Medical Office Building

1100 Goethals Drive, Richland

DIRECTIONS

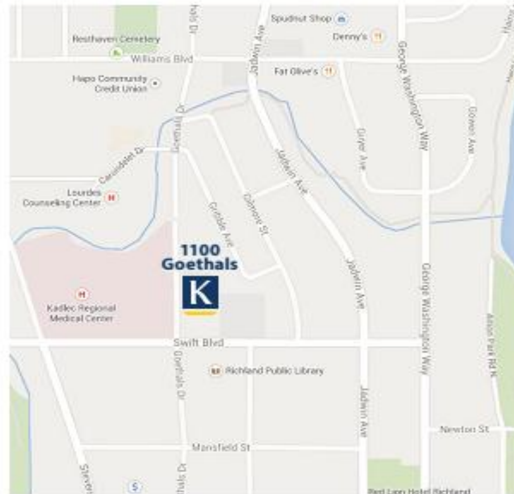
From **I-182**

Take **George Washington Way** (Exit 5B)

Turn left on **Swift Boulevard**

Turn right on **Goethals Drive** (third right)

1100 Goethals Drive is one block on the right



First Floor

Infectious Disease
(509) 942-2360

Neuroscience Center
(509) 942-3080

Second Floor

Ear, Nose and Throat
(509) 942-3288

Endocrinology
(509) 942-3288

Foot and Ankle
(509) 942-3288

General and Colorectal Surg
(509) 942-3288

Nephrology
(509) 942-3288

Urology
(509) 942-32880

Tri-Cities Laboratory
(509) 946-4887

Third Floor

Inland Cardiology
(509) 942-3272

Cardiothoracic Surgery
(509) 942-3095

Interventional Radiology
(509) 942-3095

Pulmonology
(509) 942-3095

Vascular Surgery
(509) 942-3095

KADLEC | CLINIC

www.kadlecclinic.org

MISSED APPOINTMENT POLICY:

In an effort to better serve our patients, we ask that you give us a minimum of 24 hours notice if you are unable to keep your appointment. We will be happy to reschedule your appointment for a time that is more convenient for you. This time has been reserved for you and your health care is important to us.

If you do not cancel your appointment with at least 24 hour advanced notice or you fail to keep your appointment, you will receive a charge of $100.00

In excess of two missed appointments could result in being discharged from our practice.

REFERRAL REQUEST:

If you need a referral to a specialist or have requested a referral please allow us 7-10 business days to process your request.

LATE POLICY:

If you are 15 or more minutes late for your appointment, the receptionist will do the following:

- Check with the provider or staff and see if you can be seen without delaying other scheduled appointments.
- Reschedule for another day.
- Reschedule at the end of the morning or afternoon.

CELL PHONES AND PAGERS:

To ensure that you have uninterrupted, quality time with your health care provider during your examination, we ask that you turn off your cell phone or your pager when you enter the examination room.

CO-PAYMENT POLICY:

If your insurance requires a co-payment at the time of service, you will be expected to pay this before your visit. We accept credit and debit cards. If you are not able to make your co-payment, your appointment will need to be rescheduled.

Thank you.

Your answers to this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!!

Name:______________________________ Date of Birth: __________Height: _______ Weight: ___________

REASON FOR VISIT: ____
REFERRING PHYSICIAN:____
PRIMARY CARE/FAMILY PHYSICIAN: ____

Drug Allergies: please list reaction ○ NKDA (No known drug allergies)

Type/Drug: _________________________________ Reaction: _____________________________

Type/Drug: _________________________________ Reaction: _____________________________

Type/Drug: _________________________________ Reaction: _____________________________

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Type/Drug: _________________________________ Reaction: _____________________________

Type/Drug: _________________________________ Reaction: _____________________________

Type/Drug: _________________________________ Reaction: _____________________________

Present Medications: (Please include any aspirin, over the counter vitamins, herbs and other supplements)

☐ Not taking any medication at this time

Medication / Drug Name	Dose (mg)	Frequency (times per day)

Past Medical History: (Indicate whether you have had the following, with dates if possible)

- ☐ Anemia
- ☐ Acid Reflux (GERD)
- ☐ High Blood Pressure
- ☐ AIDS/HIV
- ☐ Hepatitis A/B/C
- ☐ Pneumonia
- ☐ Seizure Disorder
- ☐ Depression
- ☐ Heart Attack
- ☐ Asthma
- ☐ Irregular Heart Beat
- ☐ Heart Disease
- ☐ Pulmonary Embolus /DVT
- ☐ Other:_________________
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Arthritis
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Tuberculosis
- ☐ Kidney Failure
- ☐ Stomach Ulcers
- ☐ High Cholesterol
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Emphysema/COPD

Surgical History: List all prior operations with dates

DATE TYPE OF SURGERY HOSPITAL / CITY

____
____
____
____
____
____
____
____
____

Family History: ☐ Adopted

Mother: ☐ Alive ☐ Deceased _________Age (Now or at Death)

