Welcome to the UW Spine Clinic

You are scheduled on _____ to see _____.

In order to best serve your needs, please bring with you the following to your appointment:

1. **Completed Questionnaire** (questionnaire enclosed)
2. **Spinal Imaging**

   Hand-carry any plain x-rays, MRI scans, CT scans, etc. that you may have had done at another facility. Radiology reports are not sufficient; we need the actual film and report. Typically, we require the x-rays to be 6 months old or less. If your insurance will not allow films to be done here, you may want to have new ones done at your clinic.
3. **Medical Records**

   Please bring any previous spinal operative notes.
4. **Insurance Referral** (if needed)

   If you belong to an HMO, bring a copy of your referral with you. If this is a worker's compensation claim, bring the claim number, the name of the insurance company and the address where the claim should be sent.

If you have any questions regarding your upcoming appointment, please do not hesitate to give us a call at (608)265-3207. Our fax number is (608)263-4995.

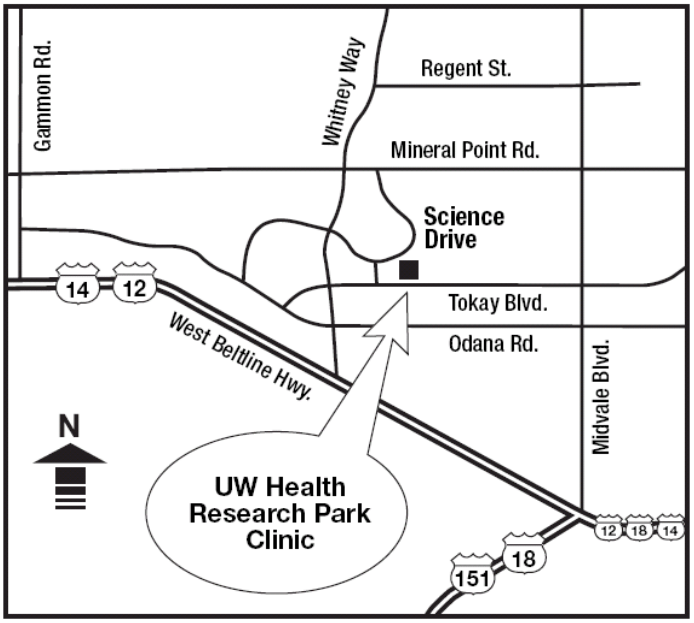
Directions

The Spine Clinic is located at the UW Health Research Park Clinic, 621 Science Drive, Madison, Wisconsin, 53711. (608) 265-3207

• From the east – take Mineral Point Road west and turn left on Science Drive (before Whitney Way).

• From the west – take Mineral Point Road east, turn right on Whitney Way and left on Science Drive.

• From the beltline (12&18) – take Whitney Way exit north, go straight through intersections of Odana and Tokay and turn right on Science Drive.



UW Health

uwhealth.org

Welcome to the UW Health Spine Clinic

To help you better prepare for your clinic visit with us, please review the following information. This comprehensive list outlines what to expect, as well as the health care providers you may encounter at a typical clinic visit. Your visit with us may or may not include all of the services listed below. Thank you again for choosing the UW Health Spine Clinic as your health care provider.

1. **Check-in and Waiting Area:** Registration/check-in will be as you enter the clinic building. After checking in, proceed to the second floor waiting area. If you are new to our clinic and have not filled out the patient health history questionnaire, please obtain one at the second floor information desk.
2. **Electronic Medical Record Update:** A medical assistant (MA) will bring you from the waiting area and take you to your clinic room. The MA will then update your current medications and health status in your electronic medical record.
3. **Preliminary Examination:** You will be seen by the physician's resident, physician assistant, nurse practitioner, or medical student, who will note your history, perform a preliminary physical examination, and determine if you need radiographic films.
4. **Radiology:** If you need new x-ray films, you will be sent down the hall to radiology. You may be asked to change into shorts or a gown for x-rays. You will then return to your clinic room. Your films will be sent electronically to your room; you do not need to hand carry any films.
5. **Physician Evaluation & Assessment:** The physician will review your history and repeat essential parts of the physical examination. At the completion of this assessment, the physician will provide you with a diagnosis and a comprehensive treatment plan.

This plan may include, but is not limited to, the following:

- **Prescription for braces/orthotics:** Depending on the type of orthotic prescribed, you may see the orthotic technician at your clinic visit or you may be asked to schedule an appointment at a later date.
- **Consult for spine physical therapy:** You may schedule a spine physical therapy appointment at any provider covered by your insurance.
- **Referral to other health care providers:** Contact information will be provided at your clinic visit. Appointments may be scheduled at the Spine Clinic check-out desk, or you may be directed to schedule them on your own.
- **Follow-up appointment:** Proceed to the Spine Clinic check-out desk to schedule your next appointment. Any doctor orders will have been sent to them electronically.

