VIRGINIA
BRAIN & SPINE CENTER
In Partnership with ValleyHealth

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Dear New Patient,

Thank you for choosing the Virginia Brain and Spine Center for your Neurosurgical care. Please read this packet carefully and follow all the instructions prior to your appointment in order to prevent any delays in your care.

You will need to bring the following information with you to your appointment:

- **Forms 1-4 within this packet completed prior to your arrival**
- **Insurance card(s), Photo I.D., Co-payment if applicable**
- **A list of the medications that you are currently taking**
- **Any imaging studies on CD and the corresponding reports if not completed at a Valley Health facility**

We request that you arrive 15 minutes early to *ALL* appointments for proper check in. Arrival past your appointment time may result in your appointment being rescheduled. If you are unable to keep your appointment, you must notify us at least 24 hours in advance. Failure to do so will result in a $25 no show fee.

If you need to cancel or change your appointment or have general questions regarding your appointment, please contact our scheduling coordinator at (540) 771-2299.

Patient Portal Access

The MyHealthRecord Patient Portal will allow you to easily access notes and results, request prescription refills, cancel or change appointments, and correspond with your care providers. After your first appointment at the Virginia Brain and Spine Center, you will receive an email from MyHealthRecord with instructions on setting up your personal Patient Portal Access account. **You must register your new account from a computer only**, but can access the Patient Portal 24/7 from any device (computer, smartphone, or tablet) once the account is created. You can download the free portal app at your Apple or Android store (enter MyHealthRecord in the search field). We strongly encourage you to set up your Patient Portal as soon as possible in order to improve access and communication regarding your care.

Again, thank you for choosing the Virginia Brain and Spine Center.

Form 1: Demographics and Medications

Please Print Legibly

Patient's Full Name (First – Middle – Last)	Sex: M ☐ F ☐	Patient's Birth Date	Last 4 of SSN:
Cell Phone: E-Mail Address:			Preferred method of contact o Text o E-Mail
Emergency Contact Name:		Emergency Contact Phone Number:	

Medication List

Please complete the section below, or provide a list of your current medications

(please include over the counter & non-prescriptions, along with your daily medication's)

o Not currently taking any medication

	Name:	Strength:	Schedule:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Form 2: Clinical Information

Patient Name_____ **Date of Birth**_____

Chief Complaint: Please check all those that apply to today's visit

Brain
- ☐ Headache
- ☐ Seizure
- ☐ Dizziness
- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Tumor
- ☐ Trauma

Neck/Arm/Hand

	Left	Right
☐ Neck Pain	☐	☐
☐ Arm Pain	☐	☐
☐ Arm Numbness	☐	☐
☐ Arm Weakness	☐	☐

☐ Other:_____

Back/Leg/Foot

	Left	Right
☐ Back Pain	☐	☐
☐ Leg Pain	☐	☐
☐ Leg Numbness	☐	☐
☐ Leg Weakness	☐	☐

Allergies to Medications: Please check any allergies that apply **or check here☐ if none**

☐ Penicillin's ☐ Other:_____

Vaccines: Please check all that apply **or check here ☐ if none**

☐ Flu Date Received: _____ ☐ Pneumonia Date Received: _____

☐

Past Medical History: Please check all that apply to your medial history **or check here☐ if no to all**

- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Lyme Disease
- ☐ Meningitis
- ☐ Lupus
- ☐ Thyroid
- ☐ Hypertension
- ☐ TIA
- ☐ Rheumatoid Arthritis
- ☐ Major Trauma
- ☐ Anxiety
- ☐ Depression
- ☐ Hyperlipidemia
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Shoulder Arthropathy
- ☐ Epilepsy/Seizures
- ☐ Parkinson's Disease
- ☐ Other:
- ☐ Stroke
- ☐ Atrial Fibrillation
- ☐ Asthma
- ☐ COPD
- ☐ Kidney Disease
- ☐ Neuropathy
- ☐ Hip Arthropathy
- ☐ Carotid Stenosis
- ☐ Tumor
- ☐ Ulcers
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Gerd
- ☐ Pulmonary Embolism
- ☐ DVT
- ☐ Knee Arthropathy
- ☐ Arthritis
- ☐ Sleep Apnea

