CENTRAL TEXAS BRAIN & SPINE

PATIENT NAME: _____ DATE: ____/____/____

❑ Married ❑ Single ❑ Other Title _____ *(If minor child, please complete information at bottom of page.)*

Social Security #: ____/____/____ Date of Birth: ____/____/____ Age: _____ ❑ Male ❑ Female

ADDRESS: _____

City: _____ State: _____ Zip: _____ EMAIL: _____

HOME PH#: _____ CEL PH#: _____

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____

City: _____ State: _____ Zip: _____ WORK PH#: _____ ext. _____

SPOUSE (FULL) NAME: _____ PH#: _____

SPOUSE EMPLOYER: _____ OCCUPATION: _____

REFERRED BY: ❑ FRIEND /PATIENT ❑ DOCTOR: _____ PH#: _____

ADDRESS: _____

PRIMARY INSURANCE CO: _____ NAME OF INSURED: ❑ SELF ❑ OTHER

*IF OTHER: NAME: _____ S.S.#_____ DOB:_____ RELATIONSHIP: _____

POLICY #:_____ I.D.#_____ GROUP #:_____

SECONDARY INSURANCE CO: _____ NAME OF INSURED: ❑ SELF ❑ OTHER

*IF OTHER: NAME: _____ S.S.#_____ DOB:_____ RELATIONSHIP: _____

POLICY #:_____ I.D.#_____ GROUP #:_____

NOTES RE: INSURANCE: _____

For a MINOR CHILD please give names of: FATHER: _____

MOTHER: _____ GUARDIAN/GUARANTOR_____

(We need at least one signature) _____

Fathers Signature / Guardian Signature / Mothers Signature

CENTRAL TEXAS BRAIN & SPINE

Carl Lauryssen, M.D.

Please DO NOT LEAVE ANY SECTIONS BLANK. I need this information to provide you with the most complete and thorough care possible. Every line is important and crucial. Thank you in advance for your attention to detail.
Dr. Lauryssen

NEW PATIENT QUESTIONNAIRE

Date: ____/____/_____

Patient Name: ☐ ☐ ☐ ☐ (Mr., Mrs., Miss, Dr.) _____

Date of Birth: ____/____/_____ Age: _____ Email: _____

Occupation: _____

Unemployed since: _____ ❑ N/A Disability since: _____ ❑ N/A

❑ Worker's Comp ❑ Student

Who referred you to our office? ❑ Friend ❑ Doctor/Chiropractor/PT/Internist

Name: _____

What is the main reason for your visit? ❑ Back pain ❑ Leg pain ❑ Neck pain ❑ Arm pain

When did your pain begin? _____Years _____Months _____Weeks _____Days ago

What are your Symptoms? (Ex: Pain, Weakness, Numbness) Please describe here:

_____

_____

_____

_____

_____

Have you had prior Spinal Surgery:

❑ No ❑ Yes: Year _____ Surgeon_____

Do not leave this blank (Please Approximate)

