THE COMPREHENSIVE SPINE CENTER

Armen Khachatryan, MD
Dr. "K"

NEW PATIENT FORM

To Our New Patients:

We need your assistance!

Please take a few minutes to look through the attached materials. Our goal is to provide you with a thorough medical evaluation. Therefore we ask that you carefully complete the attached forms.

Most of the questions can be answered with a yes or no. Please list all medications along with dosage and frequency of administration. If a question does not apply to you please write not applicable (N/A) in the appropriate space. It is very important that all the blanks are filled out prior to seeing Dr. K.

PLEASE BRING THE FOLLOWING ITEMS WITH YOU TO YOUR APPOINTMENT

Please check-off each completed item listed below:

_____ X-Rays, MRI Scans, CT Scans, any other relevant studies.
Please bring actual films or images on CD if at all possible

_____ Referring doctor's office notes

_____ Completed Spine Center forms

_____ Insurance Card(s) or other provider information

Please write a note next to any items you are not able to obtain and provide this list to the receptionist when you check in at the Spine Center Reception Desk. You may be asked to come in 30 minutes prior to your appointment for additional X-Rays.

Thank you for your careful review and completion of the enclosed material.

We, at The Comprehensive Spine Center, look forward to seeing you at our office.
We kindly ask that you arrive 30 minutes before your scheduled appointment time.

CENTER OF ORTHOPEDIC AND REHABILITATION EXCELLENCE
www.coremds.com
(801) 568-3480

Welcome to The Comprehensive Spine Center
At Center of Orthopedic and Rehabilitation Excellence

3584 West 9000 South, Suite 405, West Jordan, UT 84088
www.coremds.com

PATIENT INFORMATION for the practice of ***Armen Khachatryan, M.D***.

Office Hours: 8:00am –5pm Monday-Thursday, 8:00am-noon Friday
Office Phone: (801) 568-3480 **Fax:** (801) 568-3482

Clinic Days: Monday, Wednesday and Friday (Subject to change)
Surgery Days: Tuesday and Thursday (Subject to change)

Time Requirements

Evaluation of patients with spine-related problems is a lengthy process.
Please allow at least two (2) hours for your initial appointment.

Please complete the comprehensive "new patient forms" **prior** to your arrival at the Spine Center or allow at least thirty (30) **additional** minutes before your appointment to fill these forms out in the office. Please remember to bring them with you to the Spine Center. If you cannot read, write or speak English, please bring someone with you who may be able to assist you.

If you have to cancel or reschedule your appointment, please do so at least 24 hours prior to your scheduled appointment time.

X-rays and other Special Tests

If your health plan required you to have X-rays, MRI's, CAT scans, Myelograms, or other studies outside of the CORE or Jordan Valley Medical Center, you are kindly asked to bring these studies with you to your scheduled appointment. Failure to bring your studies to your appointment may delay your diagnosis and may require rescheduling of your visit.

Pain Medication Policy

Prescription of narcotic pain medication is limited to surgical patients. Dr. Khachatryan is trained to manage your postoperative pain needs and anticipates complete discontinuation of narcotic pain medications within three (3) months following surgery. Patients that require chronic narcotics need to have these medications be managed by their Primary Care Physician or a Pain Management Specialist.

Medication Refill Policy

Please allow 48 hours for refill requests to be honored. Have your pharmacist fax a refill request or call us in person, if possible.

We will not be able to fill prescriptions after 5:00 p.m. on weekdays or anytime on weekends and holidays. Please check your supply frequently and plan ahead accordingly.

Thank you once again for allowing us serve your back care needs.

CENTER OF ORTHOPEDIC AND REHABILITATION EXCELLENCE

Armen Khachatryan, MD
Dr. "K"

General Health Information

Name: ______________________________________ **Date of Appt:**________________
Date of Birth:____/____/____**Age:**_________**F**___**M**___ **Phone#**______________________
Address:____
Referring Doctor:______________________________
Names of Doctors who have treated you so far: ____
Chief Complaints (Medical Problems that brought you here)
1. ____
2. ____
Allergies: ____
Medicines:(Name and Dosage)____
Surgeries: What and When? Any Complications? ____
____
Other Medical Problems? ____
____
Family History (Cancer, Diabetes, Hypertension, Stroke, etc.)
Father: ___________________________________ Mother: ___________________________________
Siblings: __________________________________ Children: _________________________________
Social History
Married ___ Single ___ Widowed ___ Divorced ____ Occupation _____________________________
Smoke: No ___ Yes ___ Packs/ Day ___ Alcohol: Yes ___ No ___ How much __________________

