



NBH SCREENING FORM
(New Back & Hip Patients)
Dr. Michael Woods & Joan

Date: _____


Time: _____

Completed by: _____

1. Where is your pain located?

Tailbone  Refer to their PCP

Lower Back **Upper Back (Thoracic Spine)**
 Mid Back **Hip or Leg Pain R - L - B**

Neck 
Recommend Dr. Anthony Russo @ Montana Orthopedics in Butte (406) 496-3400 (pt will need referral from their PCP along with an MRI)

2. Has the onset of your pain been 2 weeks or less?

No

Yes 
Transfer to UC Scheduler

3. Who were you referred by?

Patient Name: _____

Phone: _____ DOB: _____

Pay Source:

Private _____

Work Comp _____

Self-Pay *(inform of self-pay policy)*

Medicaid
(physician/office referral only, except HMK)

EMA Records/Referral

Have you seen another spine surgeon for this pain?
No Yes
Who? _____

When/Where? _____

Are you seeking a second opinion? No Yes
Provider: _____

Have you had any diagnostic imaging of your spine in the last 12 mos?
None X-ray MRI CT

Date/Location: _____

Have you had any treatments within last 12 mos?
None Injections Surgery Other
Injection/Surgery type: _____

Date/Location: _____

Notes: _____

