NEW PATIENT INTAKE FORM

Today's Date: ___________________________

Name: ________________________________ ☐ Male ☐ Female Date of Birth: _____________ Age: __________

What is the **primary** reason for today's visit?

☐ Low Back Pain ☐ Neck Pain ☐ Leg(s) Pain-Right/Left ☐ Arm(s) Pain-Right/Left
☐Other____________

How long have you had this problem?

☐ 0-3 Months ☐ 3-6 Months ☐ 6-9 Months ☐ 1 year ☐ Greater than 5 years

How did this problem occur? ☐ Suddenly ☐ Gradually ☐ Motor Vehicle Accident (date): _____________________

☐ Work related injury (date): ____

Please rate your pain by **circling** the one number that best describes your **AVERAGE** pain in the last 7 days.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst imaginable pain

Please **check** all the words that describe to your pain:

☐ Throbbing ☐ Shooting ☐ Sharp ☐ Electric/Burning ☐ Numbness ☐ Tingling

Does the pain travel or radiate? ☐ Yes ☐ No

If so, where to? ☐ Leg (R/L) ☐ Arm (R/L) ☐ Buttocks (R/L) ☐ Groin ☐ Head ☐ Other________________

Which activity or position ***aggravates*** your pain?

☐ Sitting ☐ Standing ☐ Walking ☐ Other (please describe): ________________________________

Which activity or position ***relieves*** your pain?

☐ Sitting ☐ Standing ☐ Walking ☐ Other (please describe): ________________________________

Describe your sleep pattern?

☐ Normal ☐ Difficulty falling asleep ☐ Difficulty staying asleep

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PREVIOUS WORK-UP/ TREATMENT:

Have you seen other physicians/surgeons for this condition? ☐ Yes ☐ No

☐ Orthopedics ☐ Spine Surgery ☐ Hand Surgery ☐ Neurosurgery ☐ Rheumatology

Please list your most recent diagnostic tests:

☐ Lumbar MRI ☐ Cervical MRI ☐ X-Ray ☐ EMG/NCS ☐ I did NOT have any prior tests

Have you had any of the following treatments? ☐ Yes ☐ No

Treatment	Describe (# treatments, location, etc.)	Effective?
☐ Physical Therapy	__ less than 6 weeks __ more than 6 weeks	☐ Yes ☐ No
☐ Injections (Inj.)	☐ Epidural Inj. ☐ Facet Inj. ☐ Sacroiliac Joint Inj. ☐ Radiofrequency Ablation ☐ Spinal Cord Stimulation	☐ Yes ☐ No
☐ Surgery	☐ Lumbar Fusion ☐ Lumbar Laminectomy ☐ Cervical Fusion ☐ Cervical Laminectomy	☐ Yes ☐ No

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MEDICAL HISTORY:

High blood pressure (HTN) ☐ Yes ☐ No
Diabetes (T2DM) ☐ Yes ☐ No
Atrial Fibrillation (AFIB) ☐ Yes ☐ No
Acid Reflux (GERD) ☐ Yes ☐ No
Irregular heartbeat ☐ Yes ☐ No
Seizure disorder ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Fibromyalgia ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Bipolar disorder ☐ Yes ☐ No
Coronary artery disease (CAD) ☐ Yes ☐ No
Bleeding disorder ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Substance abuse (specify below) ☐ Yes ☐ No
Cancer (specify below) ☐ Yes ☐ No

SURGICAL HISTORY:

☐ Hip Surgery ☐ Back Surgery ☐ Wrist/Arm Surgery ☐ Coronary Bypass (CABG)
☐ Knee Surgery ☐ Shoulder Surgery ☐ Foot/Ankle Surgery ☐ Wrist/Arm Surgery

FAMILY HISTORY:

Please **check** any major illnesses in your family?

☐ Cancer ☐ Stroke ☐ Diabetes ☐ Heart Disease ☐ Depression/Anxiety
☐ Alcohol Abuse ☐ Illicit Drug use ☐ Chronic Pain ☐ Other________________________________

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No If yes, how much/often? ________________________________
Do you drink? ☐ Yes ☐ No If yes, how often? ________________________________
Use illicit drugs? ☐ Yes ☐ No If yes, please list: ________________________________

FUNCTIONAL HISTORY:

Please describe activities you **CANNOT** perform due to your pain:

☐ Walking long distances ☐ Exercise ☐ Self Care ☐
Other____

ALLERGIES:

☐ No allergies ☐ Latex ☐ Contrast dye ☐ Iodine ☐ Shellfish ☐ Steroids ☐ Other___________________

MEDICATIONS:

Do you take any blood thinners? ☐ Yes ☐ No

☐ Coumadin (Warfarin) ☐ Plavix (Clopidogrel) ☐ Xarelto ☐ Eliquis ☐ Other________________________

Please list your **CURRENT** medications**:**

Medication:	Dose/Frequency:

Please mark if you have used any of the following medications **IN THE PAST:**

Over-the Counters
- ☐ Tylenol
- ☐ Ibuprofen
- ☐ Naproxen
- ☐ Diclofenac

Nerve Pain
- ☐ Gabapentin
- ☐ Lyrica
- ☐ Topamax
- ☐ Cymbalta

Opioids/Narcotics
- ☐ Hydrocodone
- ☐ Tramadol
- ☐ Oxycodone
- ☐ Fentanyl
- ☐ Oxycontin
- ☐ Dilaudid
- ☐ Percocet
- ☐ Morphine

Muscle Relaxers
- ☐ Flexeril
- ☐ Tizanidine
- ☐ Baclofen
- ☐ Methocarbamol

REVIEW OF SYSTEMS: If you currently have a *problem* in any of these areas, please **check** below:

☐ Check box if none below apply to you

General
- ☐ Fevers
- ☐ Chills
- ☐ Weight loss

ENT
- ☐ Hearing loss
- ☐ Sore throat
- ☐ Difficulty Swallowing

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Blood clot

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea

Urinary
- ☐ Kidney stones
- ☐ Difficult urinating
- ☐ Urinary incontinence

Neurological
- ☐ Sensation loss
- ☐ Fainting
- ☐ Seizures
- ☐ Headache
- ☐ Coordination loss

Skin
- ☐ Easy bruising
- ☐ Bleeding disorder
- ☐Rash

Endocrine
- ☐ Heat/Cold Intolerance
- ☐ Excessive thirst
- ☐ Change in sexual desire

Psychiatry
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Suicidal ideations

ADDITIONAL INFORMATION:

Preferred Pharmacy and City: ____

Signature: ______________________________________Date: ____________________

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM