

## ***THE CENTER FOR SPINE PAIN CONFIDENTIAL INTAKE FORM***

Name \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell/Alternate Phone (\_\_\_\_) \_\_\_\_\_

Please list your preferred contact number in order (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>): \_\_\_\_ Home \_\_\_\_ Work \_\_\_\_ Cell

I give The Center for Spine Pain my permission to leave phone messages at my home, voicemail or with relative(s) regarding my appointments. \_\_\_\_ Yes \_\_\_\_ No

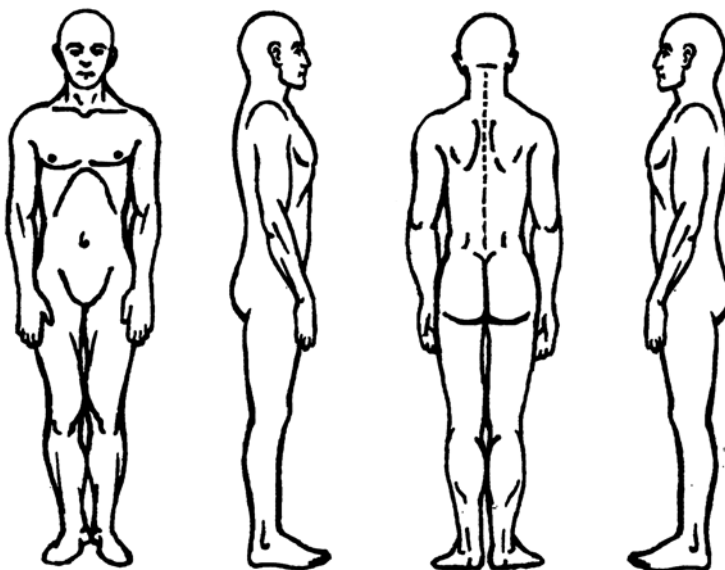
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status **S M D W** Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you hear about us? \_\_\_\_\_

### **PAIN DIAGRAM**

**Please mark your areas of complaint on the diagrams below using the symbols on the left.**

Aching ^^
Numbness +++
Pins and Needles OOO
Burning XXX
Stabbing Or Sharp ///



Severe Pain

No Pain

Please draw a horizontal line on the above line to show how bad your pain is currently.



**QUESTIONNAIRE**

- 1. How long have you had this condition? \_\_\_\_\_
- 2. Did this condition arise as a result of a motor vehicle crash or work injury?  Yes  No  
Auto/WC claim# \_\_\_\_\_ Adjuster: \_\_\_\_\_ Ph# ( ) \_\_\_\_\_
- 3. Since onset is this condition:  Improved  Unchanged  Getting worse
- 4. Is this condition interfering with your :  Work  Sleep  Daily routine
- 5. Have you had X-rays, MRI's or CT scans taken?  X-Rays  MRI  CT  None
- 6. Since you began suffering from this condition, what treatments have you tried? (Circle all that apply)
  - a. Ice/heat
  - g. Acupuncture
  - b. Rest
  - h. Chiropractic
  - c. Over the counter and/or Prescription medications
  - i. Spinal Injections
  - d. Traction
  - j. Surgical consultation
  - e. Stretching and/or exercise
  - k. Spine Surgery (list type and name of your surgeon)
  - f. Physical Therapy

\_\_\_\_\_
- 7. Which of the above offered any pain relief (if any)? \_\_\_\_\_
- 8. Do you smoke?  Yes  No How much? \_\_\_\_\_ pack(s) per day.

**PAST MEDICAL HISTORY/CURRENT ILLNESSES: Please check all problems you have experienced in the past or currently experiencing.**

- Arthritis  Osteoporosis  Poliomyelitis  Rheumatoid Arthritis  Bladder Disease
- Bleeding Tendencies  Abdominal aorta aneurysm  Peripheral vascular disease
- High Blood Pressure  Diabetes Mellitus  Heart Disease  Kidney Problems/Disease
- Hyperlipidemia (high cholesterol or triglycerides)  Seizures  Skin Lesions/rash  Stroke
- Thyroid Disease  Cancer: What Type? \_\_\_\_\_
- Other: \_\_\_\_\_

In case of an emergency, please contact \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

**CONSENT TO TREATMENT**

I hereby give permission to the doctor to release any information requested by my insurance company, physicians, or other health care providers acquired in the course of my examination and treatment. I also give consent to submit request(s) for any information from my insurance company, physicians, or other health care providers. I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services. I hereby give permission to the doctor and/or therapist to administer treatment and perform such general procedures as he/she may deem necessary in the diagnosis and/or treatment of my condition. I fully understand that this consent will remain in effect until revoked in writing. I have read and I do understand and agree to the above statements.

**Patient signature** \_\_\_\_\_ **Date** \_\_\_\_\_