Height _____' Feet _____" Inches Weight _____

NEW PATIENT QUESTIONNAIRE

Patient Name: _____

Use this Legend to fill in the areas in the diagram to the right

Numbness - - - - - - - - -

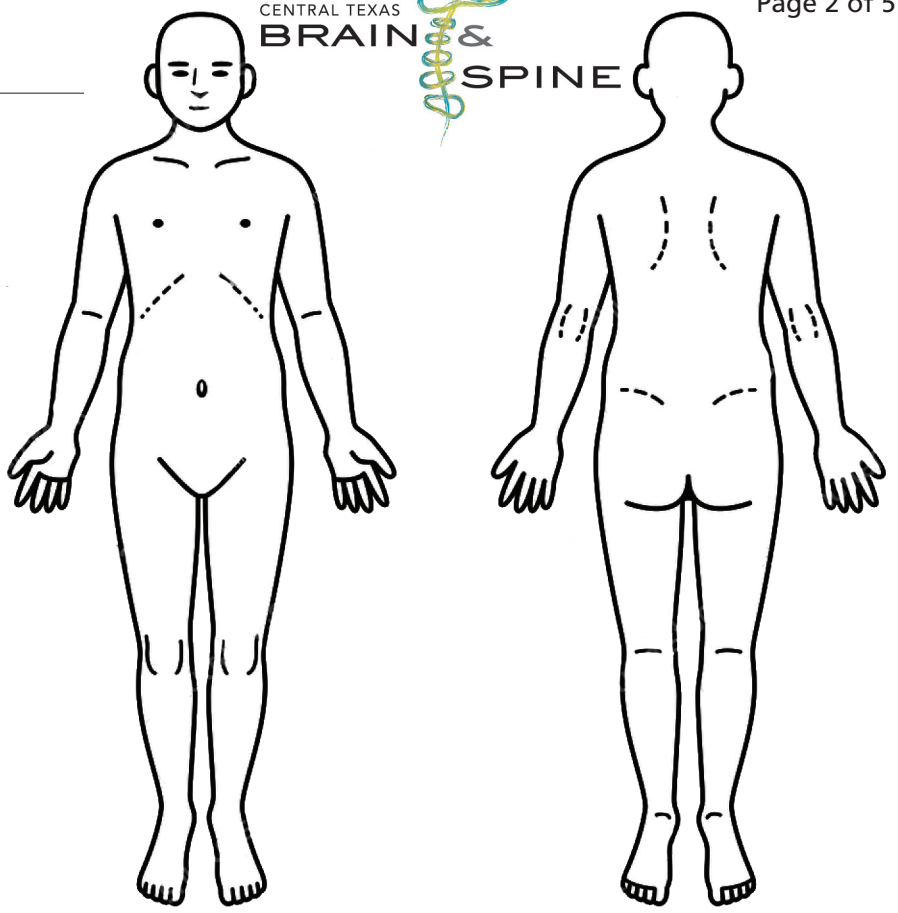
Stabbing ////////////////

Pins & Needles * * * * * *

Burning XXXXXXXX

Aching + + + + + +

Shooting ^ ^ ^ ^ ^ ^



_____ % Back Pain *(i.e. 60%)*

+

_____% Leg Pain (i.e. 40%)

=100% *(or 0% if no Back or Leg Pain)*

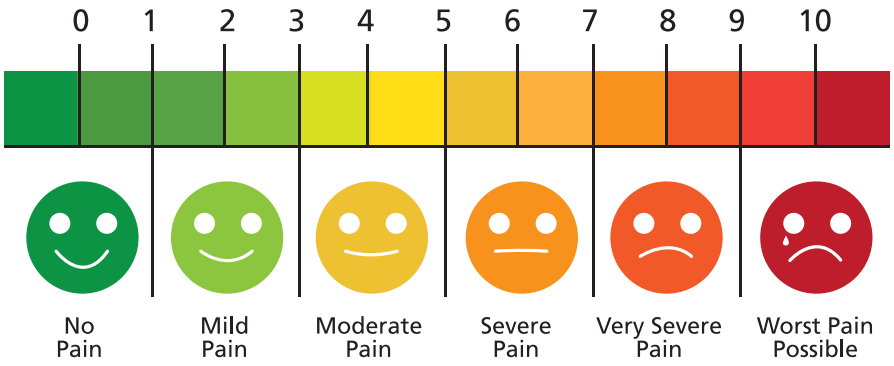
Which side hurts worse?

_____ % Right

+

_____ % Left

=100%



Back pain: _____/10

Right Leg Pain: _____/10

Left Leg Pain: _____/10

Neck Pain: _____/10

Right Arm Pain: _____/10

Left Arm Pain: _____/10

_____ % Neck Pain *(i.e. 80%)*

+

_____ % Arm/Shoulder Pain *(i.e. 20%)*

=100% *(or 0% if no Arm or Shoulder Pain)*

_____ % Right sided **ARM** Pain

+

_____% Left sided **ARM** Pain

=100%

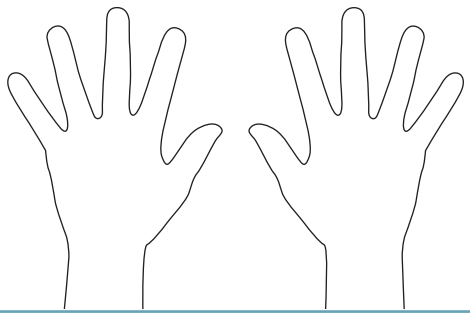
Where does you pain radiate to/go to?

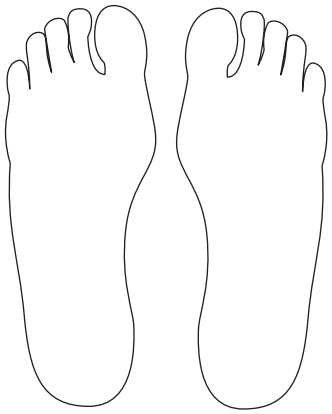
Ex: Thighs, Calves, Arm, Shoulder, Fingers

_____

Which fingers/toes does the pain radiate into?

Circle or draw on hands/feet provided here. If no finger or toe pain or numbness leave image blank.





