

SPINE INTAKE FORM

PATIENT INFORMATION:					
Patient's Name:				Date of Birth:	
PRIMARY CARE PHYSICIAN (PCP) – Name, Address, Phone #					
Contact Info:					
REFERRING PROVIDER (if different than PCP)- Name, Address, Phone #:					
Contact Info:					
Contact Info:					
HISTORY OF YOUR PAIN/SYMPTOMS – <i>Please answer the questions below</i>					
What is the main reason that you are here today?					
Tell us <u>when</u> and <u>how</u> your problem started:					
What event(s) led to your original symptoms?					
☐ Accident		☐ Work Injury		☐ Following an operation	
☐ Cancer		☐ No Obvious Reason		☐ Other:	
Please indicate where your pain/ symptoms were initially located (ex. Neck, Low back)					
Since the time of onset, my symptoms have:					
☐ Remained the same		☐ Are more severe		☐ Are less severe	
What percentage of your symptoms are in:					
_____ % Spine		_____ % Leg		_____ % Arm (example: 75% spine, 25% leg)	
ACTIVITY - <i>Please check the amount of time you can perform the following activities</i>					
Sit	Unable	15 minutes	30 minutes	45 minutes	60 minutes +
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐

PAIN DIAGRAM

On the body diagram below, please indicate where your pain is located and what it feels like using the symbols:

Numbness

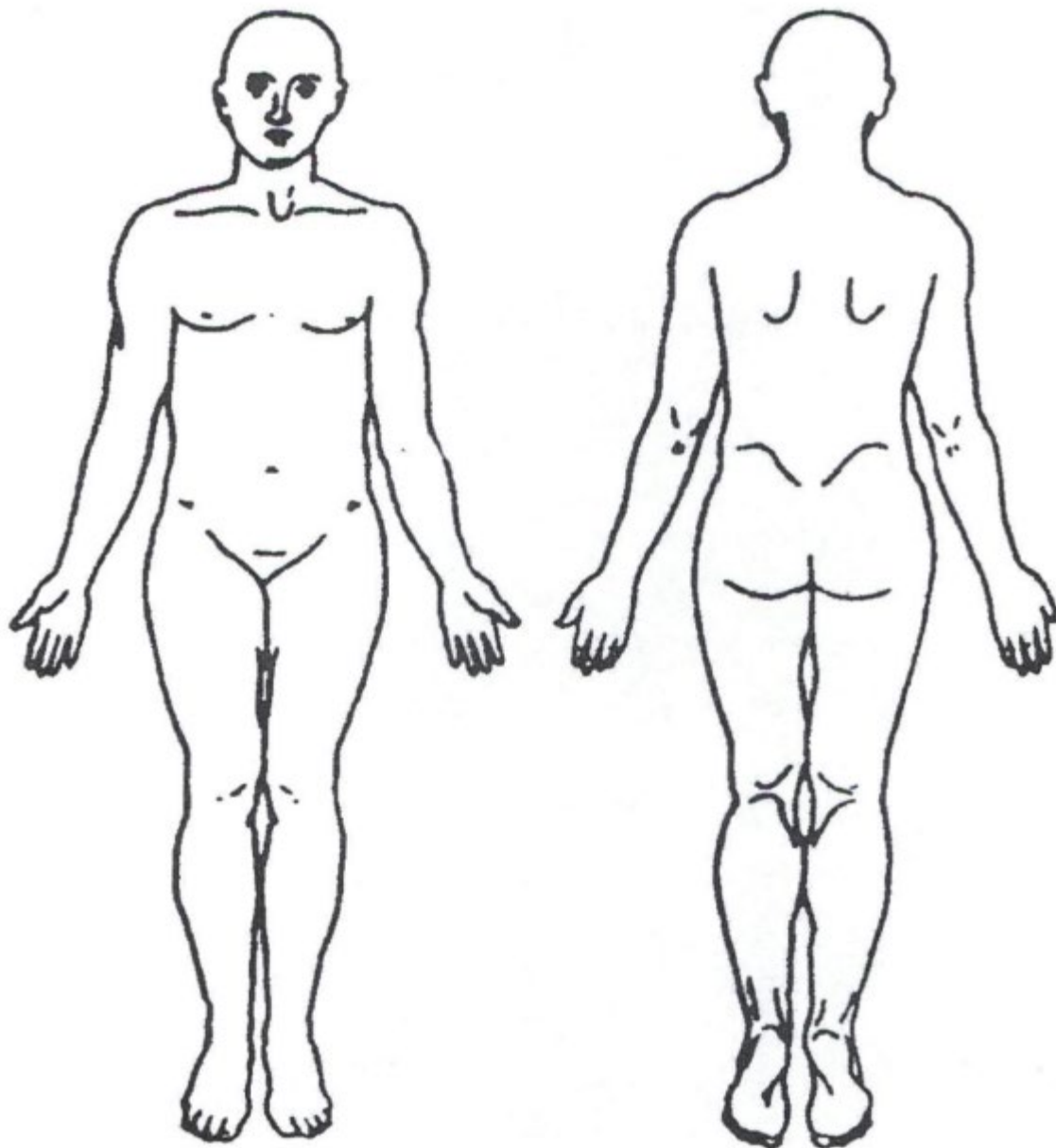
Pins & Needles
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Burning
xxxx

