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: ____________________ Age: ____________________

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.

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History of Present Complaint

1. **What is the reason for your visit?** (can check more than one)
   - ☐ Neck pain ☐ Arm pain ☐ Back pain ☐ Leg pain
   - ☐ Numbness – Location: ____________________
   - ☐ Weakness – Location: ____________________
   - ☐ Other: ____________________

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

3. **How long have you had your present symptoms?**
   ______ Days ______ Weeks ______ Months ______ Years

4. **Please enter the date when your symptoms began and briefly give details of the injury, onset or event.**
   Date: _________ / _________ / _________

   ____
   ____
   ____
   ____
   ____

5. **Please indicate how your present symptoms began:**
   - ☐ Occurred during an athletic activity
   - ☐ Occurred as a result of an auto accident
   - ☐ Occurred while working
   - ☐ Gradual onset
   - ☐ Occurred while sitting
   - ☐ Occurred while bending
   - ☐ Occurred while lifting
   - ☐ Unknown
   - ☐ Other – Please describe: ____________________

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: _________ Standing: _________ Walking: _________ Climbing: _________ Driving: _________
Lifting: _________ Twisting: _________ Bending: _________ Overhead reaching: _________ Typing: ________

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	Date stopped working: ________
Is there light duty available?	☐ Yes	☐ No	
Are you currently working light duty?	☐ Yes	☐ No	

8. **Please describe the timing of your pain or symptoms:**
   ☐ Intermittent ☐ Episodic ☐ Persistent ☐ Constant ☐ Other: ________________

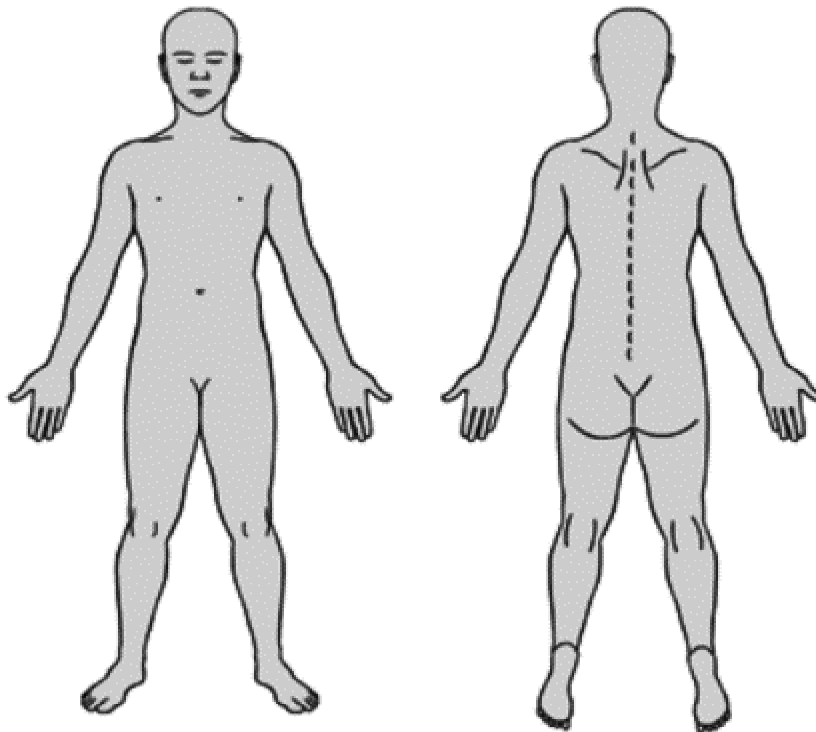
9. **Please characterize your symptoms (ex. burning, dull, sharp, stiff, throbbing):**
   ____

10. **Location of most significant pain:** ____

11. **Does the pain radiate to:**
    - ☐ Shoulder
    - ☐ Upper arm
    - ☐ Forearm
    - ☐ Hand
      - ☐ thumb
      - ☐ index finger
      - ☐ middle finger
      - ☐ ring finger
      - ☐ small finger
    - ☐ Buttock
    - ☐ Thigh
      - ☐ front
      - ☐ back
      - ☐ side
    - ☐ Knee
      - ☐ front below knee
      - ☐ back below knee
      - ☐ side below knee
    - ☐ Foot
      - ☐ inside
      - ☐ top
      - ☐ outside

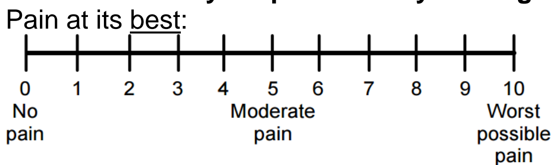
12. **Mark the areas on the body image below where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.**

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

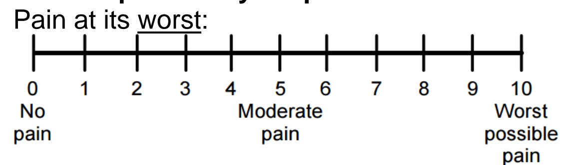


13. **Please indicate your pain level by circling the number that corresponds to your pain.**

Pain at its best:



Pain at its worst:



14. **How long can you sit?** ☐ Unable to tolerate ☐ ______ min ☐ ______ hrs ☐ Indefinitely
How long can you stand? ☐ Unable to tolerate ☐ ______ min ☐ ______ hrs ☐ Indefinitely
How long can you walk? ☐ Unable to tolerate ☐ ______ min ☐ ______ hrs ☐ Indefinitely

15. **Which of the following activities change the nature of your pain?**

	Aggravates pain	Relieves pain	Neither
Sitting	☐	☐	☐
Standing	☐	☐	☐
Rising from sitting	☐	☐	☐
Leaning forward	☐	☐	☐
Walking	☐	☐	☐
Lying on your side	☐	☐	☐
Laying on your back	☐	☐	☐
Laying on your stomach	☐	☐	☐
Driving	☐	☐	☐
Coughing, Sneezing	☐	☐	☐
Bending forward	☐	☐	☐
Morning	☐	☐	☐
Night	☐	☐	☐

16. **Do you experience any of the following?**

Numbness	☐ Yes	☐ No	location:________________
Weakness	☐ Yes	☐ No	location:________________
Difficulty walking	☐ Yes	☐ No	________________
Clumsy hands	☐ Yes	☐ No	________________
Problems with coordination	☐ Yes	☐ No	________________
Bowel dysfunction	☐ Yes	☐ No	date started: ________________
Bladder dysfunction	☐ Yes	☐ No	date started: ________________
Perineum or inner thigh numbness	☐ Yes	☐ No	________________

Treatment History

17. **Please indicate if you have undergone any of the following treatments listed.**

	Improved my pain	No difference	Worsened pain	Did not try
Physical therapy ___ x/week for ___ weeks. Dates participated: ________	☐	☐	☐	☐
TENS	☐	☐	☐	☐
Traction	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Chiropractor	☐	☐	☐	☐
Injections (epidural, facet/ nerve block, radiofrequency ablation, SI). Include type and dates				
________________	☐	☐	☐	☐
________________	☐	☐	☐	☐
________________	☐	☐	☐	☐
________________	☐	☐	☐	☐
________________	☐	☐	☐	☐

18. **Which medications have you tried to help with pain control?**

____

____

Spine History

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

Episode 1: _____ / _____ / _____ Lasted _____ days/weeks/years Treatments: ______________________________

Episode 2: _____ / _____ / _____ Lasted _____ days/weeks/years Treatments: ______________________________

20. **Have you had spine surgery in the past?** ☐ Yes ☐ No
If yes, please list which type of surgery (laminectomy, laminotomy, disc replacement, discectomy, fusion, unknown)

Type	Date	Location/Surgeon
______________________________	_____ / _____ / _____	________________________________
______________________________	_____ / _____ / _____	________________________________
______________________________	_____ / _____ / _____	________________________________

Did you improve from your surgical procedures? ☐ Yes ☐ No

Medical History

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

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood clot (PE or DVT)
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Gout
- ☐ Heart attack
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Cancer, what type _____________________
- ☐ Recent infection, describe _____________________

22. **Please list any other illnesses or injuries:**

____

____

____

23. **Do you have or have you ever had any of the following contagious or infectious diseases?**

Hepatitis ☐ Yes ☐ No If yes, what type (A, B, C, D, E)? ____________

Tuberculosis ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No

Other: ____

24. **Do you have or have you ever been under the care of a psychiatrist or psychologist?** ☐ Yes ☐ No
If yes, what is or was the diagnosis: ____

Surgical History

25. **Please list all previous surgeries and dates (other than the neck/back surgeries you have already discussed):**

____

____

____

Medications

26. **Please list your current medications and over the counter supplements. Please be as thorough as possible as this will go in your record. Attach a separate sheet if necessary.**

Name	Dose	Frequency

Allergies

27. **List any allergies to medications, latex, or contrast dyes.** ☐ No known drug, latex, or dye allergies

Name	Reaction

Social History

28. **Please indicate your marital status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated

29. **Do you have any children?** ☐ Yes ☐ No If yes, how many: ________________

30. **Occupation:** ____

31. **Do you smoke cigarettes?** ☐ Yes ☐ No, quit date: __________ ☐ No, never
    How much do you currently smoke/ used to smoke? _____ ppd for _____ years

32. **Do you drink alcoholic beverages?** ☐ Yes ☐ No, never ☐ Not currently, but I have in the past
    If yes, estimate how many beverages per day/week/month: ________ ☐ Beer ☐ Wine ☐ Liquor (mixed drinks)

33. **Have you used any other drugs?** ☐ Yes ☐ No, never ☐ No, quit ____________________
    If yes, please list which types: ____

Family History

34. **Please list any medical conditions in these family members** (ex. type of cancer, diabetes, heart attack, stroke):

Paternal grandfather: ____________________________
Paternal grandmother: ____________________________
Maternal grandfather: ____________________________
Maternal grandmother: ____________________________
Father: ____________________________

Mother: ____________________________
Brother: ____________________________
Sister: ____________________________
Son: ____________________________
Daughter: ____________________________

Review of Systems

35. **Current height:** _____ ft _____ in **Current weight:** _______lbs

36. **Please check any of the following symptoms that you have had in the past 6 months:**

Constitutional
- ☐ Appetite change
- ☐ Chills
- ☐ Night sweats
- ☐ Fatigue
- ☐ Fever
- ☐ Weight loss
- ☐ Night pain

HENT
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Nosebleeds
- ☐ Rhinorrhea
- ☐ Dental problems
- ☐ Sore throat
- ☐ Trouble swallowing
- ☐ Voice change

Eyes
- ☐ Eye pain
- ☐ Visual changes

Respiratory
- ☐ Apnea
- ☐ Chest tightness
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Difficulty breathing

Cardiovascular
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Palpitations/ irregular heartbeat

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting
- ☐ Incontinence (bowel)

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance

Genitourinary
- ☐ Difficulty urinating
- ☐ Burning with urination
- ☐ Frequency
- ☐ Bloody urine
- ☐ Urgency
- ☐ Incontinence (bladder)
- ☐ Impotence/ reduced sexual function

Integumentary
- ☐ Rash
- ☐ Wound
- ☐ Lesion

Immunologic
- ☐ Chronic infections
- ☐ Slow wound healing
- ☐ Immunocompromised

Neurological
- ☐ Dizziness
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech difficulty
- ☐ Syncope
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Easy bruising
- ☐ Easy bleeding

Psychiatric
- ☐ Depression
- ☐ Anxiety

Previous Studies

37. **Please indicate whether you have had any of the following studies:**

Study	Yes	No	Location
Regular x-ray of the spine	☐ Yes	☐ No	location: ____________
MRI	☐ Yes	☐ No	location: ____________
CT	☐ Yes	☐ No	location: ____________
CT myelogram	☐ Yes	☐ No	location: ____________
Discogram	☐ Yes	☐ No	location: ____________
Bone scan	☐ Yes	☐ No	location: ____________
EMG/ nerve study	☐ Yes	☐ No	location: ____________

PLEASE BRING THE CD WITH YOUR MRI/CT IMAGES AND THE RADIOLOGY REPORT TO YOUR FIRST VISIT

FAILURE TO DISCLOSE ALL MEDICAL CONDITIONS and ALL MEDICATIONS COULD PUT YOUR HEALTH AT RISK, and MAY RESULT IN DISCHARGE FROM THIS PRACTICE.

I certify that all information provided is true and correct.

Signature: ______________________________ Date: ____________________