COLORADO SPINE PARTNERS

PATIENT INTAKE AND HISTORY FORM

Today's date: _____Name: _____ Date of Birth:_____Age:_____

Height: _____Weight: _____

Primary Care Physician: _____Phone: _____

Referring Physician: _____Phone: _____

Preferred Pharmacy: _____City: _____Phone: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

When did the problem start? ___day(s) ago ___week(s) ago ___month(s) ago _____year(s) ago

Have you seen another physician for this issue? ___No ___Yes, who and when? _____

Have you had imaging for this problem? YES NO (XRAYS MRI CT OTHER:_____)

If so, when and where? _____

Have you had an EMG? YES NO Where:_____When:_____

Have you had Pain Injections? YES NO Where:_____When:_____

What type:_____

What treatments have you tried in the past? None

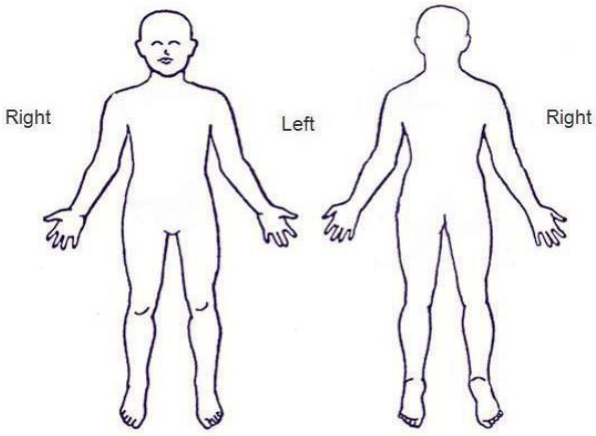
___ Application of ice ___ Application of heat ___ Physical Therapy ___Home Exercise ___ Massage ___Activity Modification ___ Brace
___ Acupuncture ___ Chiropractic Care ___ TENS Unit ___ Dry Needling ___ NSAIDS ___ Other Medication ___ Surgical Treatment

What makes your condition feel worse?_____
What makes your condition feel better?_____

SYMPTOM AND PAIN DIAGRAM:

Please be sure to fill this out as accurately as possible. This will become part of your permanent medical record and will be used to compare your progress throughout your treatment. Mark the area on your body where you feel the described sensations(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas.

Sharp/Stabbing Pain (xxx) Dull Ache (000) Numbness (---) Burning (///) Pins and Needles (***) Weakness (+++)



Cervical spine:

What is the RATIO of neck pain vs arm pain? (i.e.,80:20) _
I have noticed problems with: __Gait/Walking/Balance __Fine Motor Coordination
___Handwriting is sloppier ___Clumsiness, dropping things more frequently.
___Bowel or Bladder incontinence

Lumbar Spine:

What is the ratio of back pain vs leg pain? (i.e.,80:20) _
I have noticed problems with: __Gait/Walking/Balance __Bowel or Bladder incontinence.

Visual Analog Scale: Please circle the pain levels that most accurately represents your pain.

	0 = NO PAIN									10 = UNBEARABLE PAIN
Today's Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Least Pain	0	1	2	3	4	5	6	7	8	9	10

SOCIAL HISTORY:

Please describe your current tobacco/marijuana use habits:

___Never ___Former (I quit____years ago) ___ Current **I use:** __Cigarettes __Vaping __Marijuana __Chew/Dip

Frequency: __Current every day __Light __Heavy

Do you drink alcoholic beverages? ___Yes ___Not Currently ___ Never
If yes, what type and how many servings per week: _____

Have you ever used any illicit drugs? __Yes __Not Currently __ Never
If yes, what type of drug and how often: _____

How would you rate your exercise level? __Sedentary __Mild __Moderate __Vigorous
Are you currently working? YES: ___Full time ___Part time ___ With restrictions Occupation: _____
NO: I have not worked since_____ ___Disabled ___Retired ___Unemployed
___Homemaker ___Student ___Other: _____

MEDICATIONS:

_____ I am not currently taking any medications.
List any medications, vitamins, minerals, supplements, and alternative/herbal medications that you are currently taking:

Name of Medication	**Dose**	**Frequency**

ALLERGY HISTORY:

_____ None _____NKDA (No Known Drug Allergies)

Metal Allergies: __No __Yes Agent:_____Reaction: _____
Latex Allergies: __No __Yes Agent:_____Reaction: _____
Medication Allergies: __No __Yes Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction: _____
Agent:_____Reaction: _____
Agent:_____Reaction:_____
Agent:_____Reaction: _____
Agent:_____Reaction: _____
IV Contrast Allergies: __No __Yes Agent:_____Reaction:_____
Other Allergies: __No __Yes Agent:_____Reaction:_____
Agent:_____Reaction: _____

