Chart:

FRANK P. CAMMISA, JR., M.D.
FEDERICO P. GIRARDI, M.D.
ANDREW A. SAMA, M.D.
ALEX P. HUGHES, M.D.

Spinal Surgery
EAST RIVER PROFESSIONAL BUILDING
523 EAST 72ND STREET, 3rd Floor
NEW YORK, NY 10021

PATIENT INFORMATION

Today's Date:__________ Appt Date:__________ Chart # __________

Name: __________ Address: __________ City: ______ State: ____ Zip: ____

E-mail address: ____________________ Cell: __________

Home Telephone: __________ Business Telephone: __________

Employer: __________ Address: __________

Age: ______ Date of Birth: __________ Social Security No.: __________

Occupation: __________ Date Disability Began: __________

Work Status: Regular __________ Light Work __________ Totally Disabled __________

Marital Status: M S W D

Referring Physician (**address and telephone**): __________
Have you seen this MD? yes no

Name AND address of physicians who will need copies of your medical report:
Without correct addresses, the report will be returned to you for processing.

____

If Minor - Names of Parents:____________________

Person to Contact in and Emergency (include phone and relationship):

____

Compensation Case? ________ Auto Accident? ________ Registration State ________

Comp or Auto Insurance Carrier (Address and Telephone): __________

DO NOT MAIL THIS FORM. IT MUST BE GIVEN TO THE DOCTOR.

Chart:

WCB/NF POLICY HOLDER: ____________________ POLICY NO: ____________________
CARRIER CASE NUMBER: ____________________ WCB NUMBER: ____________________

HOSPITAL AND MAJOR MEDICAL INSURANCE

MAJOR MEDICAL COMPANY (doctor's coverage) (address, policy/group number): ____________________

____

HOSPITAL INSURANCE (address, policy/group number): ____________________

____

__ I have not hospitalization insurance / I have no major medical

DATE OF INJURY / ONSET OF SYMPTOMS: ____________________ Lawsuit Pending*: yes no

*Should any litigation arise, it is understood and agreed that the treating physician will not participate in any way in litigation except to provide true and accurate copies of any medical records in possession.

X ____________________ Signature of Patient

<u>Credit Card Authorization</u>- I authorize, when requested by me **over the phone**, use of my credit card for outstanding charges.

Fee for the initial consultation is: $600.00 This fee does not apply to patients who are covered by Medicare, Workmen's Compensation, No Fault and participating managed care plans. This charge is for the doctor's consultation only. It does not include X-Rays or other services which may be rendered. We do not accept assignment of insurance. This fee is payable ON THE DAY OF YOUR VISIT.

Delinquent payment fee, collection cost and attorneys fee:

It is understood that the patient or other responsible party shall pay Dr. Cammisa / Dr. Girardi / Dr. Sama / Dr. Hughes / Dr. Lebl within thirty days after receipt of a bill from Dr. Cammisa / Dr. Girardi / Dr. Sama / Dr. Hughes / Dr. Lebl stating that the balance is due. In the event that full payment is not made within thirty-five days of the mailing of said bill, unless agreed in writing to the contrary, the patient or other responsible party will be charged an interest rate of 9% per annum on all accounts not paid in full by the due date. If the delinquent balance is not paid in a timely manner after the final due date, and the doctor employs a collection agency or attorney, you will be required to pay collection fees and other related costs, including reasonable attorneys' fees, in addition to your balance due, plus interest as aforesaid.

Relevant state laws shall govern this understanding. Further, you agree that in any action to collect payment hereunder, you hereby waive your right to trial by jury and the right to interpose counterclaims in any action brought for enforcement of the agreement. You may bring separate action for any disputes you may have with the doctor related to the contract or otherwise.

X-Rays left at the office and X-rays taken at The Hospital for Special Surgery are stored together at the hospital (600-1134). X-Rays are not stored in our office.