Surgical History: Please check all that apply to your medical history **or check here☐ if no to all**

- ☐ S/P Craniotomy
- ☐ Hip Replacement
- ☐ Previous Stent Placement
- ☐ Hernia Surgery
- ☐ Thyroid Surgery
- ☐ Back Surgery
- ☐ Knee Surgery
- ☐ DBS
- ☐ Carotid Endarterectomy
- ☐ Vertebroplasty/Kyphoplasty
- ☐ Neck Surgery
- ☐ Heart Surgery
- ☐ VNS
- ☐ Bariatric Surgery
- ☐ IT Pump
- ☐ Shoulder Surgery
- ☐ Pacemaker
- ☐ CTR
- ☐ SCS
- ☐ Other:_____

☐

Review of Systems: Please check any symptoms you have recently experienced **or check here☐ if no to all**

General
- ☐ Fever
- ☐ Infection
- ☐ Weight Loss
- ☐ Weight Gain

Skin
- ☐ Swelling
- ☐ Edema
- ☐ Easy Bleeding or Bruising

Chest/Lungs
- ☐ Cough
- ☐ Wheezing
- ☐ Short of Breath

Heart/Vascular
- ☐ Chest Pain
- ☐ Palpitations

Psychological
- ☐ Anxiety
- ☐ Depression

Musculoskeletal/Other
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Limb Weakness
- ☐ Limb Numbness

Head/Neck
- ☐ Headache
- ☐ Vision Problems
- ☐ Hearing Loss
- ☐ Poor Balance

Abdomen/Intestines/Liver
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Incontinence
- ☐ Urinary Frequency
- ☐ Urinary Retention
- ☐ Difficulty Breathing During Exertion
- ☐ Other:_____

Family History: Please check significant medical conditions in your immediate family members **or check here☐ if no to all**

- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Stroke
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Other:_____
- ☐ Diabetes

Social History:

Occupation: _____ Retired? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No Do you drink regularly? ☐ Yes ☐ No

Form 3: Agreement for Treatment at Virginia Brain and Spine Center

Patient: _____ Date of Birth: _____

Certain medications have the potential for abuse or misuse, and we have a responsibility to minimize such occurrences. If controlled substances (such as narcotic pain medications) are prescribed for you then certain terms must be met. By signing this form, you are only agreeing to the terms if, and only if, a controlled substance is prescribed for you.

Statement of Patient Accountability Terms for Controlled Substances

Review the terms of this agreement carefully. When you sign this document, you are telling us that you (1) read it, (2) understand it, (3) agree to its terms, and (4) understand the possible consequences if you fail to follow these terms.

This agreement is only regarding the prescription of controlled substances from our practice.

1. I will only obtain controlled substances from Virginia Brain and Spine Center if given a prescription
2. I will take my medication exactly as prescribed. I agree to not change (decrease or increase) the amount of medication I take without first obtaining my doctor's permission.
3. I understand that if I obtain controlled substances from another provider while under this treatment agreement, I will no longer be able to receive controlled substances from Virginia Brain and Spine Center.
4. I understand that Virginia Brain and Spine Center does not provide long term medication management. Controlled substances will only be provided, when necessary, for a very limited time.
5. I understand that if I exhibit a history, signs, or symptoms of improper use of a controlled substance then Virginia Brain and Spine Center may choose to not provide a prescription, wean or stop prescribing, or make a referral to a Pain Management specialist for proper care.

I further understand that I must notify Virginia Brain and Spine Center if I am currently under a treatment agreement for controlled substances with another care provider and I will not be prescribed controlled substances if I am currently under a treatment agreement with another care provider.

I agree to the terms and conditions of the statements listed above

Patient Signature: _____ **Date:** _____