

The Head & Spine Pain Center (THSPC) Patient Intake Form

Welcome to The Head & Spine Pain Center. In order to accurately assess you and to determine if you are a true candidate for our care, it is important that you fill out this form as thoroughly as possible. Thank You.

Today's Date _____
Name _____ Age _____ Birthday _____ Sex M F
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Best Place To Reach You (circle one) Home / Work / Cell. May we leave a voice mail message for you? Yes / No
Employer _____ Occupation _____ Length of Employ _____
Marital Status S M W D Spouse's Name _____

How Did You Hear About THSPC? _____
How Serious Do You Think Your Problem Is? _____

What Is Your Main Problem/Symptom Prompting Your Request For A Consultation With The Doctor?

Would You Consider This Problem (circle one).. MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

1. In spite of the fact that you are not a back specialist, you are in fact the person who knows more about your back than anyone else. In your own words and in your own opinion what do you think the real problem is?

2. What are you hoping happens today as a result of your consultation with the Doctor?

3. Since your reason for coming to this office became this severe what three things has it caused you to miss the most?

3. How long have you been like this?

Patient Initials _____ Today's Date _____

4. How has your life changed since reason for this office visit became a problem?

5. What activities are you limited in?

6. What kinds of treatments have you received?

Epidural:	How Many _____	When(approx) _____
Physical Therapy:	How Long _____	When(approx) _____
Medication:	_____	When(approx) _____
Surgery:	Type _____	When(approx) _____
Other	_____	

7. When did you receive these treatments and for how long?

8. Did any of these treatments work? If so which one(s)? For how long?

9. Is there anything you can do that makes it feel better?

10. What activities/movements are guaranteed to make it worse?

11. Please describe the quality of the pain. (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc...)

12. Is it worse in the morning or is it worse as the day progresses?

Patient Initials _____ Today's Date _____

13. If you cannot find a solution to this problem what do you think will happen to you?

14. Describe what will be different in your life if you can get better.

15. When is the VERY FIRST time you recall having this problem?

List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above.

1. _____ How Long Have You Had This? _____
2. _____ How Long Have You Had This? _____
3. _____ How Long Have You Had This? _____
4. _____ How Long Have You Had This? _____

In Reference To Your MAIN PROBLEM How Often Are You Aware of This Problem? (circle one)

- Occasionally (25% of the time)
- Intermittently (50% of the time)
- Frequently (75% of the time)
- Constant (90-100% of the time)

Due To Your Main Problem.....

Have You Lost Any Time From Work? Yes No

How Much Time and What Tasks Have Been Limited? _____

Have You Lost Any Time From Your Chores/Tasks At Home? Yes No

How Much Time and What Tasks Have Been Limited? _____

Have You Lost Any Time From Your Family? Yes No

How Much Time and What Tasks Have Been Limited? _____

Have You Lost Any Time From Your Leisure Activities? (Hobbies, Travel, Sports, etc...)

How Much Time and What Tasks Have Been Limited? _____

Considering the amount of pain/discomfort you've had THIS week, how long has your problem been this severe?

On a Scale of 0-10 (10 being unbearable, 0 being No Pain or Discomfort) Please rate the following...

The HIGHEST your pain gets WITHOUT medication _____

The LOWEST your pain gets WITHOUT medication _____

The HIGHEST your pain gets WITH medication _____

The LOWEST your pain gets WITH medication _____

List ANY surgeries that you have had and the corresponding dates.

Patient Initials _____ Today's Date _____