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Spine Information Intake Form

*Please print all information.
All blanks must be filled to allow us to serve you quickly and efficiently.
Thank you for your cooperation.*

Patient Name: _____

Date of Birth: _____

Address:

Phone Home #: () _____

Work #: () _____

How were you referred? _____

Referring Physician: _____

Address: _____

Phone #: () _____

Fax #: () _____

Are there any physicians to whom you would like your medical records sent?
(Please include name and address)

Please list all other physicians with whom you have consulted in the past for your spine troubles.

History of Present Complaint

1. How long have you had your present pain?
(Please circle one)

A. Less than 1 month B. 1 to 3 months C. 3 to 6 months
D. 6 months to 1 year E. More than 1 year
2. Please enter date when your present pain began and briefly give details of injury.
Date: ____/____/____

3. Please indicate how your present pain began:
(Please circle one)

A. Occurred during an athletic activity E. Occurred while lifting
B. Occurred as a result of auto accident F. Unknown
C. Occurred while sitting G. Occurred while working
D. Occurred while bending
4. Where was your present pain initially located (circle below).

A. Neck D. Neck and arm(s)
B. Mid back E. Back and leg(s)
C. Low back F. Unknown
5. If the symptoms of your present pain have changed since the time of injury, please check the most appropriate statement:

My symptoms have remained the same
 My symptoms are more severe
 My symptoms are less severe
6. Are there any lawsuits pending or being contemplated relating to your injury? Yes No
7. Is the injury work related? Yes No

Past Back History

8. Please indicate whether or not you have had any of the following studies:

	<u>Yes</u>	<u>No</u>
➤ Regular X-ray of spine	<input type="checkbox"/>	<input type="checkbox"/>
➤ CT Scan	<input type="checkbox"/>	<input type="checkbox"/>
➤ EMG	<input type="checkbox"/>	<input type="checkbox"/>
➤ Myelogram	<input type="checkbox"/>	<input type="checkbox"/>
➤ Discogram	<input type="checkbox"/>	<input type="checkbox"/>
➤ MRI	<input type="checkbox"/>	<input type="checkbox"/>
➤ Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>

Past Back History, Con't

9. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to heal your present injury.

(Check one of each)

	<u>Helpful</u>	<u>Not Helpful</u>	<u>Not Used</u>
➤ Back School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Hot Packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Arching exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Sit up exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Epidural Steroid Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Facet Block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. You have already provided us information about your present pain. Please give the approximate dates of any other previous episodes of back problems:

Episode A: ___/___/___ Episode B: ___/___/___ Episode C: ___/___/___

11. Have you had spinal surgery in the past? (Check One) Yes, How many times? _____ No

If you answered "Yes", please complete the following:

A. What type of surgeries were performed?

- Disc removal/Laminectomy
- Fusion
- Unknown

B. What was the date of your most recent spine surgery? ___/___/___

C. Did you improve from your spine surgical procedure(s)?

- Yes No

Current Pain Profile

12. Which of the following best describes your pain ratio? (Check one)

- 100 % back/neck and 0% leg/arm pain
- 75 % back/neck and 25% leg/arm pain
- 50 % back/neck and 50% leg/arm pain
- 25 % back/neck and 75% leg/arm pain
- 0 % back/neck and 100% leg/arm pain

13. Please choose letters (in second column) to answer the questions in column one.

- | | |
|---------------------------------|--------------------------|
| ➤ How long can you sit? _____ | A. Unable to tolerate |
| ➤ How long can you stand? _____ | B. About 15 minutes only |
| ➤ How long can you walk? _____ | C. About 30 minutes only |
| | E. About 1 hour |
| | F. Indefinitely |

Current Pain Profile, Con't

14. Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaning forward (brushing teeth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review of Systems

15. Please check any of the following symptoms that you have had in the past six months.

Constitutional

- Night pain
- Night sweats
- Loss of appetite
- Fevers

Gastrointestinal

- Heartburn
- Blood in stool
- Constipation

Integumentary

- Rash
- Skin lesions

Psychiatric

- Depression
- Anxiety
- Mood swings

Genitourinary

- Difficulty with urination
- Burning with urination
- Impotence / Reduced sexual function

Cardiovascular

- Chest pain/Angina
- Palpitations/Irregular heartbeat
- Edema/Swelling

Respiratory

- Difficulty breathing
- Shortness of breath
- Chronic cough

Neurologic

- Headaches
- Tremors
- Visual changes

Endocrine

- Heat/cold intolerance
- Rapid weight gain/loss

Immunologic

- Chronic infections
- Slow wound healing

With your current symptoms, have you had loss of control of bowel or bladder function (incontinence)? Yes No

Medical and Social History

16. Are you a cigarette smoker? Yes No

If yes, how much do you smoke per day?

