DEPARTMENT OF NEUROSURGERY
Spine Center
New Patient Intake Form

Today's date: ___________________________ Date of birth: ___________________________

Your name: ___________________________ Email address: ___________________________

CHIEF COMPLAINT (CHECK ALL THAT APPLY):

☐ Neck Pain  ☐ Pain  ☐ Weakness  ☐ Numbness / Tingling / Burning
☐ Back Pain  ☐ Pain  ☐ Weakness  ☐ Numbness / Tingling / Burning
☐ Arm Pain: ☐ Pain  ☐ Weakness  ☐ Numbness / Tingling / Burning
☐ Leg Pain: ☐ Pain  ☐ Weakness  ☐ Numbness / Tingling / Burning

☐ Spinal Deformity (Scoliosis, Kyphosis, Flatback Syndrome, etc.)
☐ Other ___________________________

DESCRIBE YOUR PAIN:

Has your pain been:

Improving  ☐
Worsening  ☐
Staying the same  ☐

Have you had pain like this before? ☐ Yes  ☐ No
How long have you had your current pain? ___________

Please describe each type of pain that you experience:

Achy  ☐ Yes  ☐ No
Stabbing  ☐ Yes  ☐ No
 Burning  ☐ Yes  ☐ No
Numbness/Tingling  ☐ Yes  ☐ No

WHICH TREATMENTS HAVE YOU TRIED FOR THIS CONDITION?

Acupuncture  ☐ Yes  ☐ No  Was it helpful? ☐ Yes  ☐ No
Chiropractic  ☐ Yes  ☐ No  Was it helpful? ☐ Yes  ☐ No
Physical Therapy  ☐ Yes  ☐ No  Was it helpful? ☐ Yes  ☐ No
Other alternative therapy? ☐ Yes  ☐ No  Was it helpful? ☐ Yes  ☐ No

Which therapies and when? ___________________________

Spine Injections?  ☐ Yes  ☐ No  Was it helpful? ☐ Yes  ☐ No  How many injections? ___________

Which area of the body and when? ___________________________

Please rate your pain below:

Current Overall Pain / Discomfort (1-10, 10 being Severe):

1 2 3 4 5 6 7 8 9 10

Pain/Discomfort at its worst (1-10, 10 being Severe):

1 2 3 4 5 6 7 8 9 10

How long can you sit? ___________
How long can you stand? ___________
How long can you walk? ___________

Do you have weakness in arm(s)? ☐ Yes  ☐ No
Do you have weakness in leg(s)? ☐ Yes  ☐ No

Please complete all pages
**PAIN DIAGRAM:**
Using the appropriate symbol, draw on the body diagram *areas of stabbing or shooting pain with an X, areas of burning pain with a +, and areas of numbness with an O:*

<table>
<thead>
<tr>
<th>Key</th>
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<tbody>
<tr>
<td>Stabbing/Shooting: X</td>
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<tr>
<td>Burning: +</td>
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<tr>
<td>Numbness: O</td>
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**PAST SPINE SURGICAL HISTORY:**
*Please list all surgeries and please bring operative reports of any spine surgeries to your appointment:*

<table>
<thead>
<tr>
<th>Type of surgery/ side</th>
<th>Date</th>
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**PAIN MEDICATIONS:**
*Please list all of your current medications, including over the counter medications:*

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Number of times daily</th>
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Are you currently taking any blood thinners? ☐ Yes ☐ No
(Coumadin/Warfarin, Plavix, Aspirin, Eliquis, Xarelto, Ticagrelor, etc.
If YES, Please list: __________________________________________

**ALLERGIES:**
*Please list all known allergies and your reaction to them, particularly medications and latex:*

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<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
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Please complete all pages
REVIEW OF SYSTEMS (please check all that apply):

**Constitutional**
- □ Unexpected weight loss (more than 10 pounds in past six months)
- □ Fatigue/ tired all over
- □ Fever, chills, or sweats

**Gastrointestinal**
- □ Nausea or vomiting
- □ Diarrhea
- □ Heartburn

**Genitourinary**
- □ Frequent or hesitant urination
- □ Bladder accidents / incontinence
- □ Pain with urination
- □ Blood in urine

**Psychiatric**
- □ Anxiety
- □ Depression

**Eyes**
- □ Blurred or double vision

**Respiratory**
- □ Wheezing
- □ Shortness of breath

**Hematological**
- □ Too much bruising / bleeding

**Ears, nose, mouth, throat**
- □ Difficulty swallowing
- □ Difficulty hearing

**Musculoskeletal**
- □ Back pain
- □ Joint pain / swelling

**Cardiovascular**
- □ Chest pain
- □ Palpitations/ fast heart rate

**Neurological**
- □ Headaches
- □ Weakness
- □ Numbness
- □ Fainting spells
- □ Dizziness / vertigo

**Endocrine**
- □ Excessive urination
- □ Excessive thirst

**Employment:**
Are you currently working? □ Yes □ No If YES, occupation/title? __________________________

Is this a work-related injury? □ Yes □ No
If YES, When did it occur? __________________________

Are you currently on disability? □ Yes □ No
If YES, is there a current or upcoming litigation (lawsuit)? □ Yes □ No
Is there a current or upcoming workers' compensation hearing? □ Yes □ No

**Social History:**
- □ Single □ Married □ Domestic Partner □ Divorced □ Widowed

Do you smoke? □ Never □ Yes / how much daily: ________ □ Former / date quit: ______________________

Do you drink more than two alcoholic beverages on a daily basis? □ Yes □ No
Do you use any recreational drugs not prescribed by a doctor? □ Yes □ No

**Health Care Proxy:**
Do you have a current Health Care Proxy? □ Yes □ No
If YES, name of proxy: __________________________

*If no, and you would like more information, please see our front desk staff.*

The information on this form is accurate to the best of my knowledge. I understand this form will become part of my medical record:

Patient Signature: __________________________ Date Completed: __________________________