NEUROLOGICAL INSTITUTE OF NEW JERSEY

Patient Medical History Intake Form- Spine

Patient Name: _____ Date of Visit: __/__/__
Address: _____ City/ST/Zip: _____
Phone – Home: (__) _____ Work: (__) _____ Cell: (__) _____
Date of Birth: __/__/__ Age: ____ Sex: ❑ Male ❑ Female
Height: ____ ft. ____ in. Weight: ____ lbs. Are you: ❑ Left-handed ❑ Right-handed
Emergency Contact: _____ Relation: _____ Phone: (__) _____
Person filling out this form if not Patient: _____ Relation: _____

❑ Primary Physician: _____ Address: _____ Phone: (__) _____
❑ Pain Management _____ Address: _____ Phone: (__) _____
❑ Neurology Physician: _____ Address: _____ Phone: (__) _____
❑ Rehabilitation Physician: _____ Address: _____ Phone: (__) _____
❑ Referring Physician: _____ Address: _____ Phone: (__) _____
❑ Self Referral -- How did you hear about us? _____

A. Symptoms and Pain Assessment

1. Chief Complaint: _____
2. How long have you had these symptoms: _____ Days _____ Weeks _____ Months _____ Years
3. Describe the quality of your pain (Please CHECK in the box):
   ❑ Burning ❑ Numbness ❑ Sharp ❑ Spasms ❑ Tightness
   ❑ Deep-pressure ❑ Pinprick ❑ Shooting ❑ Stabbing ❑ Tingling
   ❑ Other (please describe) _____
4. How often do you experience the pain?
   ❑ Constant ❑ Intermittent ❑ Daily ❑ Weekly ❑ Monthly ❑ Other: _____
5. How did your pain start? ❑ Gradually ❑ Suddenly What day did your pain start? _____
6. Since the pain began, is it.. ❑ Worse ❑ Better ❑ Unchanged?
7. Does the pain radiate to an arm? ❑ No ❑ Yes -- If Yes: ❑ Right ❑ Left ❑ Both
   or a leg? ❑ No ❑ Yes -- If Yes: ❑ Right ❑ Left ❑ Both
   Do you have weakness in an arm? ❑ No ❑ Yes -- If Yes: ❑ Right ❑ Left ❑ Both
   or a leg? ❑ No ❑ Yes -- If Yes: ❑ Right ❑ Left ❑ Both
   Do you have numbness in an arm? ❑ No ❑ Yes -- If Yes: ❑ Right ❑ Left ❑ Both
   or a leg? ❑ No ❑ Yes -- If Yes: ❑ Right ❑ Left ❑ Both
8. Any changes in bowel or bladder function? ❑ No ❑ Yes --
   ❑ Bowel Incontinence ❑ Bladder Incontinence ❑ Constipation ❑ Hesitancy ❑ Others: _____
9. Was there any injury/event that caused your pain? ❑ No ❑ Yes -- Date of Injury: __/__/__
   Please describe how you were injured: _____
   a. Legal actions pending? ❑ No ❑ Yes
   b. Work related? ❑ No ❑ Yes --
      Employer at time of injury: _____
      Job Title: _____
      Worker's Compensation? ❑ No ❑ Yes --
      Name of your Attorney: _____
      Any PRIOR workers compensation injuries ❑ No ❑ Yes -- If yes, how many? _____
      List any PRIOR workers compensation cases/injuries

Date	Area Injured	Who Treated You?	Time Off Work
__/__/__			
__/__/__			
__/__/__			

   c. Any PRIOR car accidents? ❑ No ❑ Yes -- If yes, how many? _____

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List any PRIOR car accidents/injuries

Date	Area Injured	Who Treated You?	Time Off Work
/ /			
/ /			
/ /			

10. Any prior back or neck injury/pain before the event above? ❑ No ❑ Yes --
What type? (*please describe*) _____

How severe is your pain today? (*please CIRCLE the number to indicate how bad you feel your pain is today*)
No pain → 0 1 2 3 4 5 6 7 8 9 10 ← Worst pain