Cause of Death/Medical problems: ____

Father: ☐ Alive ☐ Deceased _________Age (Now or at Death)

Cause of Death/Medical problems: ____

Please indicate family members (parent, sibling, maternal or paternal grandparent, aunt or uncle) with any of the following conditions:

☐ *Cancer*______________________________

☐ Heart Disease__________________________

☐ High Blood Pressure_____________________

☐ Malignant Hyperthermia__________________

☐ Aneurysms_____________________________

☐ Stroke_________________________________

☐ Diabetes_______________________________

☐ Epilepsy_______________________________

☐ Congenital Problems_____________________

☐ Brain Tumors___________________________

☐ Problems with Anesthesia_________________

☐ Other__________________________________

Social History:

Are you: ☐ Working ☐ Full-time ☐ Part-time ☐ Modified Duty

Occupation: ____________________________Employer: ___________________

☐ Retired Previous occupation: ____

☐ Disabled Previous occupation: ____

Years of education/highest degree: _______________________________________

Marital Status: ☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed ☐ Other: _______

Spouse/Partner's name: ____

Number of children/ages: ____

Is there a possibility you may be pregnant? Yes No If yes, how many weeks? ___________

Tobacco Use:

Cigarettes: ☐ Never ☐ Former Quit Date_____ ☐ Current Smoker: Packs/Day____ # of years____

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use:

Do you drink alcohol? ☐ No ☐ Yes # drinks/week________

Type: ☐ Beer ☐ Wine ☐ Hard Liquor ☐ Mixed Drink

Is your alcohol use a concern for you or others? ☐ No ☐ Yes

Drug Use:

Do you use any recreational drugs? ☐ No ☐ Yes

Have you ever used needles to inject drugs? ☐ No ☐ Yes

Have you used in last year: ☐ Marijuana ☐ Amphetamines (Meth, Speed) ☐ Cocaine ☐ Heroin

☐ Other Street Drugs: ____

Please Check all that apply

CONSTITUTION
- Activity Change
- Appetite Change
- Chills
- Fatigue
- Fever
- Unexpected Weight Change

HENT
- Neck Pain
- Hearing Loss
- Tinnitus
- Sinus Pressure
- Dental Problems
- Drooling
- Mouth Sores
- Trouble Swallowing
- Voice Change

EYES
- Eye Pain
- Eye Redness
- Photophobia
- Visual Disturbance

RESPIRATORY
- Cough
- Shortness of Breath

CARDIOVASCULAR
- Chest Pain
- Leg Swelling
- Palpitations

GI
- Abdominal Pain
- Constipation
- Diarrhea
- Nausea
- Vomiting

GENITOURINARY
- Difficulty Urinating
- Dysuria
- Frequency

MUSCULOSKELETAL
- Arthralgia's (Joint Pain)
- Back Pain
- Gait Problem
- Joint Swelling
- Myalgia's (Muscle Pain)

SKIN
- Rash

NEUROLOGICAL
- Dizziness
- Facial Asymmetry
- Headaches
- Light-headedness
- Numbness
- Seizures
- Speech Difficulty
- Syncope (Fainting)
- Tremors
- Weakness

HEMATOLOGIC
- Bruises/Bleeds Easily

PSYCHIATRIC
- Agitation
- Confusion / Memory Loss
- Decreased Concentration
- Dysphonic (Changing) Mood / Depression
- Hallucinations
- Nervous/Anxious
- Sleep Disturbance

Spine Intake Form

Name: ________________________ **Age**: ______________

Are you: □ Right-handed □ Left-handed □ Ambidextrous

What would you like us to accomplish today? ____

WORK STATUS:

Employment: □ Full-time □ Part-time

Job: ________________________________ □ Homemaker □ Short-term leave □Retired □ Disability

Is this a **work compensation** case? □ Yes □ No

Any **legal action** pending regarding this issue? □ Yes □ No

HISTORY:

What is your primary problem? □ Pain □ Weakness □ Numbness □ Other:____________________

When did this problem start? _________________________________

When did you **first see a doctor** for this problem? __________________________

CURRENT SYMPTOMS:

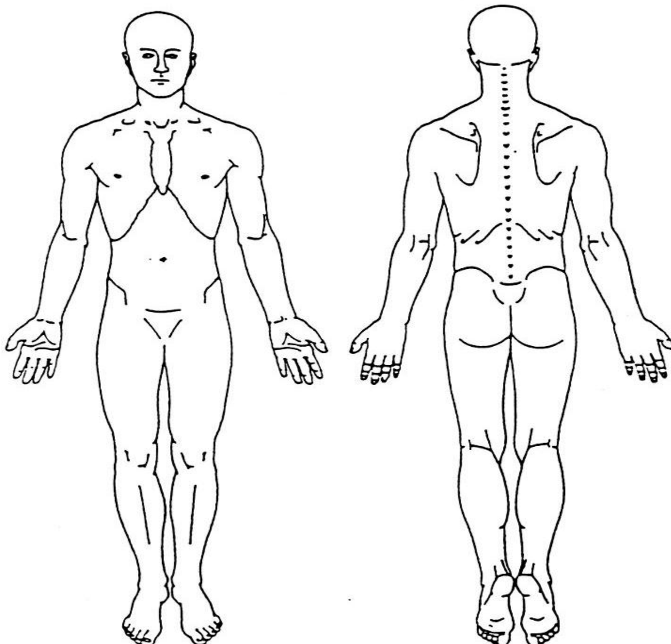
Rate your pain: 0 = no pain 10 = worst pain you can imagine

