BRIGHAM AND WOMEN'S 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

What is the main reason that you are seeking medical attention? _____

_____

Please briefly describe how your problem started: _____

_____

DESCRIBE YOUR PAIN

Has your pain been improving, worsening, or staying the same?

How long have you had your current pain?

Have you had pain like this before? ☐ Yes ☐ No

Please describe each type of pain that you experience:

Achy _____

Dull _____

Throbbing _____

Stabbing _____

Burning _____

Numbness _____

Tingling _____

Cramping _____

Please rate your pain when it is at its worst (bad day) with an X:

Mark on the scale below, with 0 being no pain and 10 being the worst imaginable.

0 ——————————————— 10

No Pain Worst Pain

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

WHAT TREATMENTS HAVE YOU TRIED FOR THIS CONDITION?

Chiropractic ☐ Yes ☐ No Was it helpful? _____

Acupuncture ☐ Yes ☐ No Was it helpful? _____

Other alternative therapy? ☐ Yes ☐ No What kind and was it helpful? _____

Physical therapy? ☐ Yes ☐ No Was it helpful? _____

When? _____

Injections? ☐ Yes ☐ No Was it helpful? _____

Which area of the body and when? _____

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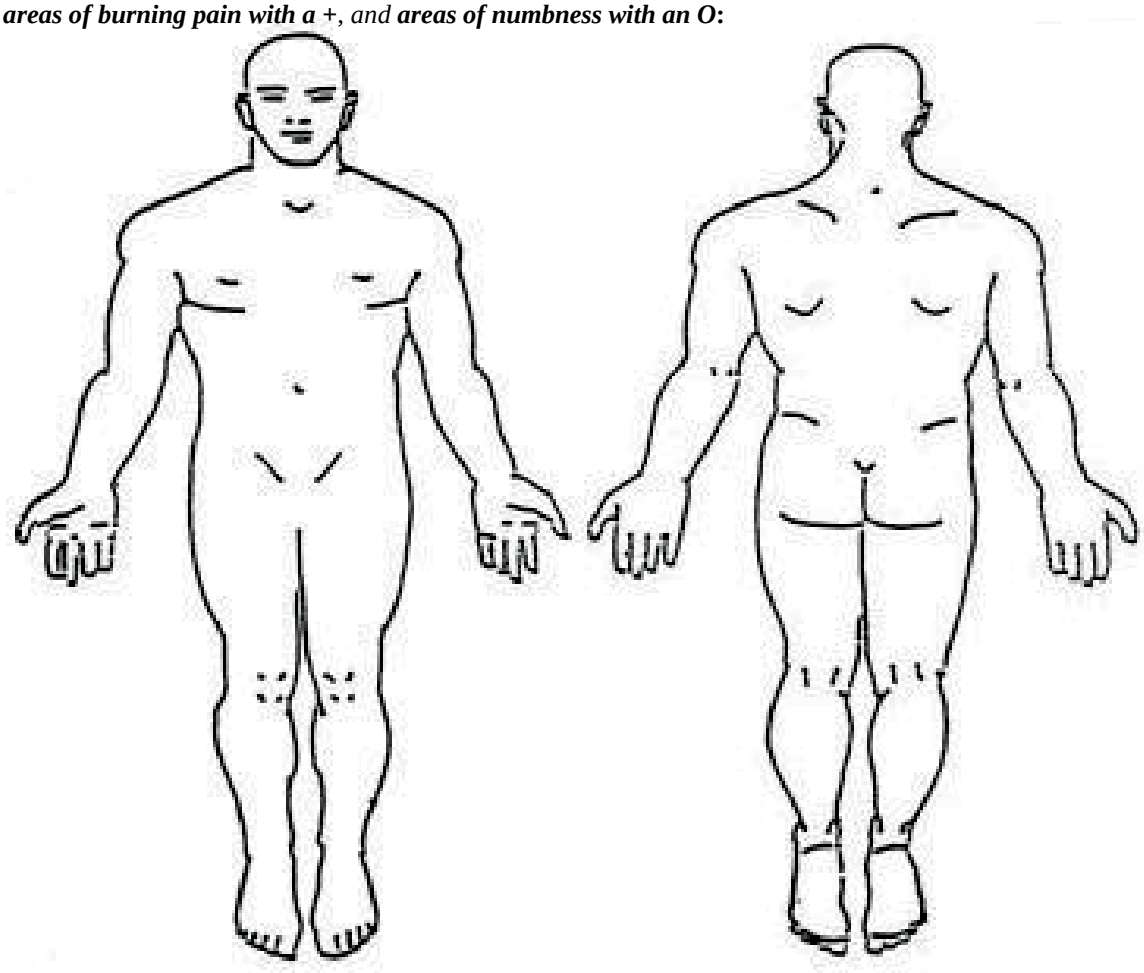
PAIN DIAGRAM

