NeuroSpine

Minimally Invasive Spine Surgery • Robotic Assisted Spine Surgery
Neurological Surgery • Regenerative Spine Medicine

Intake form

CONFIDENTIAL PATIENT INFORMATION & HISTORY

This questionnaire was designed to provide important facts regarding your medical history. `Please take the time to answer each question as completely as possible

First Name:____________________ Last Name:____________________________ MI:_______

Address:____

City/State:_________________________________Zip:____________

Home Phone: (______)________________ Cell Phone:(______)______________

Email Address: ____

Gender: ☐ Male / ☐ Female Date of Birth: _____/_____/______ Age:_________

Handedness (dominate hand use) ☐ Right ☐ Left ☐ Ambidextrous

Occupation: ____

Social Security#:______-_____-______

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow Height:________________

Emergency Contact Name: ____________________________ Weight: _______________

Relationship: _______________________________________

Emergency Contact Phone#: ___________________________

*********************************ACCIDENT INFORMATION**************************************

Is your visit today related to or a result of an accident or injury? ☐ Yes ☐ No

Is your visits related to a workers compensation? ☐ Yes ☐ No

If yes, type of accident/injury: ☐ Auto Accident ☐ Slip & Fall ☐ Other:_____________________

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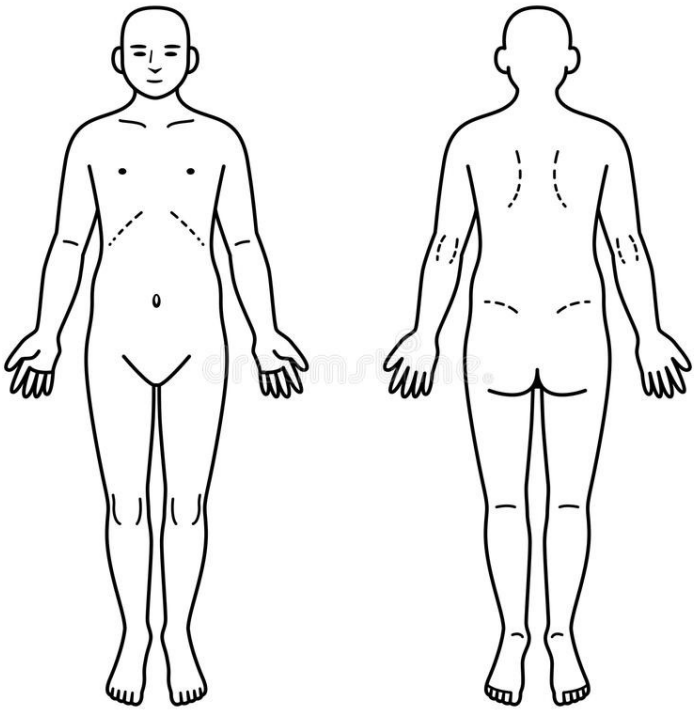
Who referred you to our office?

Pharmacy:	Phone #
Primary Care Physician:	Phone #
Preferred Imaging center:	Preferred lab facility:

Reason for today's visit	Draw your pain or symptom pattern/location
□ Neck pain □ Mid back pain □ Low back pain □ Arm pain □ Leg pain □ Arm or Leg numbness □ Brain Bleed □ Head injury □ Headache □ Hospital Follow up □ Post Op □ Other:	

Previous treatments for current symptom(s)

Treatment type	Effect on symptoms			Facility/ Frequency/Dates
Physical Therapy	□ Improved	□ No change	□ Worse	
Chiropractor	□ Improved	□ No change	□ Worse	
Medications	□ Improved	□ No change	□ Worse	
Injections	□ Improved	□ No change	□ Worse	

Do you have any limitations to your activity of daily living (ADL) due to your condition?

□ Personal hygiene – bathing/showering, grooming, nail care, and oral care.

□ Dressing – being able to make appropriate clothing decisions and physically dress and undress oneself.

□ Eating – the ability to feed oneself, though not necessarily the capability to prepare food.

