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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: _____

Address:

Phone Home #: () _____ Cell Phone#: _____

Work #: () _____

How were you referred? _____

Referring Physician: _____

Address: _____

Phone #: () _____

Fax #: () _____

Are there any physicians to whom you would like your medical records sent?
(Please include name and address)

Please list all other physicians with whom you have consulted in the past for your spine troubles and their specialty.

History of Present Complaint

1. How long have you had your present pain?

Less than 1 month 1 to 3 months 3 to 6 months
6 months to 1 year More than 1 year

2. Please enter date when your present pain began and briefly give details of injury or onset.

Date: ____/____/____

3. Please indicate how your present pain began:

Occurred during an athletic activity	Occurred while lifting
Occurred as a result of auto accident	Unknown
Occurred while sitting	Occurred while working
Occurred while bending	Gradual onset

4. Where was your present pain or symptoms initially located

Neck	Neck and arm(s)
Mid back	Back and leg(s)
Low back	Unknown

5. If the symptoms of your present pain have changed since the time of injury, please check the most appropriate statement:

My symptoms have remained the same
My symptoms are more severe
My symptoms are less severe

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 _____ Driving _____ Standing _____ Walking _____ Bending _____ Climbing _____

Lifting _____ Twisting _____ Reaching above shoulder _____ Typing/computer _____

Maximum weight that 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 If no, what date did you stop working? _____

Is there light duty work available at your job? Yes No

Are you currently working in light duty? Yes No

8. Please indicate whether or not you have had any of the following studies:

Yes No

- Regular X-ray of spine
- CT Scan
- EMG/nerve conduction study
- CT Myelogram
- Discogram
- MRI
- Bone Scan

Please indicate if you have undergone any of the following treatments listed and provides details if appropriate.

Physical therapy? Yes No _____ times per week for _____ weeks.

Did you improve with physical therapy? _____

Injections in your spine such as epidural steroid or facet block? Yes No

Type _____ Date _____

Did you get relief or improvement in your symptoms with this injection? Yes No

Type _____ Date _____

Did you get relief or improvement in your symptoms with this injection? Yes No

Helpful Not Helpful Not Used

- TENS Unit
- Traction
- Acupuncture
- Chiropractor

Previous Spine History

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

Episode A: ___/___/___ Episode B: ___/___/___ Episode C: ___/___/___

Treatment:: _____ Treatment: _____ Treatment: _____

10. Have you had spine surgery in the past? Yes, How many times? _____ No

If you answered “Yes”, please complete the following (types of surgery include laminectomy, decompression, disc replacement, laminoplasty, fusion or unknown):

Type of surgery	Date	Location/Surgeon
_____	_____	_____
_____	_____	_____

Did you improve from your spine surgical procedure(s)?

Yes No

Current Pain Profile

2. Which of the following best describes your pain or symptom ratio?

- 100 % back/neck and 0% leg/arm pain or symptoms
- 75 % back/neck and 25% leg/arm pain or symptoms
- 50 % back/neck and 50% leg/arm pain or symptoms
- 25 % back/neck and 75% leg/arm pain or symptoms
- 0 % back/neck and 100% leg/arm pain or symptoms

3. Please choose letters (in second column) to answer the questions in column one.

- | | |
|---------------------------------|--------------------------|
| ➤ How long can you sit? _____ | A. Unable to tolerate |
| ➤ How long can you stand? _____ | B. About 15 minutes only |
| ➤ How long can you walk? _____ | C. About 30 minutes only |
| | E. About 1 hour |
| | F. Indefinitely |

4. Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting			
Standing			
Rising from sitting			
Leaning forward (brushing teeth)			
Walking			
Lying on your side			
Lying on your back			
Lying on your stomach			
Driving			
Coughing/Sneezing			
Bending forward			

Review of Systems

Please check any of the following symptoms that you have had in the past six months.

Constitutional

- Night pain
- Night sweats
- Loss of appetite
- Fevers

Cardiovascular

- Chest pain/Angina
- Palpitations/Irregular heartbeat
- Edema/Swelling

Gastrointestinal

- Heartburn
- Blood in stool

Respiratory

- Difficulty breathing
- Shortness of breath
- Chronic cough

Integumentary

Rash
Skin lesions

Neurologic

Headaches
Tremors
Visual changes

Psychiatric

Depression
Anxiety
Mood swings

Endocrine

Heat/cold intolerance
Rapid weight gain/loss

Genitourinary

Difficulty with urination
Burning with urination
Impotence / Reduced sexual function

