INTERVENTIONAL
PAIN AND REGENERATIVE
MEDICINE SPECIALISTS

NEW PATIENT INFORMATION

Name: _____ Age:_____ Date of birth:_____

Primary Care Physician:_____
(name, address & phone #)

Please list the spine concerns for which you are being seen today: _____

_____

When did your symptoms begin? _____

When are your symptoms at their worst? Morning Afternoon Evening Constant Varies Do you have bowel or bladder incontinence? Yes No

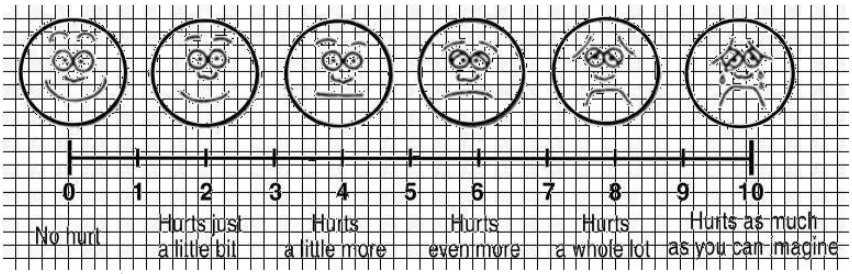
What activities or positions improve your symptoms? _____

_____

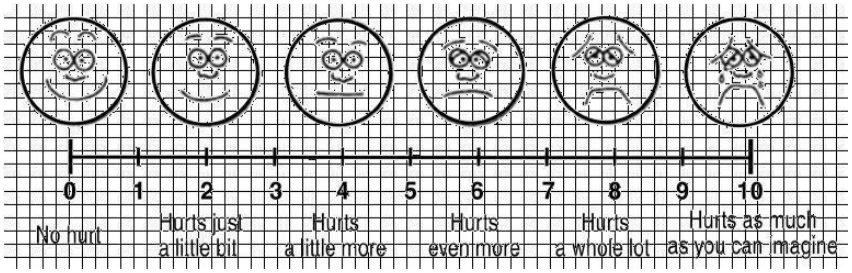
What activities or positions make your symptoms worse? _____

_____

Please rate your **back and/or leg** pain:



Please rate your **neck and/or arm** pain:



INJURY INFORMATION

Are your symptoms related to an injury? Yes No (if no, please proceed to the next section) Describe the injury: _____

_____

_____

Is this a work-related injury? Yes No

Do you have an open Worker's Compensation case? Yes No Pending

Current work status: Working full time, full duty Working full time, light duty Off work

Is this injury the result of a motor vehicle accident? Yes No

State in which accident occurred: _____

Legal action? None Potential Pending Settled

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SPINE HISTORY

Have you had previous neck or back problems requiring treatment? Yes No

Have you had prior spine surgery? Yes No (If no, please proceed to the next section)

Number of neck surgeries: _____ Surgeon:_____ Date(s): _____

Number of back surgeries: _____ Surgeon: _____ Date(s): _____

DIAGNOSTIC TESTS

Which of the following tests have you had?

None X-Ray MRI CT Scan Myelogram EMG Bone Density Bone Scan

Other: _____

FAMILY HISTORY

Do you have a family history of spine problems? Yes No Unknown

SOCIAL HISTORY

With whom do you live? Family/Spouse/Partner Friends Alone Other _____

Do you use nicotine containing products? Yes No

If yes, please describe product and length of use (years):_____

Do you drink alcohol? No Rarely Socially Daily – type & quantity: _____

Work Status:

Employed without restrictions or limitations	On disability
Employed with restrictions or limitations	Retired
Temporarily not working due to pain	Student
Not employed	Other

PAST MEDICAL HISTORY

Please select any medical problems below that apply to you.

