Frank X. Pedlow, Jr., MD, PC
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 #: _____ Cell Phone#: _____

Work #: _____

How were you referred? _____

_____

Referring Physician: _____

Address: _____

_____

Phone #: _____

Fax #: _____

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

_____

_____

_____

_____

_____

_____

History of Present Complaint

1. How long have you had your present pain?

   Less than 1 month 1 to 3 months 3 to 6 months

   6 months to 1 year More than 1 year

2. Please enter date when your present pain began and briefly give details of injury or onset.
   Date: _____/_____/_____
   _____
   _____
   _____

3. Please indicate how your present pain began:
   - Occurred during an athletic activity
   - Occurred as a result of auto accident
   - Occurred while sitting
   - Occurred while bending
   - Occurred while lifting
   - Unknown
   - Occurred while working
   - Gradual onset

4. Where was your present pain or symptoms initially located
   - Neck
   - Mid back
   - Low back
   - Neck and arm(s)
   - Back and leg(s)
   - 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 or covered by worker's compensation? Yes No
   If yes, please complete the section below. If no, please skip to the next page.

Current Job Title: _____ Employer: _____

How long have you been in this position? _____years _____months

Prior Jobs	Job Title	Employer	Number of Years
1.	_____	_____	_____
2.	_____	_____	_____

In your current job, how many hours do you spend:
Sitting _____ Driving _____ Standing _____ Walking _____ Bending _____ Climbing _____

Lifting _____ Twisting _____ Reaching above shoulder _____ Typing/computer_____

Maximum weight, which you lift or carry in your job? _____

Have you missed work as a result of your injury? Yes No If yes, how long? _____
Are you currently working? Yes No If no, what date did you stop working? _____
Is there light duty work available at your job? Yes No
Are you currently working in light duty? Yes No

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

	Yes	No
➢ Regular X-ray of spine		
➢ CT Scan		
➢ EMG/nerve conduction study		
➢ CT Myelogram		
➢ Discogram		
➢ MRI		
➢ Bone Scan		

Please indicate if you have undergone any of the following treatments listed and provides details if appropriate.

Physical Therapy? Yes No ____ times per week for _____ weeks.
Did you improve with physical therapy? _____

Injections in your spine such as epidural steroid or facet block? Yes No
Type _____ Date_____
Did you get relief or improvement in your symptoms with this injection? Yes No
Type _____ Date_____
Did you get relief or improvement in your symptoms with this injection? Yes No

	Helpful	Not Helpful	Not Used
➢ TENS Unit			
➢ Traction			
➢ Acupuncture			
➢ Chiropractor			

Previous Spine History

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

Episode A: ____/____/____ Episode B: ____/____/____ Episode C: ____/____/____

Treatment: _____ Treatment: _____ Treatment: _____

10. Have you had spine surgery in the past? Yes, How many times? _____ No

If you answered "Yes", please complete the following (types of surgery include laminectomy, decompression, disc replacement, laminoplasty, fusion or unknown):

Type of surgery	Date	Location/Surgeon
_____	_____	_____
_____	_____	_____

Did you improve from your spine surgical procedure(s)?
Yes No

Current Pain Profile

2. Which of the following best describes your pain or symptom ratio?
   100 % back/neck and 0% leg/arm pain or symptoms
   75 % back/neck and 25% leg/arm pain or symptoms
   50 % back/neck and 50% leg/arm pain or symptoms
   25 % back/neck and 75% leg/arm pain or symptoms
   0 % back/neck and 100% leg/arm pain or symptoms

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

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

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

	Aggravates Pain	Relieves Pain	Neither
Sitting			
Standing			
Rising form sitting			
Leaning forward (brushing teeth)			
Walking			
Lying on your side			
Lying on your back			
Lying on your stomach			
Driving			
Coughing/Sneezing			
Bending forward			

Review of Systems

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

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

Respiratory
- Difficulty breathing
- Shortness of breath
- Chronic cough

Continued on next page…

Integumentary
- Rash
- Skin lesions

Psychiatric
- Depression
- Anxiety
- Mood swings

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

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

Social History

Are you a cigarette smoker? Yes No, never Not currently, but I have smoked cigarettes in past

If current smoker, how much do you currently smoke per day?
_____ packs/day **OR** ___ cigarettes/day for ____ years

If you are a former smoker how many cigarettes did you used to smoke?
_____ packs/day **OR** ___ cigarettes/day for ____ years

Do you drink alcoholic beverages? Yes No, never Not currently, but I have in the past

If yes, please tell us your drinking habits:
I mostly drink (check all that apply) Beer Wine Liquor (mixed drinks/martinis)
Do you have alcoholic beverages daily? Yes No If yes, how many drinks per day ____
Do you have alcoholic beverages weekly? Yes No If yes, how many drinks per week ____
Do you have alcoholic beverages less than weekly, but at least monthly? Yes No