Immunologic

Chronic infections
Slow wound healing

** With your current symptoms, have you had loss of control of bowel or bladder function (incontinence)? Yes No

Social History

Are you a cigarette smoker? Yes No, never Not currently, but I have smoked cigarettes in past

If current smoker, how much do you currently smoke per day?
_____ packs/day **OR** ___ cigarettes/day for _____ years

If you are a former smoker how many cigarettes did you used to smoke?
_____ packs/day **OR** ___ cigarettes/day for _____ years

Do you drink alcoholic beverages? Yes No, never Not currently, but I have in the past

If yes, please tell us your drinking habits:

I mostly drink (check all that apply) Beer Wine Liquor (mixed drinks/martinis)

Do you have alcoholic beverages daily? Yes No If yes, how many drinks per day _____

Do you have alcoholic beverages weekly? Yes No If yes, how many drinks per week _____

Do you have alcoholic beverages less than weekly, but at least monthly? Yes No

Are you married? Yes No

Do you have any children? Yes No If yes, please list ages and gender

Medical History

Current height: ____ feet ____ inches Current Weight: _____ lbs

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

- | | | | |
|---------------------|---------------|---------------------------------------|-----------------|
| High blood pressure | Diabetes | Atrial fibrillation | Osteoporosis |
| High Cholesterol | GERD (reflux) | Sleep apnea | Thyroid disease |
| Asthma | COPD | Cancer, what type _____ | |
| Stroke | Heart attack | Blood clot (pulmonary embolus or DVT) | |
| Lupus | Fibromyalgia | Parkinson's Disease | Depression |
| Anxiety | | | |

Please list any and all other illnesses or injuries:

Do you have or have you ever had any of the following contagious or infections diseases?

- Hepatitis Yes No If yes, what type (A, B, C, D, E)? _____
- Tuberculosis Yes No
- HIV/AIDS Yes No
- Other _____

Are you or have you ever been under the care of a psychiatrist or psychologist?

Yes No If yes, what is or was the diagnosis _____

List all previous **surgeries** (other that the back surgeries you have already discussed)

Medications

What **medications** and over the counter supplements do you take at the present time? Please be as thorough as possible as this will go in your record. Attach a separate sheet if necessary.

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

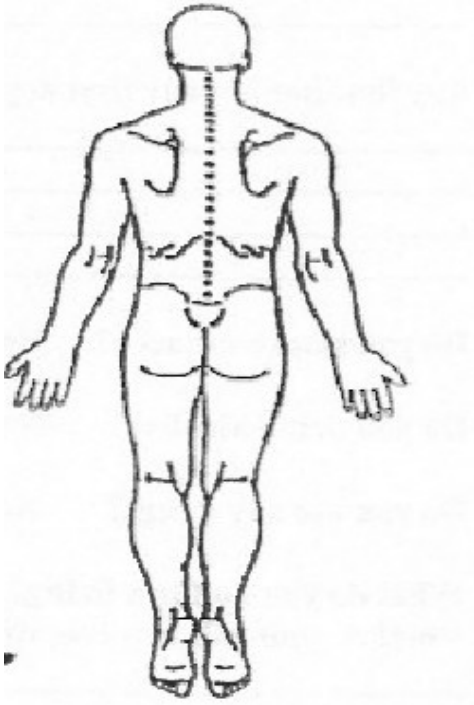
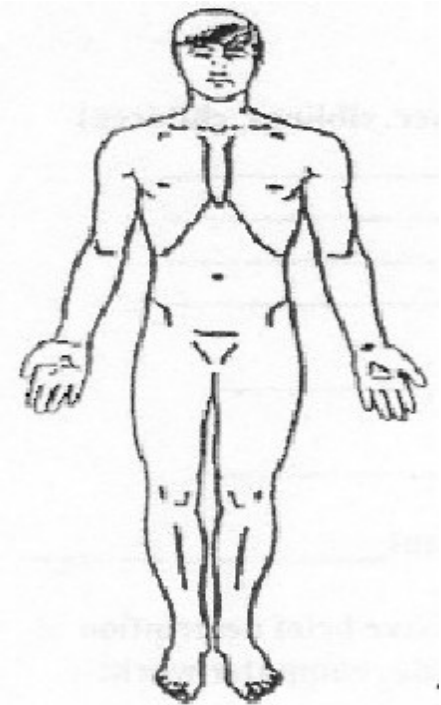
List any **allergies** to medications, latex or contrast dyes. Please include name and reaction.

No known drug or latex allergies

Ortho Pain Chart

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.

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



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

“0” = no pain to “10” = intolerable

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Pain at its worst

“0” = no pain to “10” = worst pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Pain at its best