□ Maintaining continence – being able to mentally and physically use a restroom and self cleaning oneself.

□ Toileting: The ability to get on and off the toilet.

□ Transferring/Mobility- being able to stand from a sitting position, as well as get in and out of bed. The ability to walk independently from one location to another.

NECK / CERVICAL Related Issues / Pain

When did symptoms start?	
Timing of symptoms:	constant • intermittent • mornings • nights • Other:
Current pain level:	_____/10 (0= no pain to 10 worse pain imaginable)
Duration of symptoms:	_____ days • weeks • months • years
Describe pain	Dull • achy • constant • burning • numbness • stabbing • pressure • cramping • heavy • Pins & needles • sharp • Other:
Does pain/symptoms radiate? If so where?	YES • NO Right arm • Left arm • Right leg • left leg• down spine• up spine •to head Other
What makes symptoms better?	Rest • Ice • Heat • massage • medications (OTC • pain • narcotic) chiropractic • physical therapy • laying down • Other:
What makes symptoms worse?	Standing • walking • bending • twisting • lying flat • sitting • Other:

LOW BACK / LUMBAR Related Issues / Pain

When did symptoms start?	
Timing of symptoms:	constant • intermittent • mornings • nights • Other:
Current pain level:	_____/10 (0= no pain to 10 worse pain imaginable)
Duration of symptoms:	_____ days • weeks • months • years
Describe pain	Dull • achy • constant • burning • numbness • stabbing • pressure• cramping • heavy • Pins & needles • sharp • Other:
Does pain/symptoms radiate? If so where?	YES • NO Right leg • left leg• both legs • up spine Other
What makes symptoms better?	Rest • Ice • Heat • massage • medications (OTC • pain • narcotic) chiropractic • physical therapy • laying down • Other:
What makes symptoms worse?	Standing • walking • bending • twisting • lying flat • sitting • Other:

OTHER Related Symptoms / Problems

Describe Current symptom(s)	
When did symptoms start?	
Timing of symptoms:	constant • intermittent • mornings • nights Other:
Current pain level:	_____/10 (0= no pain to 10 worse pain imaginable)
Duration of symptoms:	_____ days • weeks • months • years
Describe pain	Dull • achy • constant • burning • numbness • stabbing • pressure Pins & needles • sharp • cramping • heavy • Other:
Does pain/symptoms radiate? If so where?	YES • NO (if yes, where?)
What makes symptoms better?	Rest • Ice • Heat • massage • medications (OTC • pain • narcotic) chiropractic • physical therapy • laying down • Other:
What makes symptoms worse?	Standing • walking • bending • twisting • lying flat • sitting • Other:

Medical History

Past Medical History (current or ongoing medical problems)

☐ I have no previous medical problems
☐ High blood pressure ☐ heart attack ☐ CAD ☐ pacemaker ☐ heart Stent ☐ high cholesterol ☐ Heart problems
☐ COPD/ emphysema ☐ sleep apnea ☐ oxygen use ☐ pulmonary embolism ☐ asthma
☐ Diabetes ☐ Thyroid disorder ☐ Osteoporosis ☐ GERD ☐ reflux ☐ IBS
☐ Frequent urinary infections ☐ kidney stones ☐ prostate problems
☐ DVT ☐ osteoarthritis ☐ rheumatoid arthritis
☐ Stroke/CVA/ TIA ☐ Seizures ☐ aneurysms ☐ brain injury ☐ neuropathy ☐ multiple sclerosis
☐ Cancer: ☐ lung ☐ breast ☐ prostate ☐ colon ☐ lymphoma ☐ other:
☐ fibromyalgia ☐ posttraumatic stress disorder (PTSD)
☐ spine/back problems ☐ previous back or neck injury
Others:

Past Surgical History or ☐ No previous surgeries

☐ Appendix ☐ tonsils & adenoids ☐ Gallbladder ☐ Hip replacement ☐ Heart surgery
☐ Knee replacement ☐ Brain surgery ☐ Hysterectomy ☐ Tubal Ligation
☐ problems with anesthesia
☐ Neck or Back surgery Type:_____
☐ Other:_____