Are you married? Yes No
Do you have any children? Yes No If yes, please list ages and gender

_____

_____

Medical History

Current height: ____ feet ____ inches Current Weight: _____ lbs

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

High blood pressure	Diabetes	Atrial fibrillation	Osteoporosis
High Cholesterol	GERD (reflux)	Sleep apnea	Thyroid disease
Asthma	COPD	Cancer, what type _____	
Stroke	Heart attack	Blood clot (pulmonary embolus or DVT)	
Lupus	Fibromyalgia	Parkinson's Disease	Depression
Anxiety			

Please list any and all other illnesses or injuries:

_____
_____
_____
_____

Do you have or have you ever had any of the following contagious or infections diseases?
Hepatitis Yes No If yes, what type (A, B, C, D, E)? _____
Tuberculosis Yes No
HIV/AIDS Yes No
Other _____

Are you or have you ever been under the care of a psychiatrist or psychologist?
Yes No If yes, what is or was the diagnosis_____

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

_____
_____
_____

Medications

What **medications** and over the counter supplements do you take at the present time? Please be as thorough as possible as this will go in your record. Attach a separate sheet if necessary.

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

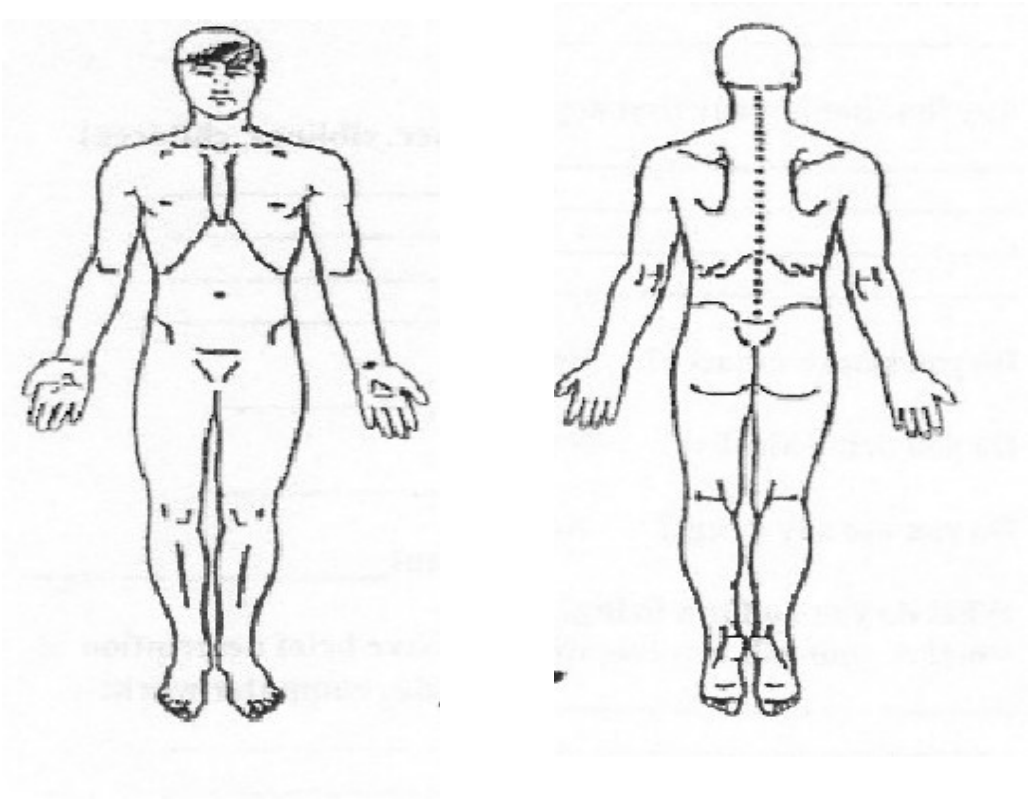
List any **allergies** to medications, latex or contrast dyes. Please include name and reaction.
No known drug or latex allergies

_____ _____

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.

= = =	o o o o	x x x x	/ / / /
Numbness = = = =	Pins & Needles = o o o o	Burning = x x x x	Stabbing = / / / /
= = =	o o o o	x x x x	/ / / /



Please indicate your pain level by circling the number that corresponds to your pain.

"0" = no pain to"10" = intolerable

Pain at its worst ☛

0 1 2 3 4 5 6 7 8 9 10

"0" = no pain to"10" = worst pain

Pain at its best ☛

0 1 2 3 4 5 6 7 8 9 10