System Review

Height: ______________ **Weight:** ______________ **L R Handed**

General
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Fever
- ❑ Chills
- ❑ Night Sweats

Skin
- ❑ Rashes
- ❑ Skin Cancer
- ❑ Other Lesions

Head
- ❑ Headache
- ❑ Dizziness
- ❑ Syncope

Eyes
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Double Vision

Ears
- ❑ Pain
- ❑ Infections
- ❑ Hearing Loss

Respiratory
- ❑ Chest Pain
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Pneumonia

Cardiovascular
- ❑ Angina
- ❑ Irregular Heart Beat
- ❑ Palpitation
- ❑ Leg Cramps

Gastrointestinal
- ❑ Indigestion
- ❑ Stomach Ulcer
- ❑ Diarrhea
- ❑ Constipation
- ❑ Dark (or Black) Stool

Genitourinary
- ❑ Frequent Urination
- ❑ Painful Urination
- ❑ Loss of Bladder Control

Musculoskeletal
- ❑ Back Pain
- ❑ Arthritis
- ❑ Joint Pain
- ❑ Broken Bones
- ❑ Muscle Wasting

Vascular
- ❑ Varicose Veins
- ❑ Blood Clot
- ❑ Easily Bruised

Neuropsychiatric
- ❑ Syncope
- ❑ Seizure
- ❑ Memory Problems
- ❑ Depression

____
Physician Signature Date

Armen Khachatryan, MD
Dr. "K"

NEW PATIENT QUESTIONAIRE

CURRENT SYMPTOMS

*Briefly describe your current complaints:*____

____

How and when did the problem begin? (gradually or suddenly?): ______________________

____

TREATMENTS

Have you been seen by another doctor for this spinal condition? **YES NO**

SURGERY – Describe any surgeries you may have had for this problem.

Type ______________________________ Type ______________________________

Surgeon ____________________________ Surgeon ____________________________

Date ______________________________ Date ______________________________

MEDICINES FOR CURRENT PROBLEM *Type?* *Amt/day?* *How long?*

Narcotics **YES NO** ____

Muscle Relaxants **YES NO** ____

Anti-inflammatory **YES NO** ____

HAVE YOU WORN BRACES OR CORSETS? **YES NO**

PHYSICAL THERAPY? **YES NO** *Improvement from Therapy?* **YES NO**

Prescribed by whom? ___________________________

Visits per week__________ how many weeks ________date of last visit ____________

Types of therapy?

☐ Active exercise ☐ Home Exercise ☐ Pool Therapy

☐ Stretching ☐ TENS Unit ☐ Traction

HAVE YOU BEEN SEEN BY SPECIALIST FOR PAIN? **YES NO**

Name of facility: _______________________________

Name of Specialist: _____________________________

Did your ability to cope with pain improve? **YES NO**

INJECTIONS

☐ Epidural steroids ☐ Facet blocks ☐ Other type of injections ______________________

How many times? ________ Did they provide relief? **YES NO**

For how long? ___________ Date of last injection? ____________

CHIROPRACTIC TREATMENTS

How many visits? ________ Did they Provide Relief? **YES NO**

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Which is more troublesome to you?(Circle) *Neck/Back* *or* *Arm/Leg* *or* *Equal*

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols shown below. Mark the areas of radiation. Include all affected areas.

Ache	^ ^ ^	Numbness	o o o	Pins & Needles	= = =	Stabbing	/ / /
	^ ^ ^		o o o		= = =		/ / /
	^ ^ ^		o o o		= = =		/ / /

Distribution of pain (Total should equal 100%)

Neck/Back Pain _____% Right Arm/Leg _____% Left Arm/Leg _____%

How bad is your neck/back pain now? (Circle one)
No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible

How bad is your Right Arm/Leg pain now? (Circle one)
No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible

How bad is your Left Arm/Leg pain now? (Circle one)
No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible

Since your pain first began, is your pain now ____Better ____ Same ____Worse