****Please allow approximately two hours for your initial clinic visit.****

Welcome to our clinic

Welcome!

Welcome to our clinic. Thank you for the opportunity to be a partner in your health care. At UW Health we strive to provide the best possible care. Our clinic is part of the University of Wisconsin. In addition to your physician, nurse practitioner or physician assistant, you may be seen by a resident physician, medical student or advanced practice nursing student.

Telephone Availability

Feel free to call any time you have concerns about your health. If you call the clinic before 4 p.m. we will make every effort to respond that day. If your call is urgent, we will review your needs and arrange for care.

To respect your privacy, we will not leave information on answering machines or share information regarding patients over the age of 18 without their permission.

After Hours Care

In the event of an emergency, call 911. For urgent questions or concerns, please call (608) 262-2122. You will be connected to the answering service. They will contact the physician on call. Our doctors admit patients to UW Hospital.

Prescriptions

Before you run out of a prescribed medication, you can renew as follows:
1. Ask your doctor during your appointment.
2. Call your pharmacy, who will contact your doctor for you.

Please contact your pharmacy at least 48 hours before your medication runs out. Chronic narcotic patients should call the clinic one week before your medication runs out.

Lab Work/Tests

You will be contacted with your test results within 14 days unless your doctor tells you otherwise. If you have not received your test results after two weeks, please call the clinic at (608) 265-3207.

Appointments - Outpatient Attendance

Please schedule your return appointment before leaving. If you have questions or concerns before your next scheduled appointment, don't hesitate to call the clinic. If you have changes in your medication, allergies or current health, please share with your provider at your next scheduled appointment. If you need to cancel an appointment, please call us as soon as possible. This allows us to meet the needs of other patients.

Please contact our registration department at (608) 262-1400 with any changes of address or insurance. We require verification of information through registration every 120 days. Contacting our registration department before your appointment will prevent delays.

Resources

Question/ Concern	Resource	Contact Information
Insurance	Please call your insurance company to verify coverage for therapy services.	
Billing	Patient Billing Service	(608) 262-2221 or (866) 841-8535
Pricing	Priceline	(608) 263-1507
Financial Hardship	Community Care Line	(608) 262-2221 or (866) 841-8535
Other Questions	Patient Relations	(608) 263-8009
On-Line prescription renewal	Pharmacy	uwhealth.org/rx

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621 Science Drive
(608) 265-3207
uwhealth.org

Patient Name:

DOB:

MR #:

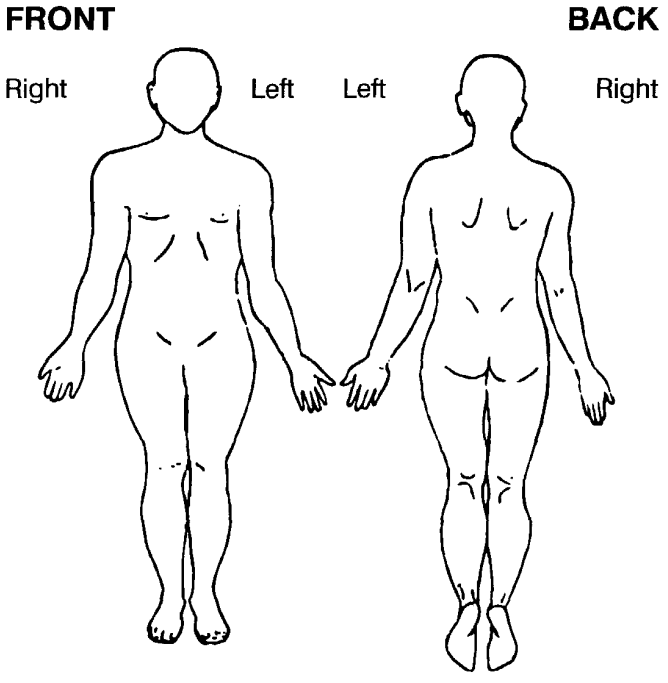
UW-Health Research Park Spine Clinic
621 Science Drive · Madison, Wisconsin 53711

INITIAL PATIENT QUESTIONNAIRE – SPINE

Date:_____

(BRING THIS QUESTIONNAIRE WITH YOU TO YOUR APPOINTMENT. DO NOT MAIL)

Mark in the areas of your body where you now feel your typical pain. Include all affected areas. Use the appropriate *symbols* indicated below: PAIN = XXXXXX NUMBNESS = OOOOOO



If more than one area, which is worse? _____

How long have you had this problem? _____

Did your symptoms follow an injury?_____ If yes; _____at work _____auto accident _____other

Describe: _____

Circle your least and greatest pain levels over the past two weeks:

(None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

Have you had neck/back symptoms before? Y___ N___

Have you ever had previous back or neck surgery? Y___ N____

If yes, describe: _____

Is the purpose of this exam to determine disability status for the government or an insurance agency? _____

Are you currently receiving any type of financial compensation for your back problem?_____

Do you have an attorney for your back problem? _____

Patient Name:

DOB:

MR #:

Please list previous radiology studies you have had for this problem.

