BRIGHAM AND WOMEN'S HOSPITAL

Patient identification area

Comprehensive Spine Center at Faulkner Hospital

New Patient Intake Form

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	Date:
Phone number:			

PRIMARY CARE PHYSICIAN (PCP)

Name	Address	Phone

REFERRING DOCTORS (if different from PCP)

Name	Address	Phone

HISTORY OF YOUR PAIN/SYMPTOMS – Please answer the questions below

What is the main reason that you are here today?

Tell us when and how your problem started:

What event(s) led to your original symptoms?

☐ Accident ☐ Work Injury ☐ Following an operation

☐ Cancer ☐ No Obvious cause ☐ Other:

Please indicate where your pain/symptoms were initially located (ex. Neck, low back)

Since the time of onset, my symptoms have:

☐ Remained the same ☐ Are more severe ☐ Are less severe

What percent of your symptoms are in:

___% spine ___% leg ___% arm (ex. 75% spine, 25% leg)

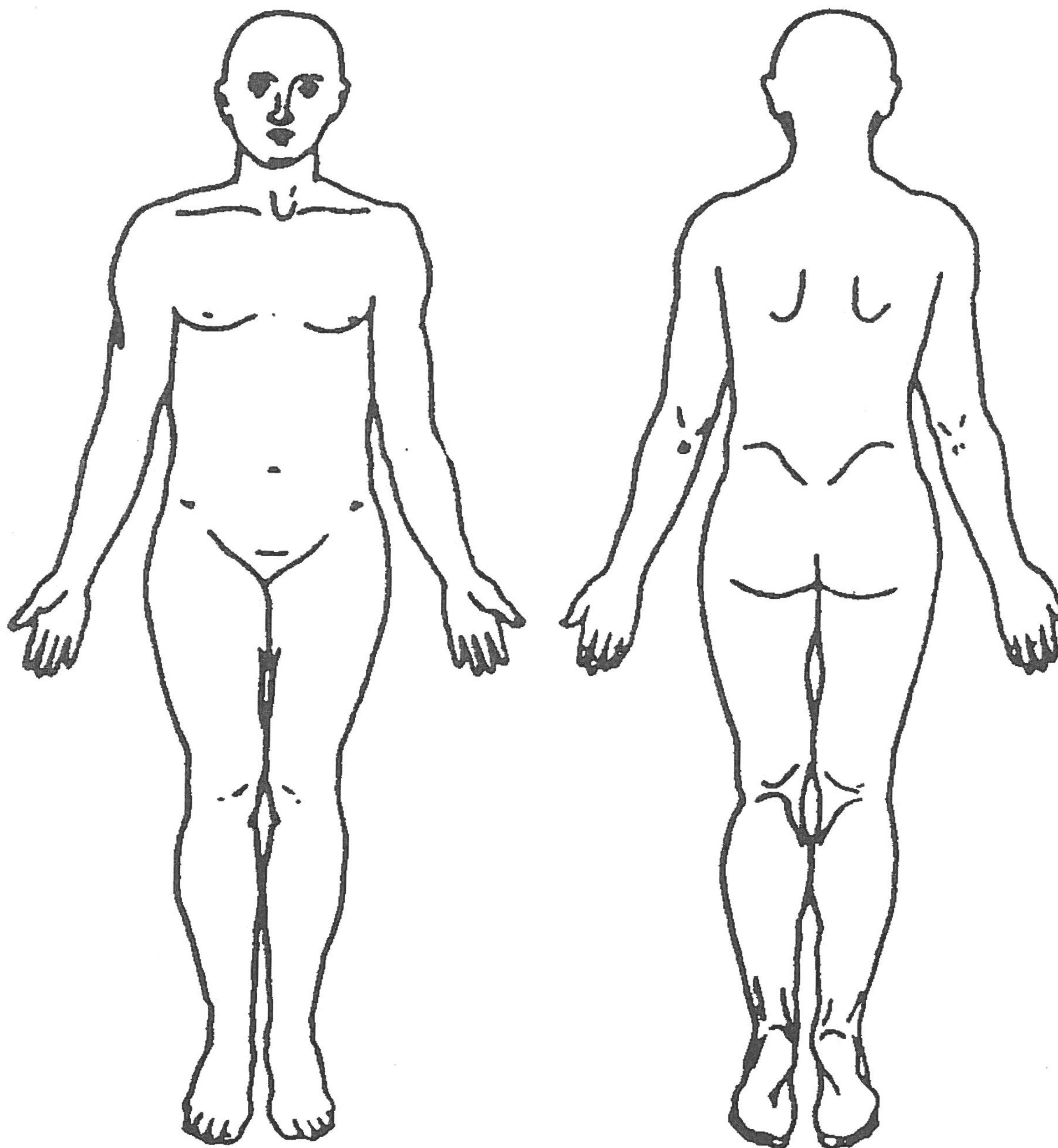
ACTIVITY (Please check the amount of time you can perform the following activities)

	unable	15 minutes	30 minutes	45 minutes	60 minutes or more
Sit	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐

PAIN DIAGRAM

On the body diagram below, please indicate where your pain is located and what it feels like using these symbols:

Numbness --- Pins & needles .... Burning xxx Aching +++ stabbing /// other OOO



PREVIOUS TREATMENTS (Please circle any treatments you have tried for your current problem)

Treatment	Date	Did it help?	Treatment	Date	Did it help?
Nerve Blocks		No Yes	Physical Therapy		No Yes
Acupuncture		No Yes	Psychotherapy		No Yes
Chiropractor		No Yes	Injections		No Yes
Massage		No Yes	Surgery		No Yes
Brace/Collar		No Yes	Other (specify)		No Yes

PREVIOUS DIAGNOSTIC TESTING (Please enter any testing performed for your current problem)

Test	Date	Test	Date
MRI		Myelogram	
CT Scan		EMG/NCV	
X-Ray		Bone Scan	
Discogram		Other (specify)	

REVIEW OF SYSTEMS *(Please check all that apply)*

Constitutional

- ☐ Unexpected weight loss more than 10 lbs in the past six months
- ☐ Unexpected weight gain more than 10 lbs in the past six months
- ☐ Fatigue/tired all over
- ☐ Fever, chills or sweats

Eyes

- ☐ Blurred or double vision
- ☐ Failing vision

Ears, Nose Mouth and Throat

- ☐ Difficulty hearing
- ☐ Difficulty swallowing
- ☐ Sore or hoarse throat
- ☐ Nose bleeds
- ☐ Sinus trouble or congestion

Cardiovascular

- ☐ Heart murmur
- ☐ Chest pain
- ☐ Palpitations/fast heart rate
- ☐ Shortness of Breath
- ☐ Swollen ankles

Gastrointestinal

- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Heartburn

Genitourinary

- ☐ Frequent or hesitant urination
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Bladder accidents/incontinence
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Frequent bladder infections
- ☐ Erectile dysfunction/problems getting an erection

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Neurological

- ☐ Headaches
- ☐ Loss of strength
- ☐ Weakness
- ☐ Numbness
- ☐ Fainting spells
- ☐ Dizziness/vertigo

Psychiatric

- ☐ Anxiety
- ☐ Depression

Hematological

- ☐ Too much bruising or bleeding
- ☐ Swollen glands

Musculoskeletal

- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle stiffness
- ☐ Osteoporosis

PAST MEDICAL HISTORY *(Please check all that apply)*

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Asthma or Wheezing
- ☐ Bleeding or Clotting Problem
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ GERD/Reflux
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Psychiatric Problems
- ☐ Seizure or Epilepsy
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease

☐ Arthritis (specify location)______________________________

☐ Cancer (specify type)______________________________

☐ Other (specify)______________________________

PAST SURGICAL HISTORY

Year	Surgery	Hospital	Doctor

ALLERGIES (Please list all allergies including medication, food, environment and latex)

Allergy	Reaction (What happens?)

CURRENT MEDICATIONS

(Please list all medications you are currently taking including prescribed, over-the-counter, herbs and vitamins)
If there aren't enough lines, please list additional medications on a separate page instead of using the back of this form

Medication Name	Dose/Frequency	Started	Prescribing MD

FAMILY MEDICAL HISTORY Do you have a family history of the following? (*Please check all that apply*)

- ☐ Back Disorder
- ☐ Bleeding/ Clotting problem
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Neuropathy/nerve disease
- ☐ Heart disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer
  If Yes, type ____________________

Other:______________________________

SOCIAL HISTORY			
Are you working? ☐ Yes ☐ No	If yes, what is your job/title:______________________________		
Work Status:			
☐ Full Time	☐ Part Time (hours per week)	☐ Homemaker	☐ Retired Years
Unemployed______years		Unemployed_______years due to pain	
How would you describe your job:			
☐ Sit alot	☐ Light activity	☐ Medium activity	☐ Heavy acitivty
Are you on disability? ☐ Yes ☐ No	**Date Started:**	**Reason:**	
Marital Status (please circle one)	Divorced / Partner / Married / Single / Widow / Separated		

BEHAVIORAL HEALTH	
Do you smoke? If yes how much:	☐ No ☐ Yes
Do you drink more than **two** alcoholic beverages per day on a **DAILY** basis?	☐ No ☐ Yes
Do you use recreational drugs or narcotics not prescribed by a doctor? If yes, please explain:	☐ No ☐ Yes
How do you like to learn? ☐ Talking with your nurse or doctor ☐ Reading ☐ Video (if available)	

FALL RISK ASSESSMENT	
Have you fallen (not a slip or a trip) in the last 6 months?	☐ No ☐ Yes
Do you need help to walk or change your clothes?	☐ No ☐ Yes

FUNCTIONAL STATUS					
Do you use?	☐ Cane	☐ Walker	☐ Braces	☐ Wheelchair	☐ None of these
Do you exercise?	☐ No	☐ Yes	If so, what type:		

HEALTH CARE PROXY (For information on health care proxy, please see front desk)	
Do you have a health care proxy? If yes, name of health care proxy______________________	☐ No ☐ Yes

The information on this form is accurate to the best of my knowledge. I understand that this form will become part of my medical record.

Patient Signature:____ Date___________

I have reviewed the above information with the patient:

Comments:____

Signature____________________MD/NP CID ☐☐☐☐☐ Date:_______ Time:______ AM/PM