11. Pain Rating

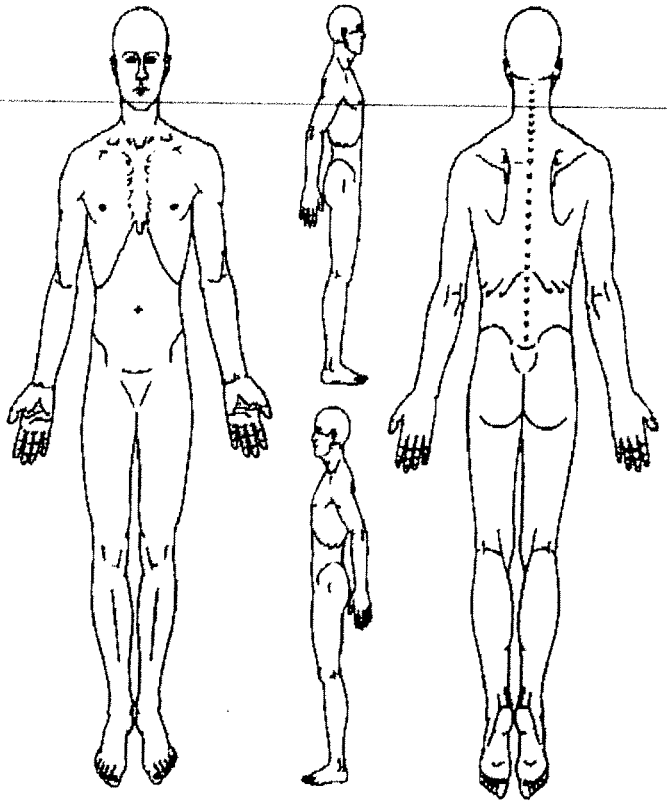
Please rate your **AVERAGE** level of pain on the following scale (CIRLE one number)
No pain → 0 1 2 3 4 5 6 7 8 9 10 ← Worst pain

Please rate your **WORST** level of pain on the following scale (CIRLE one number)
No pain → 0 1 2 3 4 5 6 7 8 9 10 ← Worst pain

Please rate your **BEST** level of pain on the following scale (CIRLE one number)
No pain → 0 1 2 3 4 5 6 7 8 9 10 ← Worst pain

Using the symbols given below, mark the areas on your body where you feel the described sensation include all affected areas.

= = = Numbness
XXX Burning
IIIII Stiffness/Tightness
→ Shooting
ooo Pins&Needles
******** Stabbing
(((((Aching



12. Do you have pain at night?
- ❑ No
- ❑ Yes

13. Does your pain wake you up from sleep?
- ❑ No
- ❑ Yes

14. What makes your pain better?
- ❑ Acupuncture
- ❑ Bending
- ❑ Chiropractic
- ❑ Epidural Injections
- ❑ Lying Down
- ❑ Massage
- ❑ Medications
- ❑ Nerve Blocks
- ❑ Physical Therapy
- ❑ Sitting
- ❑ Standing
- ❑ Walking
- ❑ Others: _____

15. What makes your pain worse
- ❑ Bending
- ❑ Coughing/Sneezing
- ❑ Lying Down
- ❑ Neck Movement
- ❑ Sitting
- ❑ Standing
- ❑ Walking
- ❑ Others: _____

16. What time of the day is your pain at its worst?
- ❑ Morning
- ❑ Afternoon
- ❑ Evening
- ❑ Night
- ❑ Not Applicable

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B. Previous Treatment and Evaluation

1. What diagnostic test have you had for this problem?
   1. Blood/Laboratory _____ ❑ Discogram _____ ❑ Myelogram _____
   2. Bone Scan _____ ❑ EMG _____ ❑ X-Ray _____
   3. CT Scan _____ ❑ MRI _____
2. Please CHECK any of the following if you have tried for your pain or discomfort:
   4. Acupuncture ❑ Facet Blocks ❑ Physical Therapy
   5. Anti-inflammation Medications ❑ Narcotic Medications ❑ Surgery
   6. Chiropractic ❑ Nerve Blocks ❑ TENS
   7. Epidural Injections Others: _____
3. Please LIST **Physicians** who have treated you for this:

Physician Name	Address	Phone Number
		( )
		( )
		( )

4. Please LIST **Imaging Studies** you have had for this:

Imaging Study Name	Date

5. Please LIST **Medications** you have taken for this:

Medication Name	Dose	Route	Frequency	Time/Date Last Taken

6. Please LIST prior **Injections/Physical Therapies** for this:

_____

_____

_____

C. Medical/Surgical History

1. Please LIST **Spine Surgeries** you have had in the past?

Spine Surgery	Date

2. Please LIST **Non-Spinal Surgeries or Hospitalizations** you have had in the past?

Non-Spinal Surgery	Date

3. Please LIST **all Other Medications** you are currently taking you have had in the past?

Medication Name	Dose	Route	Frequency	Time/Date Last Taken

4. Allergies:
   Medication: ❑ No ❑ Yes -- If Yes, please provide details: _____
   Food: ❑ No ❑ Yes -- If Yes, please provide details: _____
   Latex: ❑ No ❑ Yes --
   Contrast: ❑ No ❑ Yes History of Anesthesia Reaction: ❑ No ❑ Yes

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5. Please CHECK the box if you currently have any problems to the following systems:

- ❑ Abdominal Pain
- ❑ Abnormal Scars
- ❑ Anemia
- ❑ Anger
- ❑ Angina
- ❑ Anorexia
- ❑ Arrhythmia
- ❑ Asthma/Wheezing
- ❑ Back Pain
- ❑ Bleeding Tendency
- ❑ Bruising
- ❑ Change/Loss of Appetite
- ❑ Changes in Hair or Nails
- ❑ Chest Pains
- ❑ Constipation
- ❑ Cough
- ❑ Coughing up Blood
- ❑ Deafness
- ❑ Decreased Hearing
- ❑ Decreased Vision
- ❑ Dental Problems
- ❑ Dentures
- ❑ Depression
- ❑ Diarrhea
- ❑ Difficulty Breathing
- ❑ Difficulty Swallowing
- ❑ Dizziness
- ❑ Double Vision
- ❑ Dryness
- ❑ Dysesthesia
- ❑ Dysphasia
- ❑ Fatigue/Weakness
- ❑ Fever/Chills
- ❑ Ear Ache or Infection
- ❑ Easy Bruising/Bleeding
- ❑ Edema
- ❑ Emphysema/COPD
- ❑ Eye Infections (Irises)
- ❑ Fainting/Blackouts/Passing Out
- ❑ Frequent Infection of Urine
- ❑ Glasses/Contacts
- ❑ Glaucoma
- ❑ Goiter
- ❑ Hallucinations
- ❑ Headaches
- ❑ Heartburn/Acid Influx
- ❑ Heat/Cold Intolerance
- ❑ Hoarseness
- ❑ Hot Flashes
- ❑ Impotence
- ❑ Increased/Excessive Thirst or Hunger
- ❑ Increased Frequency of Urination
- ❑ Incontinence (Loss of Control)
- ❑ Jaundice
- ❑ Joint Pain/Stiffness (Arthritis)
- ❑ Kidney Stones
- ❑ Leg Swelling
- ❑ Loss of Hearing
- ❑ Loss of Vision
- ❑ Lumps or Sores
- ❑ Mood Swings
- ❑ Muscle Aches
- ❑ Muscle Cramping
- ❑ Muscle Wasting
- ❑ Muscle Weakness
- ❑ Nasal Stuffiness/Discharge
- ❑ Nausea/Vomiting
- ❑ Nervousness/Anxiety
- ❑ Nervous Breakdown
- ❑ Night Sweats
- ❑ Nosebleeds
- ❑ Numbness/Tingling (arms, legs, face)
- ❑ Pain/Burning when you Urinate
- ❑ Palpitations
- ❑ Paralysis
- ❑ Past Blood Transfusions
- ❑ Pleuritic Chest Pain
- ❑ Pneumonia/Bronchitis
- ❑ Rectal Bleeding or Black, Tarry Stool
- ❑ Reduced Force of Urination
- ❑ Seizures
- ❑ Sexual Dysfunction
- ❑ Shortness of Breath
- ❑ Sinusitis
- ❑ Sleep Disturbance
- ❑ Sore Throat
- ❑ Suicidal Thoughts
- ❑ Swelling in the Legs
- ❑ Swelling of Joints
- ❑ Tinnitus (Ringing in Ear)
- ❑ Tremors/Involuntary Movements
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vertigo/Dizziness
- ❑ Weight Loss/Gain

