NEW JERSEY
NECK & BACK
INSTITUTE, P.C.

Spine Wellness Intake Form

Patient Name:_____ **Date of Birth:** _____

Age: _____ **Weight:**_____ **Height:** _____

Primary Care Physician:_____

Are you RIGHT or LEFT handed? (circle) **Social Security Number:** _____

Clinical Information

Please fill this form out in its entirety. Thank you for cooperation.

Chief Complaint: _____

1. **How did your injury occur:**
   - ☐ None/Spontaneous onset ☐ Fall or injury: please describe_____
   - ☐ Motor Vehicle Accident Date of Injury _____
   - ☐ Sports/recreational injury
   - ☐ Other- please describe: _____
2. **What are your symptoms:** _____
3. **When did your symptoms begin?** _____
4. **Do you have any numbness? If yes, where?**_____
5. **Do you have any tingling? If yes, where?** _____
6. **Do you have any weakness? If yes, where?** _____
7. **Any change in your bowel or bladder habits as a direct result of your injury?**

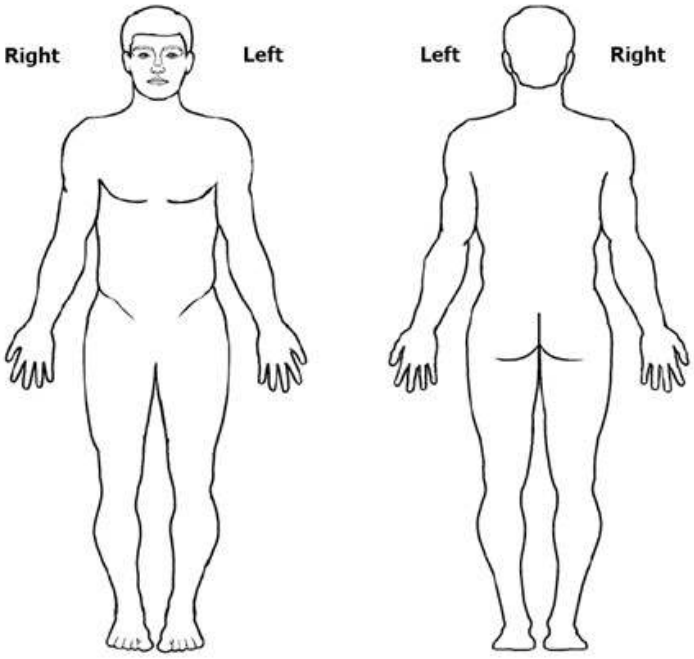
   ☐ **Yes** ☐ **No If yes, please describe:** _____

8. **Since the pain began it has:** ☐ Improved ☐ Not changed ☐ Worsened ☐ Comes and goes
9. **Does the pain you experience awaken you from sleep?** ☐ **Yes** ☐ **No**
10. **Do any of the activities listed below alter your level of pain?**

Activity	Aggravates the pain	Relieves the Pain	Neither
Sitting			
Standing			
Walking			
Lying down on your back			
Lying down on your stomach			
Lying down on your side			
Leaning forward			
Leaning backwards			
Bending forward			
Bending backwards			
Twisting			
Lifting			
Driving			
Coughing or sneezing			

Using the symbols given below mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Tingling	Burning	Stabbing	Other
^^^^^	=======	oooooo	xxxxxxx	//////////	……

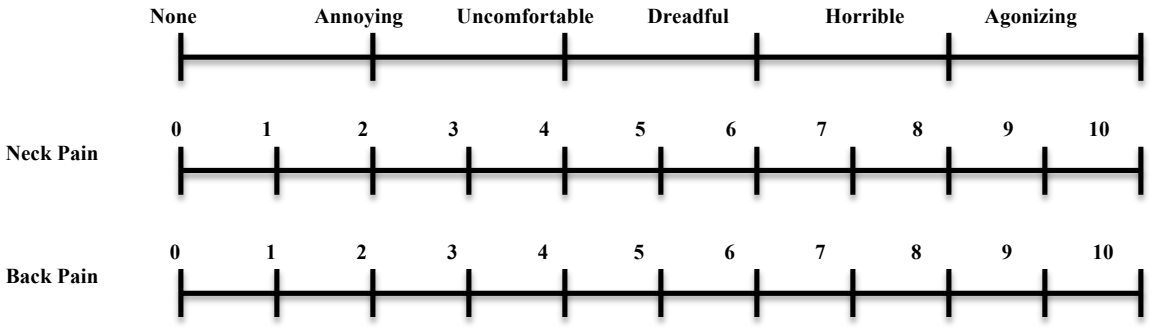


Pain in arm(s) compared with neck_____worse_____same_____less

Pain in leg(s) compared with back _____worse _____ same_____less

Pain Scale

Please place an "x" on the appropriate level



11. If you have tried any of the items listed below please check and then circle if any were helpful in relieving your pain:

☐ Physical therapy ☐ Traction ☐ Active exercise ☐ Brace/collar
☐ Heat / Cold ☐ Medication(s) ☐ Holistic or alternative therapies
☐ Manipulation ☐ Pain psychology ☐ Chiropractor ☐ TENS Unit
☐ Spinal injections Date of Last Injection: / / Did it help? ☐ Yes ☐ No
Name of physician who performed your injection:

12.

