tremors	□seizures	□memory problems	□TIA
□stroke	□depression	□headaches	□anxiety
□emotional problems	□ADD/ADHD		

Men

□difficulty with erection	□prostate cancer	□prostate hypertrophy	□vasectomy

Past Medical History

□heart failure	□asthma	□thyroid disease	□hepatitis
□hypertension	□cancer	□depression/anxiety	□HIV
□diabetes	□orthopedic	□lung disease	□other

Mark the location of your symptoms on the diagram below:

SP

Grip Strength (R) (L)

IMP

(R) (L)

____ ° ____ Ext.

____ ° ____ Flex.

____ ° ____ Pro.

RIGHT LEFT

LEFT RIGHT

LEFT RIGHT

SP

SLP

NAME: ______________________________

DATE: ______________________________

HEIGHT: ________ WEIGHT: ________

RED: PAIN
GREEN: NUMBNESS & TINGLING

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PLEASE READ REGARDING UPDATED INSURANCE CHANGES

As of January 1, 2015, many insurance companies have changed their plans and policies.

It is PATIENT RESPONSIBILITY to know their insurance plan, for example:

1. Is the doctor you are seeing IN NETWORK with the plan?

2. Do you require an INSURANCE REFERRAL to see the doctor? If so, is that referral in place for today's visit? Be aware of the date range of the referral and how many visits are authorized. If there is not a referral, and one is required, today's visit will not be covered by your insurance.

3. Your COPAY AMOUNT which is due at the time of the appointment.

If you are unsure about any of these things, please contact your insurance by calling the number on your card or checking on their website. Keeping up to date with your insurance plan will better assist us with your healthcare.

We appreciate your involvement and cooperation.

Signature ____ Date _______________