	Date	Location
MRI		
CT Scan		
Myelogram		
Bone Scan		
EMG		
X-rays		

PREVIOUS TREATMENT:

Put a check next to each type of treatment you have had for you back/neck in the past. Then check the column that best describes the effect of the treatment.

Treatment	Check if you have had this	Did it make things Better	Worse	No change
Hot packs/ice				
Ultrasound				
Massage				
TENS/E-Stim				
Yoga/Tai-Chi				
Exercises				
Traction				
Bed Rest				
Pool therapy				
Biofeedback				
Injections				
Braces/Splints				
Medication				
Acupuncture				
Chiropractic Adjustments				

MEDICAL HISTORY:

Have you ever had:

____AIDS or HIV testing	____Phlebitis or blood clots	____Kidney Stones	____GERD
____Asthma/Breathing problems	____Stroke	____Arthritis	____High Cholesterol
____Cancer	____Thyroid trouble	____Seizures	
____Radiation/Chemotherapy	____Kidney Infections	____Ulcer	
____Migraine or other severe head pain	____Heart Disease	____Tuberculosis	
____High Blood Pressure	____Diabetes	____Hepatitis	
____Chronic Fatigue Syndrome	____Fibromyalgia	____Other:	

Patient Name:

DOB:

MR #:

REVIEW OF SYSTEMS:

Check all that apply.

Constitutional
Fever___
Chills___
Night sweats___
Weight loss___
Loss of appetite___

Allergy/immune
Drug allergy___
Seasonal allergy___
Food allergy___
Iodine allergy___
Transplant___

Neurologic
Paralysis___
Tremors___
Spasticity___
Seizures___
Muscle atrophy___
Double vision___

Musculoskeletal
Joint stiffness/swelling___
Muscle pain/swelling___
Fatigue___
Fractures___

Hemolymphatic
Anemia___
Excessive bleeding___
Easy bruising___
Lymphoma___
Leukemia___
Cancer___
Lymph node swelling__

CV/Respiratory
Shortness of breath___
Wheezing___
Cough___
Coughing up blood___
Chest pains___
Palpitations___
Leg swelling___

Gastrointestinal
Difficulty swallowing___
Heartburn___
Nausea/vomiting___
Constipation___
Diarrhea___
Blood in stools___
Stomach pain___

Endocrine
Obesity___
Thyroid disorder___
Diabetes___
Menopause___
Menstrual irregularities___
Pelvic Pain___
Addison's disease___

HEENT
Loss of vision___
Eye Redness___
Headaches___
Dizziness___
Glaucoma___

Skin/integumentary
Rash___
Ulcer___
Eczema___
Hives___
Sexual Difficulties___

Genitourinary
Pain urinating___
Incontinence___
Blood in urine___
Dribbling___
Pregnant___
Last Menstrual Period (date) ___

Psychiatric
Poor sleep___
Depression___
Anxiety___
Stress at work/home___

PAST SURGICAL HISTORY:

Year	Operation	Place Hospitalized

ALLERGIES:

Name of medicine/substance	Type of reaction	Date

Patient Name:

DOB:

MR #:

MEDICINES: List all medicines that you take, including the doses and how often you take them. Include vitamins and nonprescription medicine.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

FAMILY HISTORY:

Spinal Problems	Y___	N___	If yes, describe: _____
Bleeding Disorders	Y___	N___	If yes, describe: _____
Heart Disease	Y___	N___	If yes, describe: _____
Cancer	Y___	N___	If yes, describe: _____
Diabetes	Y___	N___	If yes, describe: _____

SOCIAL HISTORY:

How many years of schooling? (circle one)

Less than high school high school graduate technical school diploma 1-3 years of college

College graduate post graduate or professional degree

Marital Status: Single___ Married____ Divorced____ Remarried____ Widowed____ Separated____

Who lives with you at home?_____

Work status: Working___ Not Working____ Student____ Disabled____ Retired____

Primary Occupation: _____ Employer:_____

How long have you worked at your present job? _____ If not working, last date worked:_____

Have you ever smoked? _____Type/Amount:_____ Years:_____ If quit, when?_____

Amount of alcohol consumed in a typical week? _____ Cups of caffeinated drinks per day?_____

Have you used: Marijuana _____ Cocaine _____ Heroin_____ Other_____

Do you get any regular exercise? Describe:_____

Completed by: _____Date: _____

If not completed by patient, relationship to patient:_____

Reviewed by: _____ Date:_____Time:_____