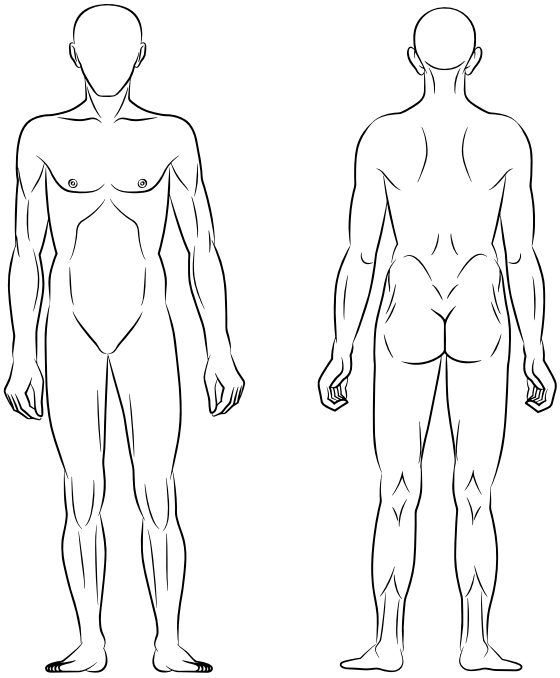
Spine New Patient Intake Form

Patient Information

Patient Name:_____ Date of Birth:_____
Primary Care Provider:_____

Pain History

Chief Complaint (Reason for your visit today)?_____
Does this pain radiate? If so where_____
Please list any additional areas of pain:_____



Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

Stabbing pain ////
Burning pain OOO
Aching pain XXX
Pins & needles VVV
Numbness ===

How often does the pain occur?

□ Constant □ Changes in severity but always present

□ Intermittent (comes and goes)

Pain Description

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

Check all of the following that describe your pain:

□ Dull/Aching □ Hot/Burning □ Shooting □ Stabbing/Sharp □ Cramping
□ Numbness □ Spasming □ Throbbing □ Squeezing □ Tightness
□ Tingling/Pins and Needles

When is your pain at its worst?

□ Mornings □Daytime □ Evenings □ Middle of the night □ Always the same

Pain Description Continued

Are there any activities or positions that significantly **worsen** your symptoms?

❒ Sitting
❒ Standing
❒ Walking
❒ Nothing
❒ Lifting
❒ Lying down
❒ Ice
❒ Heat
❒ Coughing/Sneezing
❒ Bending
❒ Bowel or bladder movements
❒ Moving
❒ Rest
❒ Other _____

Are there any activities or positions that significantly **improve** your symptoms?

❒ Sitting
❒ Standing
❒ Walking
❒ Nothing
❒ Lifting
❒ Lying down
❒ Ice
❒ Pain Medication
❒ Heat
❒ Coughing/Sneezing
❒ Bending
❒ Bowel or bladder movements
❒ Moving
❒ Rest

❒ Other _____

Onset of Symptoms

Approximately when did this pain begin?_____
What caused your current pain episode?_____
How did your current pain episode begin?
□ Gradually □ Suddenly
Since your pain began how has it changed?
□ Improved □ Worsened □ Stayed the same
Are you currently taking any pain medications? Yes or No
If so, what are you taking? _____
Who is your prescriber? _____

If you have had **spine surgery** please provide details regarding your spine surgery, including the date and location where it was performed: _____
_____
_____

If you have completed **physical therapy** please provide details regarding your physical therapy, including the date and location where it was performed: _____
_____
_____

Mark the effect each of the following have on your pain level:

	Increases	Decreases	No Change
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

_____

_____

Please mark all fo the following treatments you have used for pain relief:

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

Other_____

Associated Symptoms

	No	Yes	Comments
Numbness/Tingling	☐	☐	_____
Weakness in the arm/leg	☐	☐	_____
Balance Problems	☐	☐	_____
Bladder Incontinence	☐	☐	_____
Bowel Incontinence	☐	☐	_____
Joint Swelling/Stiffness	☐	☐	_____
Fevers/chills	☐	☐	_____