Social History (☐ None of the below)

☐ Current or previous smoker/tobacco use. Packs/ day_____, How many years?_____
☐ Alcohol use: Drinks/day _____, Drinks/week_____
☐ Recreational drugs use ☐ caffeine use Stress level: ☐ low ☐ medium ☐ High

Family History

☐ Back or Spine problems ☐ Bleeding disorders ☐ Heart Disease ☐Diabetes
☐ Aneurysms ☐ Stroke/TIA ☐ Cancers
Father age_____age if passed?_____ Mother age:_____ age if passed away_____
Other:

Allergies: (please list) ☐ No Known Drug Allergies	**Please list reaction**

Patient Name Date

Current Medications:
Please list ALL medications you currently take. Please include ANY vitamins, herbal supplements, over-the-counter medications as well as pain medications, muscle relaxers If you do not take any medications, please write "none".

☐ No changes from previous visit	

Review of Systems *(please circle any current or ongoing problems listed below)*	
Constitutional	Fevers•chills•weight loss•weight gain•fatigue•nights sweats
Eyes	Vision loss • double vision• blurred vision• glaucoma• cataracts• glasses
ENT	Hearing loss• hearing aids • runny nose•hoarseness of the voice•swallowing problems
Cardiovascular	Chest pain•irregular heart beat•cardiovascular disorder • swelling of the legs
Respiratory	Shortness of breath• cough• oxygen use
Gastrointestinal	Heartburn • abdominal pain • nausea • vomiting • dark or bloody in stool diarrhea • constipation • incontinence of stool
Genitourinary	Painful or burning urination • blood in urine• difficulty starting or stopping urination• urinary retention • incontinence of urine •increased frequency
Hematology	Bleeds easy • Blood clots swollen glands or lymph nodes
Endocrinology	Heat intolerance • cold intolerance • excessive thirst • excessive hunger
Neurological	Headaches• problems walking• balance problems• loss of consciousness • muscle weakness• extremity numbness/tingling • tremors
Musculoskeletal	Neck pain • thoracic pain• low back pain• extremity pain• decreased range of motion of joint(s) Joint swelling
Skin	Rash • non-healing sores • skin growth
Reproductive	Erectile dysfunction • decreased sexual drive• menopause
Psychiatric	Memory loss • depression • anxiety • post-traumatic stress disorder • restless sleep

*********ACCIDENT RELATED INFORMATION*********

Was your injury a result of:	☐ Auto Accident ☐ Slip & Fall ☐ Other:
Accident Date:	If Auto, amount of damage to your vehicle: $_____
Please describe how this accident happened: _____ _____ _____	
Your Current Symptoms? _____ _____	
Name of doctor(s) currently treating you for this injury?	
Have you ever been treated for any previous accidents?	☐ Yes ☐ No When?:_____
Have you had any of the following treatments for your current injury?	Physical Therapy ☐ Yes ☐ No Chiropractic Treatment ☐ Yes ☐ No Traction ☐ Yes ☐ No E-Stim/TENS Treatment ☐ Yes ☐ No Trigger Point Injections ☐ Yes ☐ No Epidural Steroid Injections ☐ Yes ☐ No Medications ☐ Yes ☐ No
Do you have an attorney? ☐ Yes ☐ No	Attorney/Firm Name:
Contact person at firm & phone #	

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MEDICAL RECORDS RELEASE FORM

Patient: _____ DOB:_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician / person / facility/ entity listed below:

The information you may release subject to this signed release form is as follows:

☐ Complete Records	☐ History and physical	☐ Progress Notes
☐ Care Plan	☐ Treatment record	☐ Operative Reports
☐ Hospital Reports	☐ Medication record	☐ Other (specify)

Release my protected health information to the following physician, person, facility, entity and/or those directly associated with my medical care:

Name:_____

Address:_____

City, State, Zip:_____

The purpose/reason for this release of information is as follows:

_____ _____

Signature Date

_____ _____

Patient Name Signature of Patient or Personal Representative

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