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___Abnormal EKG	___Depression/Anxiety	___Liver Disease	___Angina
___Anemia	___Diabetes Type I/Type II	___Myocardial Infarct	___Arrhythmia
___Anesthesia Complication	___Fracture	___Osteoarthritis	___Arthritis
___Asthma	___Heart Failure	___Osteoporosis	___Atrial Fibrillation
___Blood Transfusion	___Hepatitis	___Pulmonary Hypertension	___Bleeding Disorder
___Cancer:_____	___HIV/AIDS	___Seizures	___Cataracts
___Cirrhosis	___Hyperlipidemia	___Sickle Cell Anemia	___Chronic Fatigue
___Clotting Disorder/DVT	___Hypertension	___Sleep Apnea	___Chronic Pain
___COPD	___Hyper/Hypothyroidism	___Stroke/TIA	___Colon Polyps
___Coronary Disease	___Kidney Disease	___Substance Abuse	___Disabilities
___Diverticulitis	___Heart Valve Disease	___Pneumonia	___Obesity
___Fibromyalgia	___Hemodialysis	___Restless Leg Syndrome	___Gout
___GERD	___IBS	___Rheumatoid Arthritis	___Lyme Disease
___GI Bleeding	___Kidney Stones	___Sciatica	___Alzheimer's Disease
___Glaucoma	___Lupus	___Scoliosis	___Multiple Sclerosis
___Gunshot Wound	___Macular Degeneration	___Tuberculosis	___Parkinson's Disease
___Head/Brain Injury	___MVA	___UTIs	___Peripheral Neuropathy
___Hearing Loss	___Peripheral Artery Disease	___Vascular Disease	___Difficulty Swallowing
___Heart Failure Diastolic	___Peritoneal Dialysis	___Vertigo	___History of MRSA

Other: _____

_____

PAST SURGICAL HISTORY

____**None (**Please mark as applicable, date does not need to be exact)

Procedure	Year	Procedure	Year	Procedure	Year
__Achilles Repair	_____	__Arthroscopic Knee – Left	_____	__Amputation	_____
__ Ankle Surgery	_____	__Arthroscopic Knee – Right	_____	__Angioplasty	_____
__Thoracic Spine Surgery	_____	__Knee Replacement – Lt	_____	__Appendectomy	_____
__Lumbar Spine Surgery	_____	__Knee Replacement – Rt	_____	__Cardiac Bypass Surgery	_____
__Elbow Surgery	_____	__Meniscus – Left	_____	__Cardiac Pacemaker	_____
__Foot Surgery	_____	__Meniscus – Right	_____	__Cardiac Valve	_____
__Hand Surgery	_____	__Cervical Spine Surgery	_____	__C-Section	_____
__Hip Replacement – Lt	_____	__Rotator Cuff Repair – Lt	_____	__Colostomy/ Colectomy	_____
__Hip Replacement – Rt	_____	__Rotator Cuff Repair – Rt	_____	__Gallbladder	_____
__ACL Repair – Left	_____	__Arthroscopic Shoulder – Lt	_____	__Gastric Bypass	_____
__ACL Repair – Right	_____	__Arthroscopic Shoulder – Rt	_____	__Hernia Repair	_____
__ORIF Fracture – Left	_____	__Carpal Tunnel Surgery – Lt	_____	__Small Bowel	_____
__ORIF Fracture – Right	_____	__Carpal Tunnel Surgery – Rt	_____	__Thyroidectomy	_____

Other:_____

_____

_____

Have you experienced any adverse events associated with surgery or anesthesia?

___No ___Yes, if so, please give pertinent details: _____

_____

FAMILY HISTORY:

___ Adopted (Unknown History)

Place an "X" under the correct family member with the condition.

	Mother	Father	Sister	Brother	Child
Alcohol/ Substance Abuse					
Anesthetic Complications					
Asthma					
Broken Bones					
Cancer:					
type:					
Clotting Disorder					
Collagen Disease					
Dementia					
Diabetes Type I					
Diabetes Type II					
Dislocations					
Heart Disease					

	Mother	Father	Sister	Brother	Child
Hypertension					
High Cholesterol					
Kidney Disease					
Liver Disease					
Lung/Resp Disease					
Mental Illness					
Osteoporosis					
Rheumatologic Disease/Arthritis					
Scoliosis					
Severe Sprains					
Stroke					
Thyroid Problems					
Anxiety/Depression					

Other:_____

_____