AXIS SPINE CLINIC

NEW PATIENT INTAKE FORM

Name:_____ Age:_____ Gender: M / F Primary Care Physician:_____

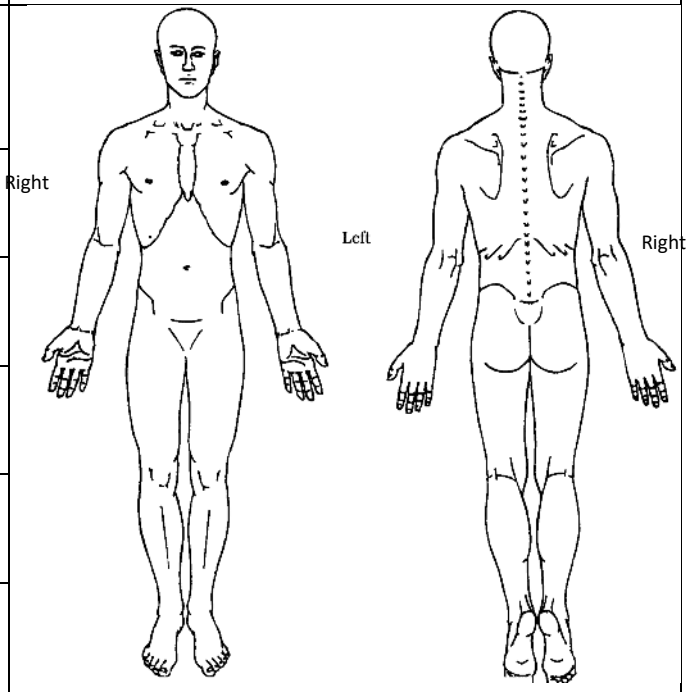
Occupation:_____ Currently working?: Y / N Work injury: Y / N Date of Injury:_____

Reason for visit: ***(circle all that apply)***
Neck pain Mid-back pain Low-back pain
RT arm pain RT leg pain LT arm pain LT leg pain

Mark the location of your pain using the symbols given below:
NUMBNESS - X PINS/NEEDLES – 0
BURNING - / STABBING - = ACHE - <

Your current pain is: *(none)* 0 1 2 3 4 5 6 7 8 9 10 *(severe)*

Highest amount of pain: *(none)* 0 1 2 3 4 5 6 7 8 9 10 *(severe)*



How long have you had your pain?
_____ Days - Weeks - Months - Years ***(circle one)***

If symptoms are due to an injury, what type of injury did you have?

The pain is: ***(circle all that apply)***
Continuous Occasional Improving Worsening

When is your pain worse? ***(circle all that apply)***
Morning Daytime Evening Night time

Describe your pain:

What makes your pain worse? ***(circle all that apply)***
Lifting Bending Laying Sitting Standing Driving
Changes in weather Walking Coughing Sneezing

What makes your pain better? ***(circle all that apply)***
Medications Bending Laying Sitting Standing
Walking Changing positions Medicines *Nothing*

What associated symptoms do you have? ***(circle all that apply)***
Numbness Weakness Catching Giving out

Do you have any recent changes in controlling your bowel or bladder? ***(circle one)***
Yes No

Do you have any unexplained fevers above 101.5°F? ***(circle one)***
Yes No

Do you have any *unexplained* weight loss greater than 15 pounds? ***(circle one)***
Yes No

What treatments have you tried for this problem?

Medications (List) _____

Physical Therapy (how long, where) _____

Surgery (what, when, where) _____

Circle all that apply

Chiropractic Care * Acupuncture * Massage Therapy * Epidural Steroid Injections * Facet Injections * Joint Injections * Trigger Point Injections * *Nothing*
Other:

Social History: Who lives with you? ***(circle all that apply)*** Self * Spouse * Child(ren) * Parent(s) * Roommate * Significant Other * Caregiver * Group Home * Other: _____

On Disability: *(circle one)* Yes No
If yes, please explain:

Tobacco Use: ***(circle one)*** Yes No How much?_____
Alcohol Use: ***(circle one)*** Yes No How much?_____
Illegal Drug Use: ***(circle one)*** Yes No
What/How much? _____

Medical History (circle all that apply):

Cancer (what type):
Heart Disease
High Blood Pressure
High Blood Fats/Cholesterol
Vein trouble/Blood Clots
Stroke/TIA
Asthma
Sleep Apnea
Lung Disease
Esophageal Reflux/Stomach Ulcers
Liver Disease/Hepatitis
Kidney/Bladder Disease
Abnormalities of Female Organs
Abnormalities of Prostate
Diabetes Mellitus
Thyroid Disease
Abnormal Bleeding
Blood Problems(Anemia, High/Low White count)
Joint Disease
Anxiety/Depression/Psychiatric Illness
History of Substance Addiction
Skin Disease
Other:_____

Surgical History (List):

Review of Systems: Do you currently have any of the following medical symptoms? (circle all that apply)

Unexpected weight change
Rash
Visual Disturbances
Cough
Shortness of Breath
Chest Pain
Hearing Loss
Swelling in Legs
Constipation
Incontinence of Bowel
Nausea/Vomiting
Incontinence of Bladder
Muscle Weakness
Balance Problems
Seizures
Sleep Disturbance
Depression
Appetite Changes
Abnormal Bleeding
Anxiety
Other: