Self-Referral Questionnaire

Name: _____ Age: _____

Phone Number: _____

Name and Phone Number of Primary Care Physician (if you have one):

_____

How did you hear about us? _____

Insurance Information: _____

Brief Description of Your Symptoms:

How long have you had these symptoms? _____

Please circle all that apply below:

Pain Location: **Head** **Neck** **Mid-Back** **Low Back**

Pain goes into: **Right Arm** **Left Arm** **Right Leg** **Left Leg**

Numbness: **Right Arm** **Left Arm** **Right Leg** **Left Leg**

Weakness: **Right Arm** **Left Arm** **Right Leg** **Left Leg**

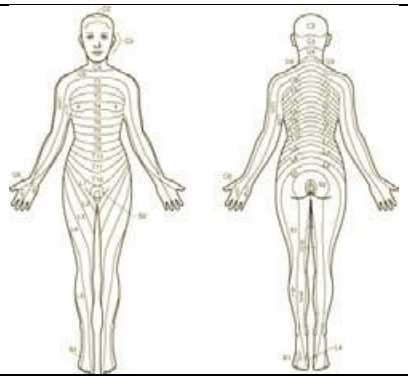
Have you had surgery for this or a similar problem before? Please explain:

_____

_____

Have you had any non-surgical treatment for this problem in the past 12 months (e.g. medications, physical therapy, steroid injections)? _____

_____



After you print this form, mark the location of your pain/discomfort /numbness on this diagram.

Terms and Conditions of Self-Referral Screening

Please read carefully and acknowledge your acceptance of these terms and conditions by signing below.

1. I understand that submitting a request for Self-Referral Screening to Dr. Spence's office does NOT establish a patient/doctor relationship between me and Dr. Spence. Such a relationship will develop only if I have been accepted for an evaluation and only after I have undergone such an evaluation by Dr. Spence.

2. I understand that if I am accepted for evaluation, this does not necessarily mean that I will undergo surgery. I understand that Dr. Spence will make any decisions regarding surgery only after he has personally interviewed and examined me. Additional diagnostic tests, non-surgical treatment, or no treatment may be recommended.

3. I understand that I may not be accepted as a patient by Dr. Spence. I further understand that Dr. Spence is under no obligation to provide an explanation as to why I have not been accepted for evaluation.

4. I understand that if I am not accepted for evaluation, I may still have a problem that requires medical attention. Such a determination can only be made by the physicians who have previously examined me and ordered my diagnostic studies. As such, I remain under their care.

5. I understand that if my condition suddenly deteriorates while I am undergoing the screening process, I will report immediately to an emergency room or to a doctor with whom I have previously established a patient/doctor relationship.

I fully understand and accept the terms of the Self-Referral Screening process as described above.

Name: _____

Signature: _____ Date: _____

For Office Use Only

Date Received: _____ Complete: Yes / No Date Completed: _____

Date Reviewed: _____ Decision: _____

Date Patient Informed: _____