
**Mitchell Hardenbrook, MD, PC**
**NEW PATIENT INFORMATION**

## PATIENT INFORMATION

Name: _____Male: [ ] Female [ ]
(Last) (First) (Middle)

Date of Birth:_____ Age: _____ Social Security Number: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone:_____Cell/Work Phone:_____Email:_____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Occupation:_____ Employer: _____

Primary Care Physician:_____
(Name) Phone Fax
Referring Physician:_____
(Name) Phone Fax

| PRIMARY INSURANCE | SECONDARY INSURANCE |
|---|---|
| Name_____ | Name_____ |
| ID#:_____ | ID#:_____ |
| Group#_____ | Group#_____ |
| Subscriber_____ | Subscriber_____ |
| Subscriber DOB_____ | Subscriber DOB_____ |

Is this a work-related condition?: [ ] Yes [ ] No
**Worker's Compensation Information** (if applicable):

Carrier:_____ Claim # _____

Claim Office Address: _____

Adjuster _____ Phone_____Fax_____

Date of Injury: _____ Employer_____

Are you represented by an attorney? Yes / No

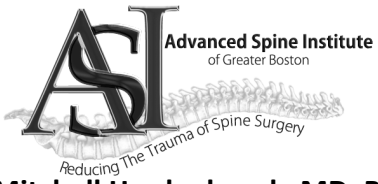
Name of attorney: _____ Phone: _____

**Assignment of Benefits, Release of Information & Payment Agreement**

I understand that payment is due at the time of service unless other arrangements have been made. I understand that Mitchell Hardenbrook, MD, PC will be filing my insurance on my behalf. I agree to have the benefits of my insurance assigned to Mitchell Hardenbrook, MD, PC.

I hereby assign to the physician for medical series rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance.

**Patient/Responsible Party Signature:_____Date:_____**




**Mitchell Hardenbrook, MD, PC**
**PATIENT HISTORY**

**PAST MEDICAL HISTORY:**

Height:_____ Weight:_____

| | | | |
|---|---|---|---|
| □ Diabetes | □ Cancer | □ Kidney Disease | □ Asthma |
| □ High Blood Pressure | □ Bleeding disorders | □ Liver disease | □ Emphysema |
| □ Heart disease | □ Seizures | □ Stroke | □ Hepatitis |
| □ Blood clots | □ Osteoporosis | □ Anxiety | □ Depression □ Other_____ |

Racial background:

| | | | |
|---|---|---|---|
| □ American Indian/Alaskan Native | □ Asian | □ Black or African American | □ White or Caucasian |
| □ Middle Eastern | □ Hispanic | □ African | □ Caribbean |
| □ Indian | □ Other_____ | | □ No response |

**PAST SURGICAL HISTORY:**

| YEAR | PROCEDURE | HOSPITAL | DOCTOR |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**ALLERGIES:**

| ALLERGY | REACTION |
|---|---|
| | |
| | |
| | |
| | |

**MEDICATIONS:** (If you have a medication list, we will simply make a copy)

| MEDICATION NAME | DOSE/FREQUENCY |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |


**Mitchell Hardenbrook, MD, PC**
**PATIENT HISTORY**

**REVIEW OF SYSTEMS:**

| | | | | |
|---|---|---|---|---|
| □ Frequent heartburn | □ Menstrual changes | □ Nervousness | □ Headaches | □ Easy bruising |
| □ Abdominal pain | □ Pain in joints | □ Depression | □ Loss of hearing | □ Swollen glands |
| □ Reflux (GERD) | □ Muscular weakness | □ Fatigue | □ Bloody nose | □ Irregular heartbeat |
| □ Change in bowel movements | | □ Skin sores | □ Anxiety | □ Mouth sores |
| □ High blood pressure | □ Incontinence | □ Rashes/bumps | □ Fever | □ Throat problems |
| □ Swollen ankles/feet | □ Excessive bleeding | □ Numbness in any limb | □ Chills | □ Tremors |
| □ Leg cramps | □ Allergies | □ Night sweats | □ Heart problems | □ Wheezing |
| □ Blood in urine | □ Fainting | □ Insomnia | □ Chest pains | □ Frequent coughing |
| □ Bloody sputum | □ Migraines | □ Infection | □ Significant weight loss | |

**What is your work status?**

□ Currently working □ On disability □ Unemployed □ Homemaker □ Retired □ Student □ Retired

**Check all that apply.**

**Do you feel better when you are:**

□ Standing
□ Sitting
□ Lying down
□ Walking
□ Exercising
□ Other_____

**Do you feel worse when you are:**

□ Coughing/sneezing
□ Sleeping
□ Sitting
□ Standing
□ Bending
□ Lifting
□ Walking
□ Other_____

**SOCIAL HISTORY:**

How would you describe your weekly alcohol consumption?