Medical History:	Surgery?	Med?
AIDS/HIV	❑	❑
Anxiety	❑	❑
Arthritis	❑	❑
Bipolar Disorder	❑	❑
Blood Clots in Legs	❑	❑
Blood Clots in Lungs	❑	❑
Bone Fracture	❑	❑
Cancer	❑	❑
Colon Polyps	❑	❑
Depression	❑	❑
Diabetes	❑	❑
Diverticulitis	❑	❑
Epilepsy	❑	❑
Gallbladder	❑	❑
Gastric Reflux	❑	❑
Gout	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Kidney Problem	❑	❑
Liver Problem	❑	❑
Osteoporosis	❑	❑
Pacemaker	❑	❑
Rheumatoid Arthritis	❑	❑
Stomach Ulcer	❑	❑
Thyroid Disease	❑	❑

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D. *Family History*

	Alive?	If No, age at time of death?	And from what illness?	Medical Problems
Father	❑ Yes ❑ No			
Mother	❑ Yes ❑ No			

	How many in total?	How many deceased?	If deceased, from what illness?	Medical Problems
Brother				
Sister				
Son				
Daughter				

E. *Social History*

1. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Living with other
2. Education level: ❑ Grade School ❑ Jr. High ❑ High School ❑ College ❑ Post Graduate
3. Smoke cigarettes? ❑ No ❑ Yes -- How many per day? _____ For how many years? _____
4. Drink alcohol? ❑ No ❑ Yes -- How many drinks? _____ How often? _____
5. Use any type of recreational drugs? ❑ No ❑ Yes --
   Which ones? _____ How often? _____ Last use? _____

For Women only:

Age of first Menstrual Period: _____ Date of last Menstrual Period: / /

Age of Menopause: _____ Number of children: _____

Number of total pregnancies: _____ *(including miscarriages/abortions)*

Ever used birth control pills? ❑ No ❑ Yes -- Age began: _____ Duration: _____

Ever used hormone replacement? ❑ No ❑ Yes -- Age began: _____ Duration: _____

F. *Work History*

1. Are you currently? ❑ Employed ❑ Retired ❑ On Disability
   ❑ Unemployed ❑ On Sick Leave ❑ A Stay at Home Parent

If Employed or On Disability:

Employer: _____ Job Title: _____

How long have you worked there? _____ Days _____ Weeks _____ Months _____ Years

Length of time on job: _____ Hours/Day _____ Days/Week

Movements required for your job (*please CHECK in the box*)

❑ Pushing ❑ Pulling ❑ Sitting ❑ Standing ❑ Crouching ❑ Lifting ___ Pounds
❑ Stopping ❑ Crawling ❑ Bending ❑ Twisting ❑ Climbing Stairs ❑ Reaching Above Shoulders
❑ Grasping ❑ Balancing ❑ Squatting ❑ Kneeling ❑ Climbing Ladders ❑ Repeated Wrist/Hand Movements

2. Are you able to perform your usual duties? ❑ No ❑ Yes --
   If No, has your job changed since your symptoms started? ❑ No ❑ Yes ❑ Not Working
   If Not Working, when did you go on disability? _____