SPINE & PAIN CENTERS
OF NEW JERSEY & NEW YORK

INTIAL PATIENT INTAKE

PATIENT NAME:_____**DOB:**_____**DATE:** _____

Weight:_____ **Height:**_____

Chief Complaint:_____

Is Your Pain From an Auto or Worker Comp Accident? ☐**YES** ☐**NO**

Initial Pain Level (0-10 10 being worst) _____ How often is your pain present? ☐Occasional ☐Frequent ☐Constant

What makes symptoms worse?
☐Walking ☐Standing ☐Sitting ☐Lying Down

What makes symptoms better?
☐Walking ☐Standing. ☐Sitting ☐Lying Down

Medical History

Patient Medical History:		
Diabetes	☐No	☐Yes
Blood Pressure	☐No	☐Yes
Asthma/COPD	☐No	☐Yes
Stroke	☐No	☐Yes
Heart Problems	☐No	☐Yes
Kidney Problems	☐No	☐Yes
Seizure disorders	☐No	☐Yes
Bleeding/Clotting	☐No	☐Yes
Liver/Hepatitis	☐No	☐Yes
Sleep Apnea	☐No	☐Yes
Cancer	☐No	☐Yes
Thyroid	☐No	☐Yes

Previous Hospitalizations/Surgeries When?

_____
_____
_____
_____

Current Medications:

_____
_____
_____
_____
_____
_____

ALLERGIES

Dye ☐Yes ☐No
Other Medication Allergies
_____
_____
_____
_____
_____
_____
_____

Patient Social History:

Occupation:_____ ☐**Full time** ☐**Part time**

Marital status: ☐Single ☐Married ☐Separated/Divorce ☐Widowed
Use of alcohol: ☐Never ☐Rarely ☐Moderate ☐Daily
Use of tobacco: ☐Never ☐Previously but quit ☐Current packs/day____
Use of drugs ☐Never ☐Type/Frequency_____

Family Medical History, if pertinent:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

Do you have an immediate family member or close friend with history of illegal drug use or alcohol addiction? ☐Yes ☐No

Please check off if any current problems in any of the following areas:

☐General Wellness ☐Lungs/Breathing ☐Neurological ☐Chest pain ☐Reproductive/Urinary
☐Headache ☐Fatigue ☐Skin ☐Thyroid ☐Endocrine ☐Trouble Sleeping
☐Nausea ☐Ears, Nose, Throat ☐Blood/Lymph ☐Memory ☐Ringing in Ears
☐Stomach/Digestion ☐Psychiatric ☐Dizziness ☐Muscles/Joints/Bone ☐Eyes ☐Weight Loss

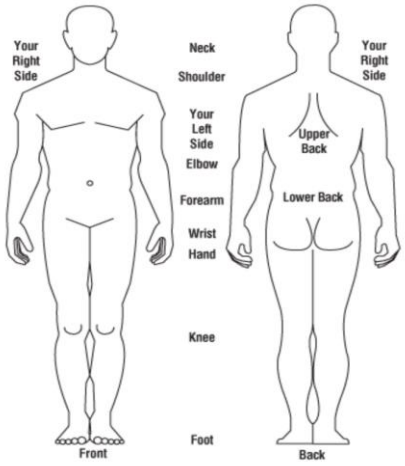
If any of above areas are checked, please explain: _____

Previous treatment? Please Check any of the following you have had:

☐Physical Therapy ☐Chiropractic Treatments ☐Anti-Inflammatory Medications
☐Nerve Blocks/Injections ☐Home based exercise/Self-care/Ice /Heat

☐MRI ☐CT SCAN ☐X-RAYS ☐EMG

Mark the location of your pain



Patient Signature: _____