□ None □ 1-7 drinks/week □ 8-21 drinks/week □ 22-35 drinks/week □ More than 35 drinks/week
□ No response

Do you currently smoke or use smokeless tobacco/nicotine products?

□ Yes, I smoke now If yes, how many packs per day do you smoke?_____ How long have you been smoking?_____
□ I am using nicotine patches
□ I use smokeless products
□ No, I do not smoke now
□ No response

How often do you use recreational drugs?

□ I never use recreational drugs
□ Less than once a week
□ 1-3 times/week
□ 4-7 times/week
□ No response


**Mitchell Hardenbrook, MD, PC**
**PATIENT HISTORY**

**FAMILY HISTORY:**

Is you father currently alive?
□ Yes □ No
What is his current age OR his age at death?_____

Is your mother currently alive?
□ Yes □ No
What is his current age OR her age at death?_____

| List your FATHER's notable medical history such as diabetes, stroke, heart disease, cancer or high blood pressure. | List your MOTHER's notable medical history such as stroke, heart disease, cancer or high blood pressure. |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**PAIN ASSESSMENT:**

Have you had any of the following treatments?
Physical therapy □ Yes □ No
Injections □ Yes □ No
Chiropractic manipulation □ Yes □ No
Medications: □ Yes □ No

Approximately how many days of bed rest have you tried to treat the current episode?_____
Approximately how many days in the past year you have missed work because of this pain?_____

Pain frequency: □ Constant □ Comes and goes
Pain is worse: □ in the morning □ Afternoon □ Evening □ Night

Description of pain:
□ Dull □ Ache □ Sharp □ Sting □ Tingle
□ Burn □ Deep □ Superficial □ Swelling □ Throbbing

Advanced Spine Institute of Greater Boston
Reducing The Trauma of Spine Surgery

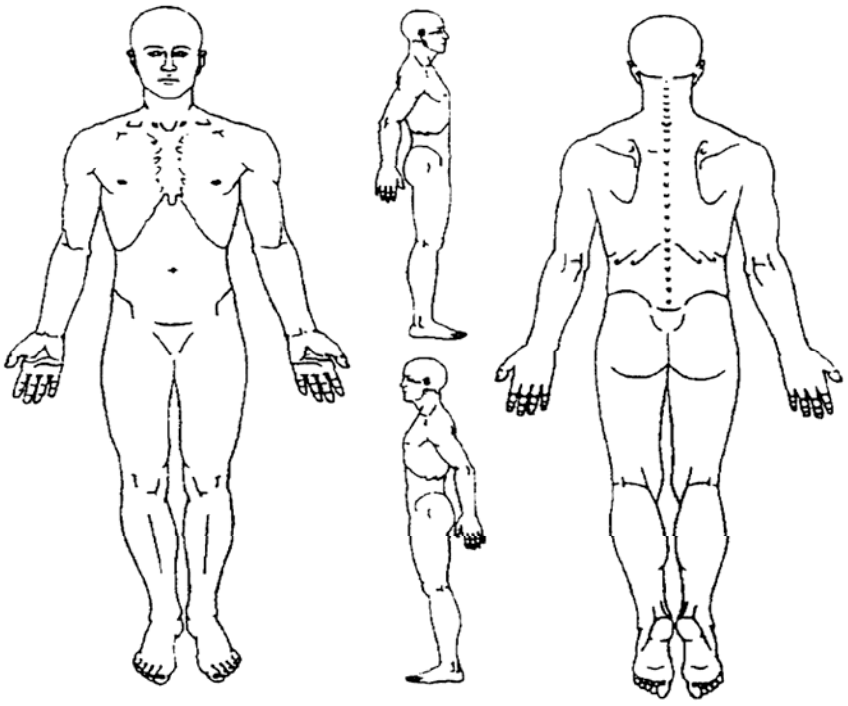
**Mitchell Hardenbrook, MD, PC**
**PATIENT HISTORY**

Please describe the **type of pain** or sensation you are currently experiencing by marking the pain diagram with the appropriate symbol using the descriptive words below.

**Dull/Aching Pain** XXXXX **Sharp/Stabbing Pain ^^^^**

**Burning Pain ::::** **Numbness/Tingling NNNNN**

Please mark on the diagram the type and location of your pain.



Indicate your level of pain in your **back** on a scale of 1-10. Please circle the appropriate response.
No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Unbearable Pain

Indicate your level of pain in your **neck** on a scale of 1-10. Please circle the appropriate response.
No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Unbearable Pain

Indicate your level of pain in your **arms** on a scale of 1-10. Please circle the appropriate response.
No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Unbearable Pain

Indicate your level of pain in your **legs** on a scale of 1-10. Please circle the appropriate response.
No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Unbearable Pain