Radiographic Studies Done

Study	Date	Location of Study
Routine X-Rays		
CT Scan		
MRI Scan		
EMG		
Myelogram		
Discogram		
Other		

Past Medical History

Medical problems/Illnesses *(please check all that apply)*

☐ Heart problems	☐ Liver problems	☐ heavy bleeding	☐ HIV/AIDS
☐ High blood pressure	☐ Ulcers	☐ Venereal disease	☐ Peripheral Vascular Disease
☐ Angina	☐ TIA (mini stroke)	☐ Stroke	☐ Restless Leg Syndrome
☐ Heart murmur	☐ Colon problems	☐ Scarlet fever	☐ Mental Illness
☐ Mitral valve prolapse	☐ Blood in stool	☐ Depression	
☐ Breathing problems	☐ Anemia	☐ Diarrhea	
☐ Tuberculosis	☐ Kidney stones	☐ Hemophilia	
☐ Kidney problems	☐ Painful urination	☐ Epilepsy	
☐ Emphysema	☐ Arthritis	☐ Fatigue	
☐ COPD	☐ Osteoporosis	☐ Emotional problems	
☐ Asthma	☐ Joint problems	☐ Psoriasis	
☐ Coughing	☐ Thyroid problems	☐ Infections	
☐ Gallbladder	☐ Migraines	☐ Hepatitis	
☐ High cholesterol	☐ Diabetes	☐ GERD or GI Ulcers	

Other medical problems: _____

Recent infection? ☐ Yes ☐ No If yes, where: _____ On antibiotics: ☐ Yes ☐ No
☐ DVT (clots in legs) Completed treatment? ☐ Yes ☐ No
☐ Cancer Type: _____

Have you had any previous back and/or neck surgery? If so please list below:
Procedure: _____
Name of Surgeon: _____
Date of Surgery: _____
Improvement after surgery: ☐ Yes ☐ No
If improvement, for how long: _____

Have you had ANY OTHER previous surgeries? If so, please list below:
Procedure: _____
Name of Surgeon: _____
Date of Surgery: _____

ALLERGIES

Allergies to medications: ☐Yes ☐No
List all medication allergies: _____

Are you allergic to latex: ☐Yes ☐No
Allergies to Iodine, shellfish or seafood: ☐Yes ☐No Reaction? _____

MEDICATIONS

List all current medications (Including over the counter and herbal supplements):

_____
_____
_____
_____

Do you take? (please circle) PLAVIX ASA COUMADIN LOVENOX NSAIDs NONE

Any history of substance abuse or illicit drug use? ☐Yes ☐No

SOCIAL HISTORY

Marital Status:	☐Single	☐Married	☐Widowed	☐Divorced
Use of Alcohol:	☐ Never	☐Rarely	☐Moderate	☐Daily
Use of Tobacco:	☐ Never	☐Previously, but quit	☐Current packs per day _____	

Are you LEFT or RIGHT handed?
Living situation: ☐ Alone ☐ with Spouse/Family ☐ With Friends
Hobbies and activities you enjoy? _____
_____
Type of Work: _____
Have you ever been on Disability? ☐Yes ☐No **When?** _____
Was Disability work-related? ☐Yes ☐No **Do you have law suits pending?** ☐Yes ☐No
If yes, explain: _____
Are there religious/cultural needs related to your care? ☐Yes ☐No
If yes, explain: _____

FAMILY HISTORY

Family Member:	Age	Major Illness	If deceased, cause of death
Mother	____	_____	_____
Father	____	_____	_____
Brother/Sister	____	_____	_____
Brother/Sister	____	_____	_____
Son(s)	____	_____	_____
Daughter(s)	____	_____	_____

Family History of Arthritis? ☐Yes ☐No **Which family member?** _____

SYSTEMS REVIEW

Did you have any of the following symptoms in the past 6 months?

Constitutional Symptoms

Good General Health Lately	☐Yes ☐ No
Recent Weight Change	☐Yes ☐ No
Fever	☐Yes ☐ No
Fatigue	☐Yes ☐ No

Hematologic/Lymphatic

Anemia	☐Yes ☐ No
Phlebitis	☐Yes ☐ No
Past blood transfusion	☐Yes ☐ No
Exposure to HIV	☐Yes ☐ No
History of Blood Clots	☐Yes ☐ No

Musculoskeletal

Osteoporosis	☐Yes ☐ No
History of fractures	☐Yes ☐ No
History of gout	☐Yes ☐ No
Rheumatoid disease	☐Yes ☐ No

Gastrointestinal

Loss of appetite	☐Yes ☐ No
Nausea or Vomiting	☐Yes ☐ No
Frequent Diarrhea	☐Yes ☐ No
Rectal Bleeding	☐Yes ☐ No
Abdominal pain or bleeding	☐Yes ☐ No
Peptic ulcer	☐Yes ☐ No
Hepatitis	☐Yes ☐ No

Neurological

Lightheaded or dizzy	☐Yes ☐ No
Tremors	☐Yes ☐ No
Paralysis	☐Yes ☐ No

Psychiatric

Depression	☐Yes ☐ No
Memory loss or confusion	☐Yes ☐ No
Insomnia	☐Yes ☐ No
Nervousness	☐Yes ☐ No

Signature of patient or person authorized to give consent. (If other than patient, state relationship)
Please refrain from using any recording devices and/or taking pictures in the clinical area, as it is not permitted.

X_____ Date: _____

Patient Signature

REVIEWED BY: _____

Sandro LaRocca, M.D.