- Less than ½ pack per day
- ½ pack per day (10 cigarettes)
- ¾ pack per day (15 cigarettes)
- 1 pack per day
- More than one pack per day

How many? _____

17. Do you drink alcoholic beverages? Yes No

- 1 to 2 drinks per day
- 3-5 drinks per day
- 1 to 2 drinks per week
- More than 5 drinks per day

How many? _____

18. Check any of the following illnesses that you have or have had in the past.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> GERD (reflux) | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Cancer, what type _____ | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Blood clot (pulmonary embolus or DVT) | |

Please list any other illnesses or injuries:

19. Do you have any Contagious/infectious diseases such as tuberculosis, hepatitis, HIV or AIDS?

Yes No If yes, please explain _____

20. Are you or have you ever been under the care of a psychiatrist or psychologist?

Yes No If yes, what was the diagnosis _____

List all previous surgeries (other than the back surgeries you have already discussed)

Medications

21. What medications and doses do you take at the present time?

_____	_____
_____	_____
_____	_____
_____	_____

****Please star which medications help most to relieve your pain****

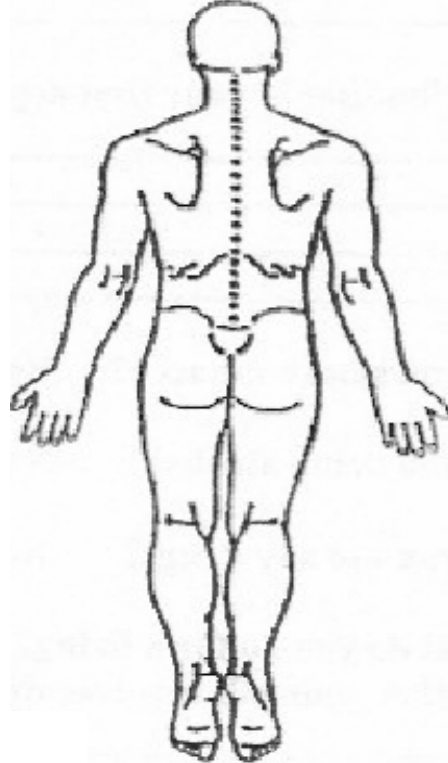
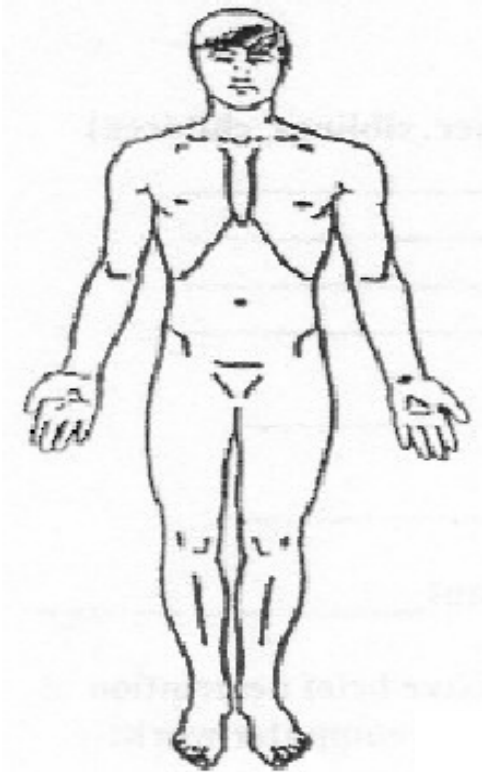
22. List any allergies to medications.

_____	_____
_____	_____

Ortho Pain Chart

Mark the areas on the body image below where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

Numbness = === === ===	Pins & Needles = o o o o o o o o o o o o	Burning = x x x x x x x x x x x x	Stabbing = /// /// ///
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Please indicate your pain level by circling the number that corresponds to your pain.

“0” = no pain to “10” = intolerable

.....
 0 1 2 3 4 5 6 7 8 9 10

Pain at its worst

“0” = no pain to “10” = worst pain

.....
 0 1 2 3 4 5 6 7 8 9 10

Pain at its best