Please note that during the course of your treatment, there will be occasionally be the need for conferences with other doctors, phone consultations with and regarding you, and the like. For this purpose we retain your signature on file authorizing us to bill your insurance carrier for these efforts. You are NOT billed directly for additional consulting services performed out of the context of your visit to us. **Please bring insurance forms, completed and signed, with you for this purpose.**

I request that payment of authorized **MEDICARE** benefits and all insurances be made either to me or on my behalf to Dr. Cammisa / Dr. Girardi / Dr. Sama / Dr. Hughes / Dr. Lebl for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for **MEDICARE** and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I authorize insurance payments be made directly to Dr. Cammisa / Dr. Girardi / Dr. Sama / Dr. Hughes / Dr. Lebl

Policy Holder's Name: ____________________ Date: ____________________

Policy Holder's Signature ____________________ Date: ____________________

Guarantor Signature: ____________________ Date: ____________________

Chart:

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EAST RIVER PROFESSIONAL BUILDING
523 EAST 72ND STREET, 3rd Floor
NEW YORK, NY 10021
--
Telephone: 212/606-1946

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also agree that ________________________ may request to use my prescription medication history from other healthcare providers or 3rd party pharmacy benefit payors for treatment purposes. Any health information disclosed pursuant to this authorization may be subject to redisclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Patient Name: ____________________

Social Security: (last 4 digits only) ____________________

Persons/Organizations authorized to use/disclose or receive my information:

____
____
____

Specific description of the information to be used to disclosed (including date(s)):

____
____

Description of each purpose of the use or disclosure of my health information:

At the request of the patient.

I understand that this authorization will expire on: ____________________ Initials __________

I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form, Initials __________

I understand that I will get a copy of this form after I sign it. Initials __________

I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on the actions the Practice has already taken in reliance on this authorization. Initials __________

____
Signature of patient

____
Date

If this authorization is signed by a patient's representative, please complete the following:

____
Printed name of patient's representative

____
Relationship to the patient

Chart:

PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY
535 East 70th Street NEW YORK, NY 10021

MEDICAL RECORD NUMBER (FOR OFFICE USE ONLY)

DATE OF VISIT

LEGAL ID TYPE ☐ DRIVER'S LIC. ☐ PASSPORT ☐ BIRTH CERT. ☐ SSN ☐ GREEN CARD ☐ OTHER

HSS PHYSICIAN

HAVE YOU EVER BEEN TO HSS FOR A DOCTOR OR HOSPITAL VISIT? ☐ YES ☐ NO — IF SO, WHAT DOCTOR AND WHEN WERE YOU SEEN?

PATIENTS FULL NAME (A appears on Legal ID) [Last, First, ML]	DATE OF BIRTH	COUNTRY

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	SEX	MARITAL STATUS	E-MAIL ADDRESS *(Optional)*	CELL PHONE *(if applicable)*	SOC SEC. NUMBER (Only far Worker's Comp. No Fault or Medicare claims)

EMPLOYMENT (If full-time student, please provide information on school)

PATIENT'S EMPLOYER (or School)	PATIENT OCCUPATION (or Student)	☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT	RETIREMENT DATE

EMPLOYER (or School) ADDRESS (#, street, city, state, zip code)	EMPLOYER (or School) PHONE

GUARANTOR (The person responsible for the bill)

☐ SELF ☐ PARENT/GUARDIAN ☐ OTHER (If guarantor is other than Self, provide person's information below)

POLICY HOLDER (If other than Self)/GUARANTOR (If parent/guardian or other (sports team manager)

POLICV HOLDER - FULL NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH

ADDRESS (#, Street, Apt. #, City, State, Zip Code)	SEX	PHONE	SOC SEC. NUMBER (Only far Worker's Comp. No Fault or Medicare claims)

EMPLOYER	OCCUPATION	☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT	RETIREMENT DATE

