Utah Spine Medicine New Patient Intake Form

Name:_____ **Date:**_____ **DOB:**_____ Gender:_____

Referring Provider:_____ Primary Care Provider:_____

What is the main issue that brings you here today?_____

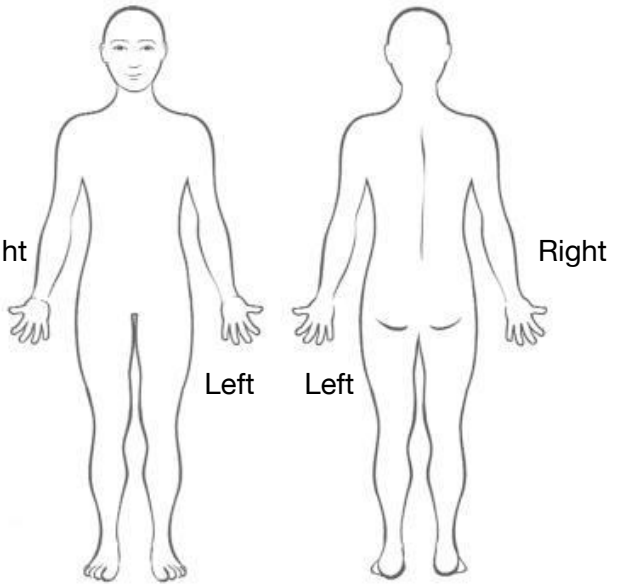
_____

Is this injury: Work related? ☐ Yes ☐ No From a motor vehicle accident? ☐ Yes ☐ No

Do you have legal representation? ☐ Yes ☐ No Date of injury_____

How did your pain begin?_____

Please Indicate the Location(s) of Your Pain:



*For Dr. Cheng (**Please DO NOT write in the box**)*

Duration

Quality

Numbness

Weakness

Bowel/Bladder

Fevers/Chills/Night Sweats/Wt.Loss

Other

What level is your pain (0 = No Pain, 10 = Worst Pain in the World)

Today (0-10) _____ Pain at its LEAST (0-10) _____ Pain at its WORST (0-10) _____

Do you have trouble sleeping? Yes No

What makes your pain increase?_____

What makes your pain decrease?_____

Do you take pain medication? ☐ No ☐ Yes Please list_____

_____

Do you take any other medication? ☐ No ☐ Yes Please list _____

_____

Do you have any allergies? ☐ No ☐ Yes Please list_____

Who have you seen for your pain? ☐ Primary Care Provider ☐ ER ☐ Urgent Care ☐ PT ☐ Chiropractor

What treatment have you tried for your pain? ☐ PT ☐ Chiropractor ☐ Acupuncture ☐ Massage ☐ Yoga

☐ Pilates ☐ Ice ☐ Heat *Responses (for Dr. Cheng)*_____

Please continue to next page.

Have you had any imaging of your spine performed? ☐ No ☐ X-ray ☐ MRI ☐ CT ☐ Bone Scan

Have you had any spinal injections? ☐ No ☐ Yes Date(s):_____

Were these injections with X-ray guidance? ☐ Yes ☐ No ☐ Don't Know

Do you have any medical issues? ☐ No ☐ Yes Please list:_____

_____

Have you had any spinal surgeries? ☐ No ☐ Yes Please list:_____

_____

Have you had any non-spinal surgeries? ☐ No ☐ Yes Please list:_____

_____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Prefer Not to Answer

Occupation/Employer:_____Last Day Worked:_____

Do you use:

Tobacco ☐ Yes ☐ No If yes, how many packs/day:_____For how many years:_____

Recreational Drugs ☐ Yes ☐ No If yes, please list:_____

Alcohol ☐ Yes ☐ No If yes, how many drinks per week:_____

Do you have any family history of medical problems? ☐ No ☐ Yes Please list:_____

_____

Review of Systems (please check all that apply)

☐ Fevers	☐ Ringing in Ears	☐ Wheezing	☐ Joint Pain/Swelling	☐ Anxiety
☐ Chills	☐ Hearing Changes	☐ Abdominal Pain	☐ Loss of Joint Mobility	☐ Depression
☐ Night Sweats	☐ Inner Ear Pain	☐ Heartburn	☐ Skin Rash	☐ Abnormal Bleeding
☐ Weight Loss/Gain	☐ Chest Pain/ Pressure	☐ Diarrhea	☐ Skin Growth	☐ Bruising
☐ Fatigue	☐ Heart Arrhythmias	☐ Constipation	☐ Itching	☐ Recurrent Infections
☐ Headaches	☐ Heart Palpitations	☐ Loss of Bowel Control	☐ Hair/Nail Changes	☐ Breast Lumps
☐ Dizziness	☐ Leg Swelling	☐ Blood in Stool	☐ Skin Dryness	☐ Breast Discharge
☐ Difficulty Swallowing	☐ Blood Clots	☐ Urinary Frequency	☐ Balance Difficulty	☐ Breast Feeding
☐ Visual Changes	☐ Shortness of Breath	☐ Urinary Urgency	☐ Walking Difficulty	☐ None
☐ Eye Redness	☐ Cough	☐ Loss of Urinary Control	☐ Other:	

I attest that the above information accurately represents my symptoms and medical history.

_____

Patient Signature