Aching
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Stabbing
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Other
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PREVIOUS TREATMENTS – Please circle any treatments you have tried for your current problem						
Treatment	Date / Year	Did it help?		Treatment	Did it help?	
Nerve Blocks		☐ No	☐ Yes	Physical Therapy	☐ No	☐ Yes
Acupuncture		☐ No	☐ Yes	Psychotherapy	☐ No	☐ Yes
Chiropractor		☐ No	☐ Yes	Injectons	☐ No	☐ Yes
Massage		☐ No	☐ Yes	Surgery	☐ No	☐ Yes
Brace / Collar		☐ No	☐ Yes	Other (specify)	☐ No	☐ Yes

PREVIOUS DIAGNOSTIC TESTING – Please enter any testing performed for your current problem			
Test	Date	Test	Date
MRI		Myelogram	
CT scan		EMG/NCV	
X-Ray		Bone Scan	
Discogram		Other (specify)	

REVIEW OF SYSTEMS – check all that apply		
Constitutional ☐ Unexpected weight loss more than 10 lbs. in the past six months ☐ Unexpected weight gain more than 10 lbs. in the past six months ☐ Fatigue / Tired all over ☐ Fever, chills or sweats Eyes ☐ Blurred or double vision ☐ Failing vision Ears, Nose, Mouth & Throat ☐ Difficulty hearing ☐ Difficulty swallowing ☐ Sore or hoarse throat ☐ Nose Bleeds ☐ Sinus trouble or Congestion Cardiovascular ☐ Heart murmur ☐ Chest Pain ☐ Palpitations / fast heart rate ☐ Shortness of Breath ☐ Swollen Ankles	Gastrointestinal ☐ Nausea or vomiting ☐ Diarrhea ☐ Ulcers ☐ Heartburn Genitourinary ☐ Frequent or hesitant urination ☐ Pain with urination ☐ Blood in urine ☐ Bladder accidents / incontinence ☐ Kidney Infection ☐ Kidney Stones ☐ Frequent bladder infections ☐ Erectile dysfunction / problems getting an erection Respiratory ☐ Cough ☐ Wheezing ☐ Shortness of breath	Neurological ☐ Headaches ☐ Loss of strength ☐ Weakness ☐ Numbness ☐ Fainting spells ☐ Dizziness / vertigo Psychiatric ☐ Anxiety ☐ Depression Hematological ☐ Too much bruising or bleeding ☐ Swollen glands Musculoskeletal ☐ Back pain ☐ Joint pain ☐ Joint swelling ☐ Muscle stiffness ☐ Osteoporosis

PAST MEDICAL HISTORY – please check all that apply			
☐ Alcoholism	☐ Depression	☐ Heart Attack	☐ Psychiatric Problems
☐ Anxiety	☐ Diabetes	☐ High Cholesterol	☐ Seizure or Epilepsy
☐ Asthma or Wheezing	☐ Emphysema	☐ High blood pressure	☐ Stomach Ulcers
☐ Bleeding or Clotting Problem	☐ Fibromyalgia	☐ Kidney Disease	☐ Stroke
☐ Chest pain	☐ Gerd / Reflux	☐ Liver Disease	☐ Thyroid Disease
☐ Heart Disease			
☐ Arthritis (specify location): _____			
☐ Cancer (specify type): _____			
☐ Other (specify): _____			
PAST SURGICAL HISTORY			
Year	Surgery	Hospital	Doctor
ALLERGIES – please list all allergies including medication, food, environment and latex			
Allergy	Reaction (what happens?)		
FAMILY MEDICAL HISTORY Do you have a family history of the following? – please check all that apply			
☐ Back Disorder ☐ Bleeding / Clotting problem ☐ High Blood Pressure ☐ Stroke ☐ Neuropathy / Nerve Disease	☐ Heart Disease ☐ Diabetes ☐ Thyroid Disease ☐ Cancer (if yes, type: _____) ☐ Other: _____		
SOCIAL HISTORY			
Are you working? ☐ Yes ☐ No If yes, what is your job/title: _____			
Work Status: ☐ Full Time ☐ Part-Time (_____ hrs per week) ☐ Homemaker ☐ Retired (year: _____) ☐ Unemployed (since year: _____) ☐ Unemployed due to pain (since year: _____)			
How would you describe your job? ☐ Sit a lot ☐ Light Activity ☐ Medium Activity ☐ Full Time			
Are you on Disability? ☐ Yes ☐ No If yes, reason: _____			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widow ☐ Separated			

