BRIGHAM HEALTH
BWH BRIGHAM AND WOMEN'S HOSPITAL

BRIGHAM HEALTH
BWH BRIGHAM AND WOMEN'S Faulkner Hospital

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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

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

WHICH TREATMENTS HAVE YOU TRIED FOR THIS CONDITION?

						Length/Time of Treatments
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? ______________________________

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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

Eyes
- ☐ Blurred or double vision

Ears, nose, mouth, throat
- ☐ Difficulty swallowing
- ☐ Difficulty hearing

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations/ fast heart rate

Gastrointestinal
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Heartburn

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

Respiratory
- ☐ Wheezing
- ☐ Shortness of breath

Psychiatric
- ☐ Anxiety
- ☐ Depression

Hematological
- ☐ Too much bruising / bleeding

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain / swelling

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: ____________________