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

□MRI of the: _____Date: _____
□X-Ray of the: _____Date: _____
□CT Scan of the: _____Date: _____
□EMG/NCV study of the: _____Date: _____
□Other Diagnostic Testing: _____Date: _____
□ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

□ Acupuncturist
□ Chiropractor
□ Internist
□ Neurosurgeon
□ Orthopedic Surgeon
□ Physical Therapist
□ Psychiatrist/Psychologist
□ Rheumatologist
□ Neurologist
□ Physical Medicine & Rehab (PM&R)
□ Other_____

Past Medical History

Have you ever had any of the following? (Please check all that apply.)

❒ Allergies
❒ Anxiety
❒ Arthritis
❒ Bladder problems
❒ Black stools
❒ Blood clots
❒ Blood diseases
❒ Blurry vision
❒ Bowel problems
❒ Broken bones
❒ Cancer
❒ Chest pain
❒ Chills
❒ Circulatory problems
❒ Depression
❒ Diabetes
❒ Difficulty swallowing
❒ Dizziness
❒ Easy bleeding
❒ Easy bruising
❒ Emphysema
❒ Fatigue
❒ Fever
❒ Head injury
❒ Heart palpitations
❒ Heart problems
❒ Headaches
❒ Hernia
❒ High blood pressure
❒ HIV/AIDS
❒ Implants
❒ Joint swelling
❒ Kidney problems
❒ Liver/Gallbladder
❒ Loss of bladder control
❒ Loss of bowel control
❒ Major trauma
❒ Metal implants
❒ Nausea
❒ Numbness/tingling
❒Osteoporosis
❒ Pacemaker
❒ Pregnancy
❒ past ❒ present
❒ Rash
❒ Rheumatoid
❒ Ringing in ears
❒ Seizures
❒ Shortness of breath
❒ Sleep problems
❒Skin problems
❒ Strokes
❒ Sweating
❒ Ulcers
❒ Vomiting
❒ Weakness
❒ Weight gain
❒ Weight loss

Please explain any checked items above and add others not listed:_____

_____

_____

Interventional Pain Treatment History

□ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
□ Joint Injection – Joint(s)_____
□ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
□ MILD (Minimally Invasive Lumbar Decompression) -_____
□ Nerve Blocks – Area/Nerve(s) -_____
□ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
□ Spinal Cord Stimulator – Trial Only/Permanent Implant_____
□ Trigger Point Injections – Where?_____
□ Vertebroplasty/Kyphoplasty – Level(s)_____
□ Other -_____
Which of these procedures listed above have helped with your pain?_____
_____
_____

Past Surgical History

Please list any surgical procedures you have had done in the past including date:
1) _____Date? _____
2) _____Date? _____
3) _____Date? _____
4) _____Date?_____
5) _____Date? _____
□ I have NEVER had any surgical procedures performed.

Social History

Occupation: _____
□ Temporary Disability □ Permanent Disability □ Retired □ Unemployed

Who is in your current household?_____

Are there any stairs in your current home? _____
If so how many? _____

Are you currently under worker's compensation? □ No □ Yes
Is there an ongoing lawsuit related to your visit today? □ No □ Yes

Alcohol Use: □ Social Use □ History of alcoholism □ Current alcoholism
□Never □ Daily use of alcohol

Tobacco Use: □ Current user □ Former user □ Never used
□ Packs per day? _____ □ How many years? _____
□ Quit Date: _____

Illegal Drug Use: □ Never □ Currently uses illegal drugs
□ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? □ Yes □ No

Allergies

Do you have any drug/medication allergies? □ Yes □ No If so, please list all medications you are allergic to:

Medication Name Allergic Reaction

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____
5) _____ _____

Topical Allergies: □ Latex □ Iodine □ Tape □ IV Contrast

Additional Questions

Do you exercise? □Yes □No

If so, what type of exercise? Example weight lifting _____

Have you had a history of an accident or injury? If **yes**, please explain and answer the next questions:

1. Was the accident at work? Yes or No
2. Are you using Workman's Compensation? Yes or No
   a. if so which Workman's Compensation company are you working with?
      _____
   b. Who is your Workman's Compensation case worker and what is their phone number?
      _____
3. Are you currently involved in litigation? Yes or No
4. Is your injury related to a motor vehicle accident? Yes or No

Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

□ Arthritis
□ Bleeding Disorders
□ Cancer
□ Diabetes
□ Headaches/Migraines
□ Heart problems
□ High Blood Pressure
□ Kidney Problems
□ Liver Problems
□ Muscle diseases
□ Osteoporosis
□ Rheumatoid arthritis
□ Seizures
□ Stroke
□ Thyroid problems
□ Other Medical Problems:
_____
_____
_____
_____

□ I have no significant family medical history

Instructions: The questionnaires on the following pages are designed to provide us with information on how your back pain has impacted your daily life.

Please complete each section and circle only ONE number that best reflects your current situation.

While you may find that two statements in a section apply to you, please choose the number that most accurately describes your current condition.

Please only fill out the questionnaire that corresponds to the area of pain you are experiencing.

Oswestry Back Disability Index-Only complete for middle or low back pain

Section 1: Pain Intensity

1. I have no pain at the moment
2. The pain is very mild at the moment
3. The pain is moderate at the moment
4. The pain is fairly severe at the moment
5. The pain is very severe at the moment
6. The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

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

Section 3: Lifting

1. I can lift heavy weights without extra pain
2. I can lift heavy weights but it gives extra pain
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
4. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
5. I can only lift very light weights
6. I cannot lift or carry anything

Section 4: Walking

1. Pain does not prevent me walking any distance
2. Pain prevents me from walking more than 1 mile.
3. Pain prevents me from walking more than ½ mile
4. Pain prevents me from walking more than ¼ mile.
5. I can only walk with crutches or a cane.
6. I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting

1. I can sit in any chair as long as I like.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me from sitting for more than 1 hour.
4. Pain prevents me from sitting for more than ½ hour
5. Pain prevents me from sitting for more than 10 minutes.
6. Pain prevents me from sitting at all.

S**ection 6: Standing**

1. . I can stand as long as I want without pain.
2. I have some pain while standing, but it does not increase with time.
3. I cannot stand for longer than one hour without increasing pain.
4. I cannot stand for longer than ½ hour without increasing pain.
5. I cannot stand for longer than ten minute without increasing pain.
6. I avoid standing, because it increases the pain straight away.

Section 7: Sleeping

1. I get no pain in bed.
2. I get pain in bed, but it does not prevent me from sleeping well.
3. Because of pain, my normal night's sleep is reduced by less than one quarter.
4. Because of pain, my normal night's sleep is reduced by less than one-half.
5. Because of pain, my normal night's sleep is reduced by less than three-quarters.
6. Pain prevents me from sleeping at all.
7.

Section 8: Social Life

1. My social life is normal and give me no pain.
2. My social life is normal, but increases the degree of my pain.
3. Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
4. Pain has restricted my social life and I do not go out very often.
5. Pain has restricted my social life to my home.
6. I have hardly any social life because of the pain

Section 9: Traveling

1. I get no pain while traveling.
2. I get some pain while traveling, but none of my usual forms of travel make it any worse.
3. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
4. I get extra pain while traveling which compels me to seek alternative forms of travel.
5. Pain restricts all forms of travel.
6. Pain prevents all forms of travel except that done lying down.