Anemia	Heart Attack	Reflux
Anxiety/Depression	Hepatitis	Seizures
Arthritis	High Blood Pressure	Sleep Apnea
Atrial Fibrillation	High Cholesterol	CPAP Settings_____
Asthma	HIV	Stomach Ulcers
Bleeding Tendency	MRSA	Stroke
Blood Clots	Pacemaker Placement	Thyroid
Diabetes	Pulmonary Embolism	Other_____

Cancer: Type & Location: _____

Cancer Disease State: Active In Remission Treatment: _____

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PAST SURGICAL HISTORY

Please select all that apply to you and indicate the year:

NONE
Appendectomy (Year _____)
Bypass/Open Heart (Year _____)
C-Section (Year _____)
Gall Bladder (Year _____)
Gastric Bypass (Year_____)
Hernia Repair (Year _____)
Hysterectomy (Year _____)
Joint Replacement (Year _____)
Shoulder Surgery (Year _____)
Other:
Type _____
Year _____

CURRENT MEDICATIONS

Please list **ALL** medications you are current taking (including over the counter meds and supplements)

NONE

MEDICATION	DOSEAGE	FREQUENCY	PRESCRIBER

Medication Allergies (Please list all medication allergies and reactions): No known drug allergies

_____

_____

Pharmacy:_____

Do you have any allergies to: Metal Iodine Shellfish Latex

REVIEW OF SYSTEMS

Please check any of the following symptoms you are currently having:

Unexplained weight loss	Headache	Chest pain
Night sweats	Memory loss or confusion	Shortness of breath
Fevers/Chills	Blurred/Double vision	Nausea/Vomiting
Rashes	Ringing in the ears	Bloody/Dark stools
Frequent/Easy bruising	Vertigo/Dizziness	Burning/painful urination

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PAIN DIAGRAM

Mark the area of your body where you feel abnormal sensations and/or pain. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

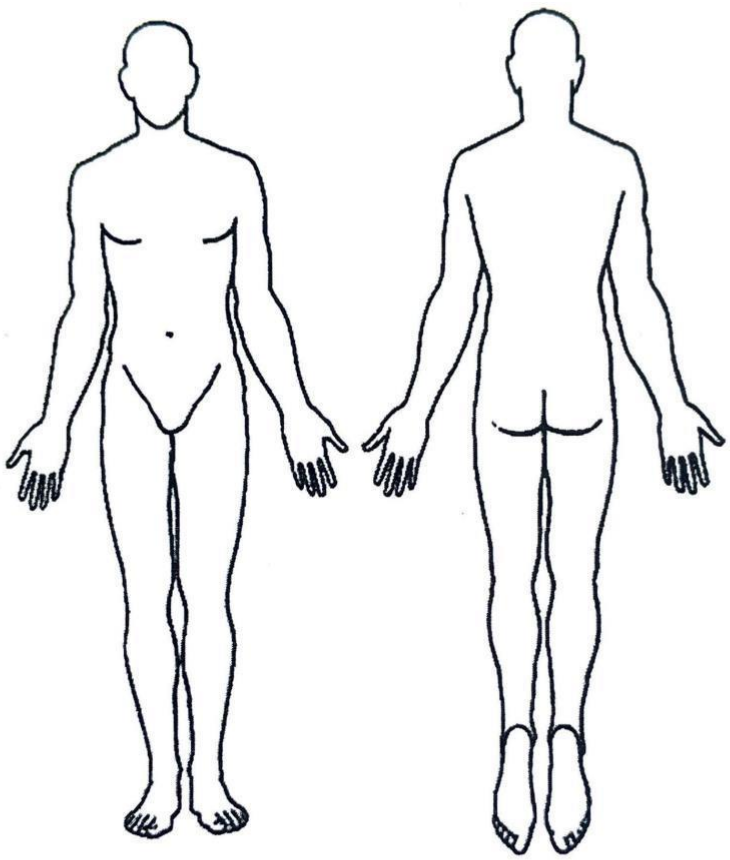
Numbness: ----------

Pins and needles: **********

Burning: xxxxxxxxxxxxxxxxx

Stabbing: //////////////////////////////

Pain: ++++++++++++++++



For Clinical Use Only

Allergies:

_____

_____

Height: _____

Weight: _____