Level of pain **right now**: 0 1 2 3 4 5 6 7 8 9 10

Level of pain at its **best**: 0 1 2 3 4 5 6 7 8 9 10

Level of pain at its **worst:** 0 1 2 3 4 5 6 7 8 9 10

Please use diagram to mark where you are currently having symptoms:
Pain = xxxxx Pins & needles = zzzzz Numbness = 00000



Frequency of problem: □ Constant □ Intermittent

Describe the pain: □ throbbing □ dull □ stiffness □ sharp □ burning

Do you have pain when you: □ lie flat □ sit □ go from sit to stand □ stand □ walk

What percent of your pain is in **your spine**? □ 0% □ 25% □ 50% □ 75% □ 100%

What percent of your pain is in **your arm/leg**? □ 0% □ 25% □ 50% □ 75% □ 100%

What, particularly, makes your pain/problem **worse**? ____

What, particularly, makes your pain/problem **better**? ____

Overall, is your problem: □ Getting better □ Getting worse □ Staying about the same

Any **prior injury** to this area? □ No □ Yes; describe: ____

Has the problem **affected** your: □ Sleep □ Work □ Recreation

At it's current level, ***is it tolerable***? □ Yes □ No

REVIEW OF SYSTEMS:

Do you have any **numbness or tingling**? □ Yes □ No

Do you have **arm or leg weakness**? □ Yes □ No

Any trouble controlling your **bowels or bladder**? □ Yes □ No

Do you have increased pain with **cough, sneeze, or strain**? □ Yes □ No

Have you had recent **unintentional weight loss**? □ Yes □ No

Have you had recent **fevers/night sweats/chills**? □ Yes □ No

Have you ever had **cancer**? □ Yes □ No

Are you taking any **vitamins or herbal** medications? □ Yes □ No

Do you have any of the **following conditions**?
□ Pacemaker □ Metal clips in your head □ Blood thinner (Coumadin or Plavix) □ Allergy to local anesthetics □ None of these

How tense or anxious have you felt in the past week?

0 1 2 3 4 5 6 7 8 9 10
Absolutely calm and relaxed — As tense and anxious as I've ever felt

How much have you been bothered by feeling depressed in the past week?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Extremely

In your estimation, what are the chances that you will be working in 6 months?

0 1 2 3 4 5 6 7 8 9 10
No chance — Very large chance

If you take into consideration your work routines, management, salary, promotion possibilities, and workmates, how satisfied are you with your job?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Completely satisfied

Any increase in pain is an indication that I should stop what I am doing until the pain decreases:

0 1 2 3 4 5 6 7 8 9 10
Completely disagree — Completely agree

<u>Testing and treatments:</u>

What tests have been done for this problem?
□ X-ray □ CT scan □ MRI □ Bone scan □ Myelogram □ EMG □ Neurology consultation

Circle any treatments you have tried; or □ **I haven't done anything** for this pain

	What was result (effective?)	**Still usig it?**
Medication		
Topicals*:* patches, creams		
Analgesics*:* Acetaminophen, Tyenol		
***Anti-inflammatories*:** Ibuprofen, Advil, Aleve, Naproxen, Diclofenac, Voltaren, Celebrex, Mobic, Feldene, Lodine, Daypro		
Prednisone, Medrol dose pack, Decadron		
***Muscle relaxers*:** Flexeril, Soma, Skelaxin		
***Anticonvulsants*:** Neurontin, Lyrica, Tegretol		
Antidepressants: Amitriptyline (Elavil), Nortriptyline (Pamelor), Duloxetine (Cymbalta), Desyrel (Trazodone), Prozac, Paxil, Zoloft, Wellbutrin, Lexapro, Celexa, Effexor		
Tramadol, Ultram, Ultracet		
***Opiods*:** Codeine, Darvocet, Hydrocodone, Vicodin, Morphine, MS Contin, Lortab, Tylox, Percocet, Oxycodone, Oxycontin, Dilaudid, Duragesic patch. Methadone, Opana, Suboxone, Fentora		
Physical therapy		
Stretching and strengthening		
Heat or ice		
Ultrasound		
TENS, electrical stimulation		
Massage		
Traction		
Aerobic exercise		
Brace		
Cane, walker or crutches		
Manipulation or Chiropractor		
Acupuncture		
Relaxation or stress management techniques		
Injection(s) (What was injected?)		
Spinal cord stimulator or medicine via a spinal pump		
Surgery		