Section 10: Changing Degree of Pain

1. IMy pain is rapidly getting better.
2. My pain fluctuates, but overall is definitely getting better.
3. My pain seems to be getting better, but improvement is slow at present.
4. My pain is neither getting better nor worse.
5. My pain is gradually worsening.
6. My pain is rapidly worsening

Neck Disability Index-Only complete for neck pain

Section 1: Pain Intensity

1. I have no pain at the moment
2. The pain is very mild at the moment
3. The pain is moderate at the moment
4. The pain is fairly severe at the moment
5. The pain is very severe at the moment
6. The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

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

Section 3: Lifting

1. I can lift heavy weights without extra pain
2. I can lift heavy weights but it gives extra pain
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
4. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
5. I can only lift very light weights
6. I cannot lift or carry anything

Section 4: Reading

1. I can read as much as I want to with no pain in my neck
2. I can read as much as I want to with slight pain in my neck
3. I can read as much as I want with moderate pain in my neck
4. I can't read as much as I want because of moderate pain in my neck
5. I can hardly read at all because of severe pain in my neck
6. I cannot read at all

Section 5: Headaches

1. I have no headaches at all
2. I have slight headaches, which come infrequently
3. I have moderate headaches, which come infrequently
4. I have moderate headaches, which come frequently
5. I have severe headaches, which come frequently
6. I have headaches almost all the time

Section 6: Concentration

1. I can concentrate fully when I want to with no difficulty
2. I can concentrate fully when I want to with slight difficulty
3. I have a fair degree of difficulty in concentrating when I want to
4. I have a lot of difficulty in concentrating when I want to
5. I have a great deal of difficulty in concentrating when I want to
6. I cannot concentrate at all

Section 7: Work

1. I can do as much work as I want to
2. I can only do my usual work, but no more
3. I can do most of my usual work, but no more
4. I cannot do my usual work
5. I can hardly do any work at all
6. I can't do any work at all

Section 8: Driving

1. I can drive my car without any neck pain
2. I can drive my car as long as I want with slight pain in my neck
3. I can drive my car as long as I want with moderate pain in my neck
4. I can't drive my car as long as I want because of moderate pain in my neck
5. I can hardly drive at all because of severe pain in my neck
6. I can't drive my car at all

Section 9: Sleeping

1. I have no trouble sleeping
2. My sleep is slightly disturbed (less than 1 hr sleepless)
3. My sleep is mildly disturbed (1-2 hrs sleepless)
4. My sleep is moderately disturbed (2-3 hrs sleepless)
5. My sleep is greatly disturbed (3-5 hrs sleepless)
6. My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

1. I am able to engage in all my recreation activities with no neck pain at all
2. I am able to engage in all my recreation activities, with some pain in my neck
3. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
4. I am able to engage in a few of my usual recreation activities because of pain in my neck
5. I can hardly do any recreation activities because of pain in my neck
6. I can't do any recreation activities at all

Modified Japanese Orthopaedic Association (mJOA) score-Neck Only

I. **Motor dysfunction score of the upper extremities**	C**ircle One**
Inability to move hands	0
Inability to eat with a spoon but able to move hands	1
Inability to button shirt but able to eat with a spoon	2
Able to button shirt with great difficulty	3
Able to button shirt with slight difficulty	4
No dysfunction	5

II. Motor dysfunction score of the lower extremities	**Circle One**
Complete loss of motor and sensory function	0
Sensory preservation without ability to move legs	1
Able to move legs but unable to walk	2
Able to walk on flat floor with a walking aid (i.e., cane or crutch)	5
Able to walk up and/or down stairs with hand rail	4
Moderate to significant lack of stability but able to walk up and/or down stairs without hand rail	5
Mild lack of stability but walk unaided with smooth reciprocation	6
No dysfunction	7

III. Sensation	**Circle One**
Complete loss of hand sensation	0
Severe sensory loss or pain	1
Mild sensory loss	2
No sensory loss	3

IV. Sphincter dysfunction	**Circle One**
Inability to urinate voluntarily	0
Marked difficulty with urination	1
Mild to moderate difficulty with urination	2
Normal urination	3

mild myelopathy	mJOA from 15 to 17
moderate myelopathy	mJOA from 12 to 14
severe myelopathy	mJOA from 0 to 11.