CENTRAL TEXAS BRAIN & SPINE

NEW PATIENT QUESTIONNAIRE

Patient Name: _____

Describe your weakness, if any, in detail: _____

_____

_____

_____

The pain is worsened/aggravated with: _____

The pain is relieved by: _____

What can you **NOT DO** because of the pain (Exercise, Walk, Run, Sexual Activities, Work, School): _____

_____

How far can you walk? _____ How far could you walk 1 year ago? _____

The pain is associated with (Ex: Headaches, Weakness) _____

Have you noticed difficulty with? (Check all that apply)

- ❑ Balance
- ❑ Weakness
- ❑ Handwriting
- ❑ Grip Strength
- ❑ Dropping items
- ❑ Buttoning your shirt
- ❑ Opening Jars
- ❑ Picking up coins
- ❑ Pain with Flexion/Bending forward
- ❑ Pain with Extension/Bending backwards
- ❑ Getting out of a chair
- ❑ Getting up out of bed
- ❑ Sleeping
- ❑ Pain with twisting
- ❑ Waking up because of pain

Physical Therapist Name: _____ Number of sessions _____

INJECTIONS: Injection Dr. _____

_____ Number of Epidural Steroid Injections: _____ In past year _____ In past 2 years

_____ Number of Selective Nerve root blocks/Injections: _____ In past year _____ In past 2 years

_____ Number of Facet Joint Injections: _____ In past year _____ In past 2 years

_____ Number of Trigger Point Injections: _____ In past year _____ In past 2 years

My most recent injection was _____ (date) and gave me _____ (days/months/years) of relief.

Chiropractor's Name: _____ Number of Sessions: _____

Acupuncture: _____ Number of Sessions: _____

CENTRAL TEXAS BRAIN & SPINE

NEW PATIENT QUESTIONNAIRE

Patient Name: _____

Is this related to an injury? ❑ Yes ❑ No ❑ Possibly Date of Injury: _____

Injury on the job/fall/sports: _____

Vehicular accident (Use this space to describe the accident)

_____

_____

_____

_____

❑ Rear end ❑ Hit from the:
❑ Head on ❑ passenger side
❑ Side swipe ❑ driver side

❑ Seatbelt/Restrained
❑ Airbag deployed
❑ Car totaled

Speed of Car which caused accident: _____ /mph

Car model you were driving: _____
Other car involved: _____

Which of the following diagnostic tests have you done?

❑ None

❑ X-rays - Date: _____
❑ MRI - Date: _____
❑ CT Scan - Date: _____
❑ Myelogram - Date: _____
❑ Bone Scan - Date: _____
❑ EMG/Nerve Studies - Date: _____

PRIMARY CARE PHYSICIAN _____

PAST MEDICAL HISTORY - Please list ANY and ALL reasons for which you have EVER seen a doctor.
If not listed here, please write in. Thank you.

❑ None
❑ High Blood Pressure
❑ Ulcers
❑ Stroke
❑ Bleeding
❑ Blood Clots
❑ Diabetes
❑ Heart Attack
❑ Thyroid
❑ IBD
❑ High Cholesterol
❑ Sickle Cell
❑ Prostate
❑ Lung Emphysema/COPD
❑ Reflux
❑ Cancer: Type _____
Treated with: ❑ Surgery ❑ Radiation ❑ Chemo

Other conditions not listed here (List ALL below) _____

_____

_____

_____

PAST SURGICAL HISTORY (List ANY and EVERY surgery you have EVER had including the date.)

❑ Difficulty with Intubation (Date: _____)
❑ Pacemaker (Date: _____)
❑ CABG (Date: _____)
❑ Cancer Surgery (Date: _____)
❑ Hysterectomy (Date: _____)
❑ C Section (Date: _____)
❑ Tonsillectomy (Date: _____)
❑ Gallbladder (Date: _____)
❑ Kidney Stone (Date: _____)
❑ Hernia (Date: _____)
❑ Appendectomy (Date: _____)
❑ Total Hip Replacement (Date: _____)
❑ Total Knee (Date: _____)
❑ Other: _____ (Date: _____)
❑ Other: _____ (Date: _____)
❑ Other: _____ (Date: _____)
❑ Other: _____ (Date: _____)
❑ Other: _____ (Date: _____)

CENTRAL TEXAS BRAIN & SPINE

NEW PATIENT QUESTIONNAIRE

Patient Name: _____

MEDICATIONS *(please list MEDICATIONS, DOSE and HOW TAKEN)*

1. _____ , _____ , _____
2. _____ , _____ , _____
3. _____ , _____ , _____
4. _____ , _____ , _____
5. _____ , _____ , _____
6. _____ , _____ , _____

How many times daily do you take Narcotics? _____/Times a day

FAMILY HISTORY

❑ Heart Disease ❑ Cancer ❑ Dementia ❑ Stroke ❑ Diabetes

ALLERGIES TO MEDICATIONS *(List all reactions, this could be of life saving importance)*

