ORTHOPAEDIC SPINE INSTITUTE  **NEW PATIENT INTAKE FORM**

NAME:_____ **DATE:**_____

Age/DOB: _____**Gender:** M / F / _____ **Referral Source**:_____

Chief Complaint: (What is the problem? Example: back pain, neck pain, etc.):

_____

_____

History: (How and when did your problem begin?)

_____

_____

Please indicate any treatments you have had so far: (Check all that apply)

____**None**

____Epidural Injections

____Physical Therapy (how long and where)_____

____Surgery (when and where)_____

____Medications (for this problem)_____

Please categorize your pain: (Please circle ONE)

None to mild Mid mild to moderate moderate

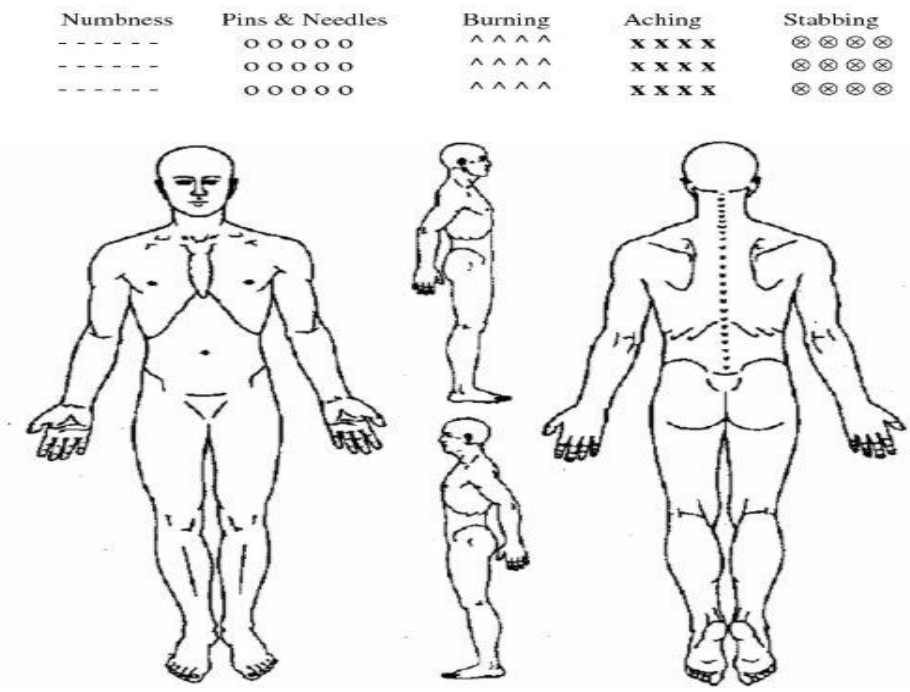
moderate to severe severe unbearable

My pain is: (Please circle **ALL** that apply)

constant intermittent achy burning deep superficial

improving worsening

Using the symbols given, mark the areas on the body where you feel the described sensations. Include all affected areas.



Modifying factors (What makes your pain better or worse? Please check all that apply)

____Better with activity ____Worse with activity ____Better with rest ____Worse with rest
____Better with sleep ____Worse with sleep ____better with medicines ____Nothing

____Changing positions help(describe):_____

Please use the key below to answer the following questions:

0–Not at all **1**–To a slight degree **2**–To a moderate degree **3**–To a great degree **4**–All the time

When I'm in pain.....

_____ I worry all the time about whether the pain will end.
_____ I feel I can't go on.
_____ It's terrible and I think it's never going to get any better.
_____ It's awful and I feel that it overwhelms me.
_____ I fell I can't stand it anymore.
_____ I become afraid that the pain will get worse.
_____ I keep thinking about how much it hurts.
_____I anxiously want the pain to go away.
_____I can't seem to keep it out of my mind.
_____ I keep thinking about how badly I want the pain to stop.
_____ There's nothing I can do to reduce the intensity of the pain.
_____ I wonder whether I can do to reduce the intensity of the pain
_____ I wonder whether something serious may happen.

Total:_____

Past Medical History (Please check all that apply): ____**NEGATIVE**

____arthritis	____fibromyalgia	____gout	____hearing loss
____stroke	____coronary disease	____heart attack	____arrhythmia
____asthma	____COPD	____high blood pressure	____GERD
____ulcers	____thyroid disease	____hepatitis	____cancer
____anemia	____diabetes	____colitis	____neuropathy
____excessive bleeding	____DVT (clots)	____osteoporosis	____pulmonary embolism

Past Surgical History (Please list any prior surgeries and approximate dates): _____**NONE**

_____

_____

If you have had surgery, have you had any problems with anesthesia? Please explain:

_____

Do you have any of the following problems? (Please check all that apply) _____**NONE**

____recent weight loss or gain	____hearing loss	____nausea or vomiting
____fever/chills	____sore or dry throat	____heartburn (reflux)
____blurred vision	____shortness of breath	____body aches
____skin rashes	____chronic cough	____pain in multiple joints
____headache	____chest pains or tightness	____difficulty with urination
____heart palpitations	____abdominal pains	____constipation/diarrhea
____nausea or vomiting	____burning with urination	____swelling in arms or legs
____depression	____mood swings	___dizziness/balance problems

Family History (Does anyone in your family have a history of the following?)

Please indicate **M** for mother's side or **F** for father's side:

____arthritis	____stroke	____osteoporosis	____hearing loss	____mult. fractures
____coronary disease	____heart attack	____arrhythmia	____asthma	____COPD
____high blood pressure	____GERD	____ulcers	____thyroid disease	____hepatitis
____cancer	____anemia	____diabetes	____colitis	____neuropathy
____substance abuse	____DVT (clots)	____pulmonary embolism		____anesthesia problems

Drug Allergies (Please check or list others): ____**NONE**

____penicillin ____keflex or cephalosporins ____sulfa ____IVP dye ____aspirin

Others_____

Do you give us consent to obtain your medication history? Yes No

Current Medications (PRINT CLEARLY) List all medications or supply us with a separate list: ____**NONE**

_____

_____

Pharmacy Information: (Please write down the name and address of your current pharmacy)

_____

_____

Primary Care Doctor:(Please write down the name, address and phone number of your physician)

_____

_____

_____

Please list your height and weight: Height_____ Weight_____

Occupation: (What is your job title and description?)

_____

_____

Social History: (Please check the appropriate space):

Smoking History Smoked at least 100 cigarettes in your life? Yes No

If yes ____Current Every Day Smoker ____Smoker, Current Status Unknown
____Current Same Day Smoker ____None of the above
____Former Smoker ____Not Asked

Details

Cigarettes per day _____ Years smoked_____

Do you use smokeless tobacco? Yes No

Are you at risk for secondhand smoke? Yes No

Comments: _____

Alcohol Use: ____None ____Socially ____Daily.

If daily, how much and what do you drink?

_____

Recreational Drugs Please list any recreational drug use:

_____

History of substance abuse? ____No ____Yes

If yes please explain:

_____

_____

Patient or Guardian Signature **Date**