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*****:**



PAST MEDICAL HISTORY:

Please check any of the following difficulties which you now have now or in the past:

Asthma	☐ Yes	☐ No	When		
COPD	☐ Yes	☐ No	When		
Emphysema	☐ Yes	☐ No	When		
Tuberculosis	☐ Yes	☐ No	When		
CHF	☐ Yes	☐ No	When		
Heart attack	☐ Yes	☐ No	When		
Heart murmur	☐ Yes	☐ No	When		
Hypertension	☐ Yes	☐ No	When		
Kidney Disease	☐ Yes	☐ No	When		
Stroke	☐ Yes	☐ No	When		
Anemia	☐ Yes	☐ No	When		
Blood transfusion	☐ Yes	☐ No	When		
Clotting disorder	☐ Yes	☐ No	When		
Sickle cell anemia	☐ Yes	☐ No	When		
Meningitis	☐ Yes	☐ No	When		
Seizures	Yes	No	When _____		

Anxiety	☐ Yes	☐ No	When		
Depression	☐ Yes	☐ No	When		
Substance Abuse	☐ Yes	☐ No	When		
Arthritis	☐ Yes	☐ No	When		
Nerve/muscle disease	☐ Yes	☐ No	When		
Osteoporosis	☐ Yes	☐ No	When		
Cataracts	☐ Yes	☐ No	When		
Glaucoma	☐ Yes	☐ No	When		
GERD	☐ Yes	☐ No	When		
Ulcers	☐ Yes	☐ No	When		
Allergies	☐ Yes	☐ No	When		
Diabetes Mellitus	☐ Yes	☐ No	When		
HIV/AIDS	☐ Yes	☐ No	When		
Thyroid disease	☐ Yes	☐ No	When		
Cancer	☐ Yes	☐ No	When		
				What kind	_____

Other relevant medical history _____

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PAST SURGICAL HISTORY:

Please list all surgeries and please bring operative reports of any spine surgeries to your appointment:

Type of surgery/ side Date

_____

_____

_____

MEDICATIONS:

*Please list **all** of your **current medications**, including over the counter medications:*

Name Dosage Number of times daily

_____

_____

_____

_____

_____

_____

_____

Are you taking any blood thinners? (Coumadin, Warfarin, Plavix, Aspirin, etc) ☐ Yes ☐ No

Please list, including dosage: _____

ALLERGIES

Please list allergies and your reactions to them, particularly medications:

_____

_____

EMPLOYMENT

Are you currently working? ☐ Yes ☐ No If yes, what is your occupation/title? _____

Is there current or upcoming litigation (lawsuit)? ☐ Yes ☐ No

Is there a current or upcoming worker's compensation hearing? ☐ Yes ☐ No

SOCIAL HISTORY:

☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Highest level of education: ☐ Elementary ☐ High School ☐ College ☐ Graduate/Professional Degree

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Do you currently smoke tobacco? ☐ Yes ☐ No If yes, how much daily? _____

Prior tobacco use? ☐ Yes ☐ No If yes, how much? _____

Do you use drugs? ☐ Yes ☐ No If yes, which and how often? _____

Do you use alcohol? ☐ Yes ☐ No If yes, how much a day? _____

Prior alcohol or drug abuse? ☐ Yes ☐ No If yes, which and how much? _____

Do you exercise? ☐ Yes ☐ No If yes, what and how often? _____

Please complete all pages

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FAMILY HISTORY

Condition	Yes	No	type/affected relative	Condition	Yes	No	type/affected relative
Cancer	☐	☐	_____	Heart Disease	☐	☐	_____
Glioma	☐	☐	_____	High Cholesterol	☐	☐	_____
Aneurysms	☐	☐	_____	Hypertension	☐	☐	_____
Other conditions	☐	☐	_____	Diabetes	☐	☐	_____
Bleeding/Clotting Problems	☐	☐	_____				

REVIEW OF SYSTEMS:

Please check any of the following difficulties which you now have, or which you have experienced over the past six months:

Constitutional:

Fever	☐ Yes	☐ No	When _____
Weight loss or gain	☐ Yes	☐ No	When
Excessive fatigue	☐ Yes	☐ No	When _____

Eyes:

Blurry vision	☐ Yes	☐ No	When
Double vision	☐ Yes	☐ No	When

Ear, Nose, Throat:

Hearing difficulty	☐ Yes	☐ No	When _____
Ear pain/infection	☐ Yes	☐ No	When _____
Ringing in ears	☐ Yes	☐ No	When _____
Nose bleeds	☐ Yes	☐ No	When
Nasal drainage/congestion	☐ Yes	☐ No	When _____
Sore or hoarse throat	☐ Yes	☐ No	When _____
Balance problems	☐ Yes	☐ No	When _____

Heart

Chest pain or angina	☐ Yes	☐ No	When _____
High blood pressure	☐ Yes	☐ No	When _____
Heart trouble	☐ Yes	☐ No	When _____
High cholesterol	☐ Yes	☐ No	When _____

Lungs

Shortness of breath	☐ Yes	☐ No	When _____
Coughing/wheezing	☐ Yes	☐ No	When _____

Gastrointestinal

Nausea/vomiting	☐ Yes	☐ No	When _____
Heartburn	☐ Yes	☐ No	When _____
Diarrhea	☐ Yes	☐ No	When _____
Ulcers or gastritis	☐ Yes	☐ No	When _____

Endocrine:

Excessive urination	☐ Yes	☐ No	When _____
Excessive thirst	☐ Yes	☐ No	When

Genitourinary:

Urinary tract infections	☐ Yes	☐ No	When _____
Painful urination	☐ Yes	☐ No	When
Blood in your urine	☐ Yes	☐ No	When
Incontinence	☐ Yes	☐ No	When

Musculoskeletal:

Broken bones	☐ Yes	☐ No	When _____
Arm or leg weakness	☐ Yes	☐ No	When _____
Arm or leg pain	☐ Yes	☐ No	When _____
Joint pain or swelling	☐ Yes	☐ No	When

Neurological:

Fainting spells	☐ Yes	☐ No	When _____
Seizure	☐ Yes	☐ No	When _____
Memory loss	☐ Yes	☐ No	When _____
Disorientation	☐ Yes	☐ No	When _____

Psychiatric:

Anxiety	☐ Yes	☐ No	When _____
Depression	☐ Yes	☐ No	When _____

Hematologic/Lymphatic:

Bruising	☐ Yes	☐ No	When _____
Hemophilia	☐ Yes	☐ No	When _____
Jaundice	☐ Yes	☐ No	When _____

HEALTH CARE PROXY

Do you have a Health Care Proxy currently? ☐ Yes ☐ No

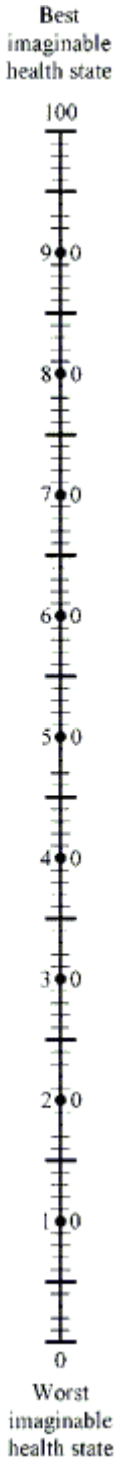
If no, and you would like more information, please see our receptionist.

Place patient sticker here

YOUR HEALTH STATE:

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.



Your own health state today

CURRENT STATUS

Please check one box in each group below that best describes your own health today:

Mobility

☐ I have no problems in walking about
☐ I have some problems in walking about
☐ I am confined to bed

Self-Care

☐ I have no problems with self-care
☐ I have some problems washing or dressing myself
☐ I am unable to wash or dress myself

Usual Activities

☐ I have no problems with performing my usual activities
☐ I have some problems with performing my usual activities
☐ I am unable to perform my usual activities

Pain/Discomfort

☐ I have no pain or discomfort
☐ I have moderate pain or discomfort
☐ I have extreme pain or discomfort

Anxiety/Depression

☐ I am not anxious or depressed
☐ I am moderately anxious or depressed
☐ I am extremely anxious or depressed

The information on this form is accurate to the best of my knowledge:

Patient Signature: _____ Date Completed: _____

I have reviewed the above information with the patient:

Physician Signature: _____ Date Reviewed: _____

Clinical ID #: _____