Today's Date: _____

Name: _____

DOB: _____

Weight: _____

Height: _____

APEX SPINE INSTITUTE

NEW PATIENT INTAKE PAPERWORK

Onset of Symptoms

Approximately when did this pain begin?_____

What caused your current pain episode? _____

Is your pain the result of a Motor Vehicle Accident or Personal Injury (legal term used to describe an injury sustained to you by the negligence of another) ☐ Yes ☐ No

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since you pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

What makes the pain better? _____

What makes the pain worse? _____

MARK ALL OF THE FOLLOWING ACTIVITIES THAT ARE ADVERSELY/NEGATIVELY AFFECTED BY YOUR PAIN:

☐ Enjoyment of life ☐ Normal Work ☐ General Activity ☐ Recreational Activities

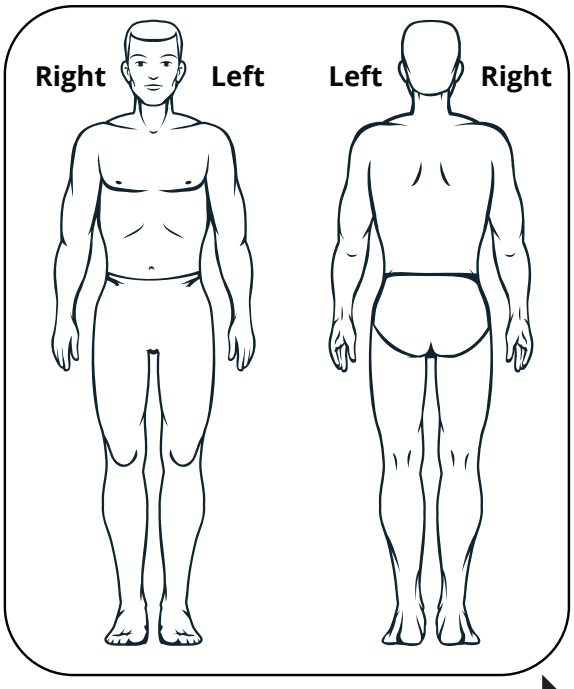
☐ Walking ☐Mood ☐ Relationships with People ☐Other: _____

_____ What number on the pain scale (0-10) best describes your pain right now?

_____ What number on the pain scale (0-10) best describes your worst pain?

_____ What number on the pain scale (0-10) best describes your average pain over the last month?

Use this diagram to indicate the location of your pain



Pain Description

Check all of the following that describe your pain:

☐ Dull ☐ Electric ☐ Hot/Burning ☐ Numbness

☐ Stabbing/Sharp ☐ Cramping ☐ Throbbing ☐ Deep

☐ Shooting

What word best describes the frequency of your pain?

☐ Constant ☐ Intermittent

When is your pain at its worst?

☐ Morning ☐ During the day

☐ Evenings ☐ Middle of the night

☐ Worse on activity ☐ Worse at rest

In the past three months have you developed ANY NEW:

☐ Bladder Incontinence (not including frequency) ☐ Bowel Incontinence (not including diarrhea or constipation)

☐ Balance Problems ☐Chills ☐ Difficulty Walking ☐ Fevers ☐ Nausea ☐Vomiting

☐ **Numbness/Tingling-Where?** _____ ☐ **Weakness-Where?**_____

☐ **I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS.**

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

☐ MRI of the _____Date: _____ Facility: _____

☐ X-Ray of the _____Date: _____ Facility: _____

☐ CT scan of the _____Date: _____ Facility: _____

☐ EMG/NCV study of the _____Date: _____ Facility: _____

☐ Other diagnostic testing: _____

☐ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

☐ Physical Therapy

☐ Chiropractic

☐ Spine Surgery

☐ Epidural Steroid Injection - (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection - Joint(s) _____

☐ Medial Branch Blocks of Facet Injection - (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Radiofrequency Ablation - (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Spinal Column Stimulator- (circle one) Trial Only/ Permanent Implant

☐ Other: _____

☐ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.**

Do you take any of these Blood Thinners? (Mark all that apply)

☐ Aspirin ☐ Fish Oil	☐ Aggrenox	☐ Coumadin/Warfarin	☐ Effient/Prasugrel
☐ Lovenox/Enoxaparin	☐ Plavix/Clopidogrel	☐ Pletal/Cilostazol	☐ Pradaxa/Dabigatran
☐ Ticlid /Ticlopidine	☐ Brilinta/Ticagrelor	☐ Xarelto/Rivaroxaban	☐ Eliquis/Apixaban
☐ Heparin/Subcutaneous	☐ Arixtra/Fondaparinux	☐ Edoxaban/Savaysa	
☐ Other: ____			

Patient Signature: _____ Date: _____