_____

_____

_____

SOCIAL HISTORY

Who do you live with?: ❑ Alone ❑ Family _____Kids ❑ Significant Other

Occupation _____

Tobacco Use: ❑ None ❑ Smoking for _____Years _____Packs/day

Alcohol Use: ❑ None ❑ Drink ❑ Drink Socially/Occasionally ❑ Quit/Sober _____Years

Drug Use: ❑ None ❑ Marijuana ❑ Heroin ❑ IV Drug use ❑ Sober _____Years

REVIEW OF SYSTEMS *(Please check a box Yes or No, do not leave blank)*

GENERAL/CONSTITUTIONAL
Recent unexplained weight loss: ❑ Yes ❑ No
Fevers: ❑ Yes ❑ No

SKIN/BREAST
Have you had MRSA/Staph Infection?: ❑ Yes ❑ No

EYES/EARS/NOSE/MOUTH/THROAT
Head: Lightheadedness, dizziness: ❑ Yes ❑ No
Vision: Blurred or double vision: ❑ Yes ❑ No
Nose: Obstruction, discharges: ❑ Yes ❑ No
Dental: Gingivitis, Infections: ❑ Yes ❑ No
Neck: Stiffness: ❑ Yes ❑ No

CARDIOVASCULAR
Chest pain: ❑ Yes ❑ No

RESPIRATORY
Shortness of breath: ❑ Yes ❑ No

GASTROINTESTINAL
Incontinence of stool: ❑ Yes ❑ No

GENITOURINARY
Incontinence of urine: ❑ Yes ❑ No

MUSCULOSKELETAL
Muscular pains: ❑ Yes ❑ No

NEUROLOGIC/PSYCHIATRIC
Anxiety: ❑ Yes ❑ No
Depression: ❑ Yes ❑ No

CENTRAL TEXAS BRAIN & SPINE

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

EXPLANATION:
This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act.

Patient Name: _____ DOB: ___/___/___ SSN: ___/___/___

INFORMATION TO BE RELEASED FROM:

Name/Facility: _____

Address: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED TO :

CARL LAURYSSEN, M.D.
Phone: (512) 730-0000
Fax: (512) 835-8101

INFORMATION TO BE RELEASED:

_____

_____

_____

I am aware of and/or have been advised of the provisions of existing State and Federal Statutes, Rules and Regulations which provide for my right to confidentiality of the information in these records.

I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization before any records can be released, also that I may refuse to sign, but in that event the records cannot be released.

Signature: _____ Date: ___/___/___

Signature of parent/guardian: (If minor) _____

Relationship to patient: _____

CENTRAL TEXAS BRAIN & SPINE

Neurosurgical Specialists of Texas Notice of Privacy Practices

Phone: (512) 730-0000

NOTICE OF PRIVACY PRACTICES

To our patients

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Neurosurgical Specialists of Texas is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances.
The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to a court or administrative order
3. If required to do so by a law enforcement official
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities
6. To federal officials for intelligence and national security activities authorized by law
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. *We are not required to agree to your request;* however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to ***Privacy Officer*** or you may call ***(512) 730-0000*** for further information.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to ***Neurosurgical Specialists of Texas.*** You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office at (512) 730-0000. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. ***Neurosurgical Specialists of Texas*** will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact ***Neurosurgical Specialists of Texas.***

CENTRAL TEXAS BRAIN & SPINE

PHONE: (512) 730-0000
FAX: (512) 835-8101

Carl Lauryssen, M.D.

Minimally Invasive Spine Surgery Diplomate,
American Board of Neurologic Surgery Diplomate,
Canadian Board of Neurologic Surgery Fellowship Trained, Spinal Surgery

INVESTOR DISCLOSURE

Dr. Carl Lauryssen is involved in medical research development of products and implants and may be a consultant and/or invest in a company whose products are used in your surgery. By signing this consent form, you are acknowledging this disclosure and that you were provided with the opportunity to have all of your questions answered regarding the selection of devices used in your surgery.

The following are the current companies in which Dr. Lauryssen is involved:
Alphatech, Amedica, Benvenue Medical, Crosstree, Dallen Medical, Depuy Spine, Globus, Graphic Surgery, INCAS, Intrinsic Therapeutics, K2M, Medtronic-Kyhpon, Paradigm, Replication Medical, Spinal Kinetics, Spineology SpineView, Surgitech.

Disclaimer:
Informed consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s), including no surgery. The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your spinal surgeon may provide you with additional or different information that is based on all the facts in your particular case and the current state of medical knowledge. Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

Patient Name: _____

Signature: _____ Date: ____/____/____

Witness/Legal Representative: _____

Signature: _____ Date: ____/____/____