Recent Spine MRI or other spine imaging?

If so, please notify the front desk

NEW PATIENT INTEGRATED SPINE AND PAIN EVALUATION FORM

Name: _____ **Date of Birth**: _____

How were you referred?

☐Physician:_____ ☐Relative/Friend

☐Internet:_____ ☐Other:_____

What is your primary concern?

☐Lower Back Pain ☐ Hip/Leg Pain

☐ Neck Pain ☐ Shoulder/Arm Pain

☐ Mid Back pain ☐Other/ Please describe: _____

How long have you had this pain? _____ Days ____ Weeks ___ Months ___ _Years

Onset: ☐Gradual ☐ Quick/Acute (please select the box that best applies)

☐Spontaneous ☐ Accident/Trauma (please select the box that best applies)

History of Prior Symptoms: ☐Yes ☐ No

Please indicate the quality your pain/discomfort:

☐Electrical /Burning ☐ Sharp ☐Dull/Achy ☐Numbness/Tingling

Is your pain due to an Injury or Work Related Condition? ☐Yes ☐No

What activities increase and/or decrease your pain?

Activity	Increases Pain	Decreases Pain
Sitting		
Standing		
Walking		

Please list current and prior PAIN medications you have taken:

Name of Medication	Dose in mg/g	Daily Frequency

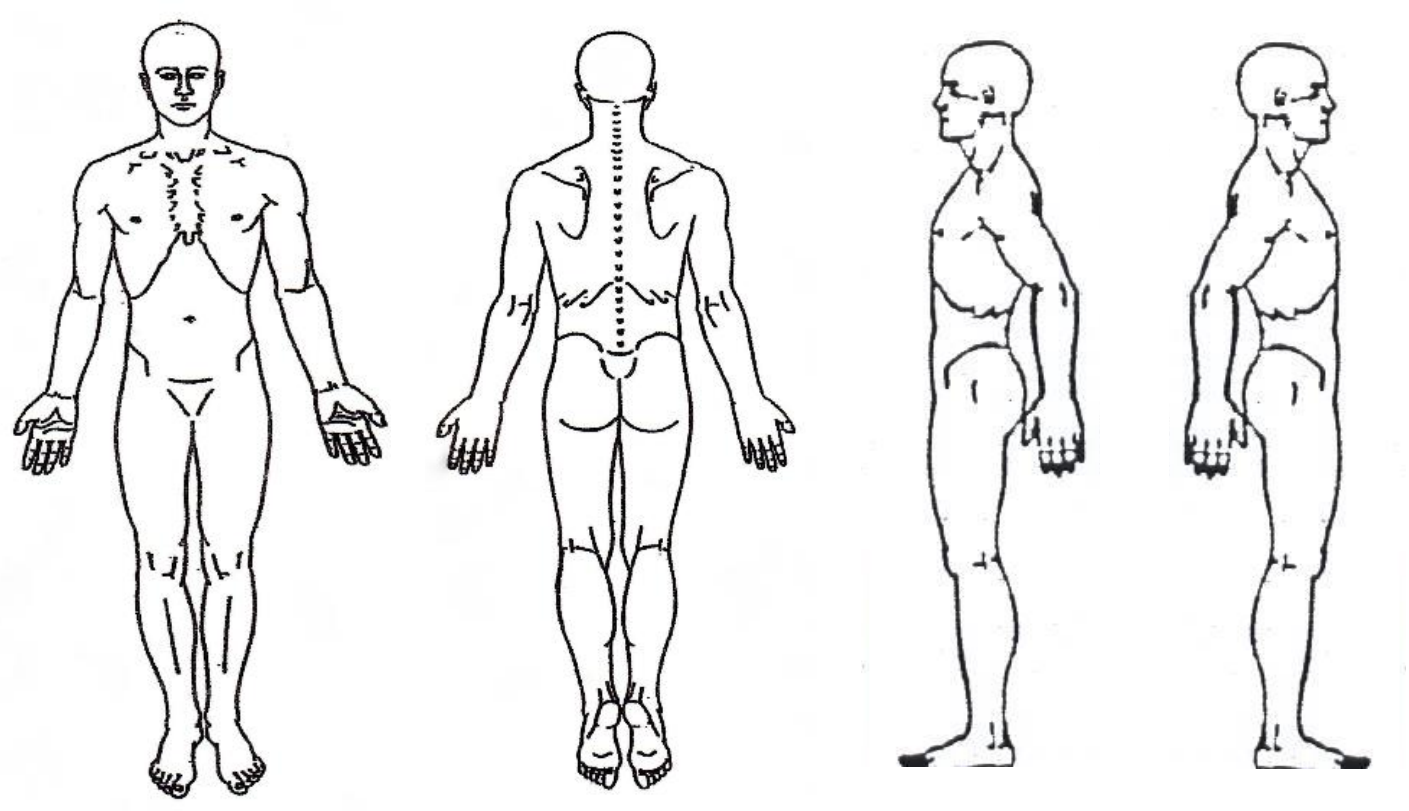
Please indicate any current or prior treatments for your pain:

TREATMENT	TYPE	DATE
Surgery		
Injections		
Physical Therapy		
Other		

Pain Diagram

Draw the location of your pain on the figures below; please indicate the type of pain by using the key:

Aching	Burning	Stabbing	Pins & Needles	Numbness
X X X X	**^ ^ ^ ^**	**_ _ _ _**	**+ + + +**	**O O O O**



Draw a line to indicate your usual level of pain on the scale below:

No Pain Worse Pain Possible