EMPLOYER ADDRESS (#, Street, Apt. #, City, State, Zip Code)	EMPLOYER PHONE

EMERGENCY CONTACT

FULL NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH (Only when minor is under your health coverage policy)

ADDRESS (#, Street, Apt. #, City, State, Zip Code)	SEX	PHONE

REFERRING PHYSICIAN INFORMATION (If applicable)

REFERRING PHYSICIAN & ADDRESS

ACCIDENT RELATED INFORMATION (Applies if your visit today is due to any accident or Injury)

HOW DID YOUR INJURY OCCUR?	TYPE OF INJURY
DATE OF INJURY	PLACE OF INJURY (City, State)

PRIMARY INSURANCE (Please enter Worker's Comp and No Fault Information if applicable as Primary Insurance, otherwise enter Health/Medical Coverage)

INSURNACE COMPANY NAME	PHONE NUMBER
INSURANCE COMPANY ADDRESS	NAME OF CLAIMS ADJUSTER (if applicable)

POLICV NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (for Worker's Comp and No Fault Claims)	WCB CASE NUMBER (if applicable)

SECONDARY INSURANCE (For Worker's Comp/No Fault patients, please enter Health/Medical Coverage as Secondary)

INSURNACE COMPANY NAME	PHONE NUMBER	
INSURANCE COMPANY ADDRESS	POLICV NUMBER	GROUP/PLAN NUMBER

For Medicare Patients Only

ARE YOU CURRENTLY RESIDING IN A SKILLED NURSING FACILITY OR INPATIENT REHAB FACLITY? ☐ YES ☐ NO — IF YES, PROVIDE NAME OF FACILITY

SKILLED NURSING FACILITY/REHAB FACILITY ADDRESS	PHONE NUMBER OF FACILITY

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT - I certify that the information given by me is correct. I understand that this information is entered into a database, and I hereby authorize the sharing of such information with Hospital affiliated physicians who are responsible for my care and their offices. I hereby also authorize the release of information related to my medical care, as requested by government agencies and/or insurance carriers. I hereby assign benefits to the Hospital and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered.

MEDICARE PATIENTS - I certify that the information given by me In applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles on all services and a 20% co-insurance on ancillary services When Medicare is deemed the secondary insurance, I will follow payment terms under Hospital policies.
EFFECTIVE DATE- These statements shall be effective from the date of the signature below until December 31 of the current year, unless you notify HSS otherwise in writing at the address written above.

PATIENT OR GUARDIAN SIGNATURE ______________________ DATE ______________

Chart:

NECK DISABILITY INDEX:

INSTRUCTIONS:

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which most closely describes your problem right now.

Patient Name: ______________________ Date:________________ Chart#: ______________

NECK DISABILITY INDEX

SECTION 1: Pain Intensity

A. I have no pain at the moment. (0 pts)
B. The pain is mild at the moment. (1 pt)
C. The pain comes and goes and is moderate. (2 pts)
D. The pain is moderate and does not vary much. (3 pts)
E. The pain is severe but comes and goes. (4 pts)
F. The pain is severe and does not vary much. (5 pts)

SECTION 6: Concentration

A. I can concentrate fully when I want to with no difficulty. (0 pts)
B. I can concentrate fully when I want to with slight difficulty. (1 pt)
C. I have a fair degree of difficulty in concentrating when I want to. (2 pts)
D. I have a lot of difficulty in concentrating when I want to. (3 pts)
E. I have a great deal of difficulty in concentrating when I want to. (4 pts)
F. I cannot concentrate at all. (5 pts)

SECTION 2: Personal Care (Washing, Dressing)

A. I can look after myself without causing extra pain. (0 pts)
B. I can look after myself normally, but it causes extra pain. (1 pt)
C. It is painful to look after myself and I am slow and careful. (2 pts)
D. I need some help but manage most of my personal care. (3 pts)
E. I need help every day in most aspects of self care. (4 pts)
F. I do not get dressed, I wash with difficulty and stay in bed. (5 pts)

SECTION 7: Work

A. I can do as much work as I want to. (0 pt)
B. I can only do my usual work, but no more. (1 pt)
C. I can do most of my usual work, but no more. (2 pts)
D. I cannot do my usual work. (3 pts)
E. I can hardly do any work at all. (4 pts)
F. I cannot do any work at all. (5 pts)

SECTION 3: Lifting

A. I can lift heavy weights without extra pain. (0 pts)

SECTION 8: Driving

A. I can drive my car without neck pain. (0 pts)

Chart:

B. I can lift heavy weights, but it causes extra pain. (1 pt) C. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table. (2 pts) D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3 pts) E. I can only lift very light weights. (4 pts) F. I cannot lift or carry anything at all. (5 pts)	B. I can drive my car as long as I want with slight pain in my neck. (1 pt) C. I can drive my car as long as I want with moderate pain in my neck. (2 pts) D. I cannot drive my car as long as I want because of moderate pain in my neck. (3 pts) E. I can hardly drive my car at all because of severe pain in my neck. (4 pts) F. I cannot drive my car at all. (5 pts)
SECTION 4: Reading A. I can read as much as I want with no pain in my neck. (0 pts) B. I can read as much as I want with slight pain in my neck. (1 pt) C. I can read as much as I want with moderate pain in my neck. (2 pts) D. I cannot read as much as I want because of moderate pain in my neck. (3 pts) E. I cannot read as much as I want because of severe pain in my neck. (4 pts) F. I cannot read at all because of neck pain. (5 pts)	**SECTION 9: Sleeping** A. I have no trouble sleeping. (0 pts) B. My sleep is slightly disturbed (less than 1 hour sleepless). (1 pt) C. My sleep is mildly disturbed (1-2 hours sleepless). (2 pts) D. My sleep is moderately disturbed (2-3 hours sleepless). (3 pts) E. My sleep is greatly disturbed (3-5 hours sleepless). (4 pts) F. My sleep is completely disturbed (5-7 hours sleepless). (5 pts)
SECTION 5: Headache A. I have no headaches at all. (0 pts) B. I have slight headaches that come infrequently. (1 pt) C. I have moderate headaches that come infrequently. (2 pts) D. I have moderate headaches that come frequently. (3 pts) E. I have severe headaches that come frequently. (4 pts) F. I have headaches almost all the time. (5 pts)	**SECTION 10: Recreation** A. I am able to engage in all of my recreational activities with no pain in my neck at all. (0 pts) B. I am able to engage in all of my recreational activities with some pain in my neck. (1 pt) C. I am able to engage in most, but not all of my recreational activities because of pain in my neck. (2 pts) D. I am able to engage in only a few of my recreational activities because of pain in my neck. (3 pts) E. I can hardly do any of my recreational activities because of pain in my neck. (4 pts) F. I cannot do any of my recreational activities at all. (5 pts)

SCORING:

Simply count up the points and plug the total in below: For each question there is a possible of 5 points: 0 for the first question; 1 for the second question; 2 for the third question, etc.

Chart:

Raw Score	**Level of Disability**
0 - 4	No Disability
5 - 14	Mild Disability
15 - 24	Moderate Disability
25 - 34	Severe Disability
35 - 50	Completely Disabled

Name:
Chart:
Date:

Name: ______________________________ Date: ______________

Age: ______________________________

Please circle one: Left hand dominant Right hand dominant Ambidextrous

Previous spinal surgery (*Include date, procedure, names of surgeons, results and/or complications):

____

____

____

List your primary symptoms in order of importance (i.e. low back pain, neck pain, headaches, arm/leg weakness, sensation changes, imbalance, etc):

1) ______________________________

2) ______________________________

3) ______________________________

Do you have any of the following symptoms (if yes, please write location, severity, pertinent details):

Weakness: ______________________________

Numbness: ______________________________

Pins & Needles: ______________________________

Balance Impairment: ______________________________

Gait disturbance (i.e. limping, leaning forward, etc.): ______________________________

Bowel or bladder dysfunction: ______________________________

Date of onset of symptoms (Please describe any trauma/injury, motor vehicle accident, gradual, etc.):

____

____

____

Surgeons or other doctors seen for this condition:

____

____

____

Any history of spine problems prior to current symptoms: (If yes, please give brief history)

____

____

Name:
Chart:
Date:

Have you had any of the following treatments for these symptoms (include dates, number of sessions, injections, etc. and please indicate if these were helpful):

Epidural Steroid Injections: ______________________________

Facet Injections: ______________________________

Trigger Point Injections: ______________________________

Physical Therapy: ______________________________

Chiropractic Care: ______________________________

Acupuncture: ______________________________

Oral Steroids (i.e. Prednisone, Medrol 6-day pack): ______________________________

Other Treatments (please describe): ______________________________

List tests taken with date: (X-rays, MRI, CT, Myelogram, Discogram, EMG, Bone Scan)

____

____

____

Have you had a fracture or broken bone over the age of 50? _______ Yes _______ No

Do you take Vitamin D and Calcium? _______ Yes _______ No

If you have pain, please complete the following two questions:
Please rate your current pain on a scale of 0-10, with 0 being no pain and 10 being so severe that you could not live with it for more than a few minutes:

_______ Back _______ Right buttock/leg _______ Left buttock/leg

_______ Neck _______ Right arm _______ Left arm

Which of the following aggravate your pain (Please check those that apply):

_______ Sitting _______ Standing _______ Walking

_______ Driving _______ Lying flat on back _______ Lying flat on stomach

_______ Changing positions (i.e. rising from sitting to standing, rolling over in bed)

_______ Bending (i.e. brushing teeth over sink)

_______ Pushing an object (i.e. heavy door, vacuum cleaner)

_______ Coughing, sneezing, bearing down (Valsalva)

Do your symptoms affect your ability to fall or stay asleep? (Please check yes or no)

_______ Yes _______ No

Are symptoms worse at a particular time of day? (If so, please check):

_______ Upon rising in the morning _______ At the end of the day _______ During the night

Is your condition:

_______ Getting worse over time _______ Getting better since initial onset _______ The same over time

Name:
Chart:
Date:

PAST MEDICAL HISTORY
Are you currently having or have you had any of the following conditions (check all that apply):

_______ Heart Attack
_______ Seizure
_______ Stroke
_______ Asthma
_______ COPD
_______ Emphysema
_______ Pneumonia
_______ High Blood Pressure
_______ High Cholesterol
_______ Acid Reflux/GERD
_______ Diabetes
_______ Stomach Ulcers
_______ IBS
_______ Thyroid Issues
_______ Osteoporosis
_______ Osteopenia
_______ Rheumatoid Arthritis
_______ Hepatitis/Liver Disease
_______ HIV
_______ Tuberculosis
_______ Urinary Problems
_______ Gout
_______ Lupus
_______ Cancer
_______ Anemia
_______ Clotting/Bleeding Disorder
_______ Anxiety
_______ Depression
_______ Glaucoma/Cataracts
_______ Migraines/Headaches
_______ Other: ____

PREVIOUS SURGERIES (Please include date)

CURRENT MEDICATIONS (Please include prescription drugs, over-the-counter medications, vitamins, and supplements)

Medication:	Reason for taking:	Dose	Frequency:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

(If more medications, please attach separate medication list with all information)

Name:
Chart:
Date:

MEDICATION ALLERGIES
Please list allergies: Reaction:

____

____

____

SOCIAL HISTORY
Please check one of the following options:

_______Single _______Married _______Divorced _______Widowed

Patient accompanied at visit by: ______________________________

Occupation: ______________________________

Recreational Activities/Hobbies: ______________________________

____

Do you smoke? _______Yes _______No _______Quit (Date:______________________)

If yes or any history of smoking, number of packs per day? ______________________

How many years have you smoked in total? ______________________

Do you drink alcohol? _______Yes _______No _______Quit (Date:______________________)

If yes, number of drinks per week on average? ______________________

(1 drink = 12 oz beer, 5 oz of wine, 1.5 oz hard liquor)

FAMILY HISTORY
Have any immediate family members been diagnosed with the following conditions (please check box and list relationship to individual):

	Yes	No	Relationship
Spinal Disorders	_______	_______	______________________
Muscle/Nerve Disorders	_______	_______	______________________
Rheumatoid Arthritis	_______	_______	______________________
Diabetes	_______	_______	______________________
Cancer	_______	_______	______________________
Other	_______	_______	______________________

Name:
Chart:
Date:

THIS PAGE TO BE COMPLETED BY CLINICIAN OR M.D. AT TIME OF VISIT

REVIEW OF SYSTEMS

General ______________________________

Skin ______________________________

Neurological ______________________________

HEENT ______________________________

Cardiovascular ______________________________

Pulmonary ______________________________

Gastrointestinal ______________________________

Urinary ______________________________

Renal ______________________________

Hepatic ______________________________

Other ______________________________

PHYSICAL EXAM

VITAL SIGNS:

BP	**HR**	**RR**	**Temp**	**Height**	**Weight**

Gen:	[ ] well developed/well nourished	[ ] no acute distress
Neuro:	[ ] NC/AT	[ ] PERRL
	[ ] CTA b/l	[ ] No W/R/R
	[ ] RRR	[ ] No M/R/G
Abd:	[ ] NT/ND	[ ] Positive bowel sounds
Ext:	[ ] No edema	[ ] < 2 cap refill
Derm:	[ ] No ulcers/rashes	

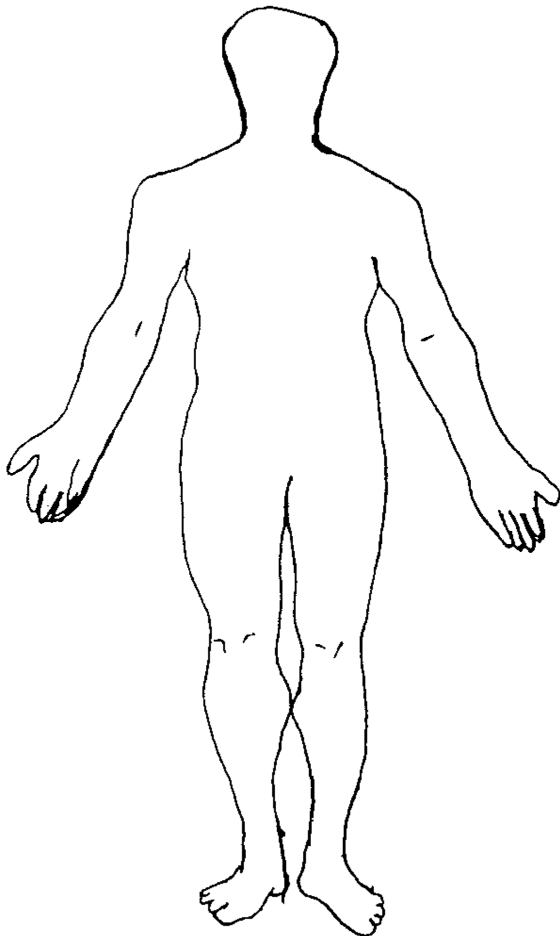
Chart:

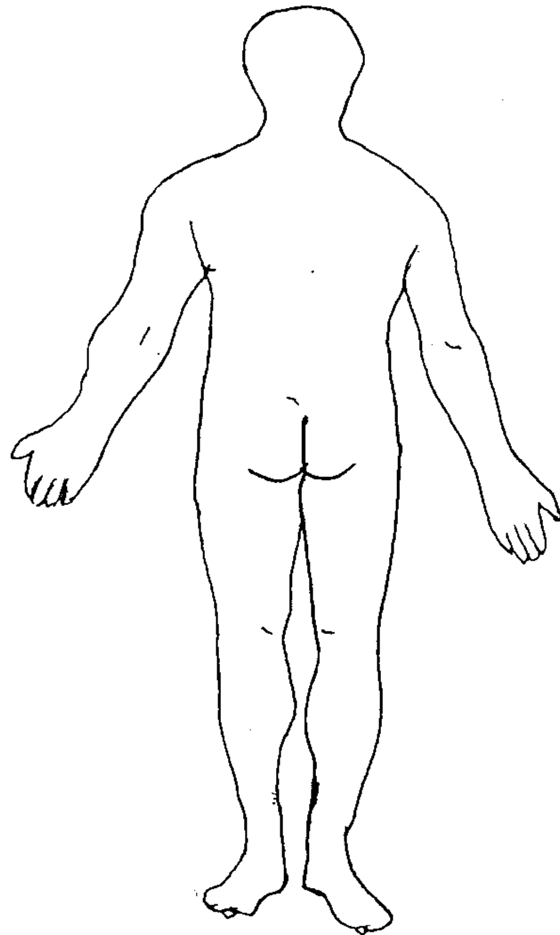
PATIENT PAIN DRAWING

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
Mark the areas of radiation, include all affected areas. To complete the picture, please draw in your face.

Aching	Numbness	Pins/Needles	Burning	Stabbing
>>>>	= = = =	|||||||	xxxxx	////////





Right *Left* *Left* *Right*

Front ***Back***

How bad is your pain now?

Please mark with an X on the body form where the pain is worst now.

Please mark on the line below how bad your pain is now.

No Pain ____________________ ***Worst Possible Pain*** ____________________

Chart:

This page to be completed by M.D. at time of visit.

CHIEF COMPLAINT **EXAMINATION** **Init:** ______________

Date dict: ______________

Neck		**Back**
	Pain	
	Loc	
	Numb	
	P/N	
	Weak	
	B/B Sx	
	B/Gait	
	Lher	
	Spur	
	Abd	
	Val	
	NP	
	Pos	
	Walk	
	Stand	
	Sit	
	Sup	
	Prone	
	Drive	
	Sleep	
	Work	
	Rec	

Reflexes

Neck	*Right*	*Left*	Back	*Right*	*Left*
B	______	______	K	______	______
T	______	______	A	______	______
BR	______	______	Clo	______	______
Hof	______	______	Bab	______	______
IRR	______	______			

Sensation

Neck	*Right*	*Left*	Back	*Right*	*Left*
C5	______	______	L2	______	______
C6	______	______	L3	______	______
C7	______	______	L4	______	______
C8	______	______	L5	______	______
T1	______	______	S1	______	______
TR	______	______			

Power

Neck	*Right*	*Left*	Back	*Right*	*Left*
D	______	______	HF	______	______
B	______	______	HA d	______	______
WE	______	______	Q	______	______
T	______	______	TA	______	______
WF	______	______	EHL	______	______
FE	______	______	Hab	______	______
GR	______	______	Hex	______	______
Fab	______	______	GS	______	______
			Hams	______	______

Heel Raise	List	Gower
TW/HW	SLR	FF
Lhermitte's	CLSR	EX
Spurling	Bowstring	Gait
Shoulder	FST	Pulse
Crpl Tnl	Prone	Rectal
Cubt Tnl	Stairs	
Hip		
SNt		

NSAID	TPI	Acupuncture
Analgesics	FI	Brace
OS	PT	Pain Clinic
ESI	Chiropractic	EMG

DX:

RX: Surgical

Conservative:

Tests:

- X-Rays ______________
- Bonescan ______________
- CT ______________
- MRI ______________
- Myelogram ______________
- EMG ______________
- Discogram ______________
- Other ______________