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LUMBAR SPINE INTAKE FORM

□ **Dr. Ginsberg** □ **Dr. Katz** □ **Dr. Moran** □ **Dr. Rudin** □ **Dr. Straight**

PATIENT INFORMATION

Date: _____ **Name:** _____ **Age:** _____ **FSO MR #:** _____

CONCERN

(Describe your back pain, please check all that apply.)

□ **Back Pain** □ **Leg Pain** □ **Right** □ **Left** □ **Bilateral**

Date of Injury/Onset of Pain: _____ □**Auto Accident** □**Work Comp** □**Personal Injury** **Dates off work:** _____

Work Status: □ Currently working _____ hrs/wk

□ Not working □ unemployed □ retired

Severity : □ 0 (no pain) □ 1□ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (excrutiating pain)

Status of Pain: □ Improved □ No change □ Worse □ Resolved

Frequency of Pain: □ Daily □ Constant □ Intermittent □ Occasional

Location of Pain: □ Resolved

	R	L	BL
Back	□	□	□
Leg	□	□	□
Buttock	□	□	□
Groin	□	□	□

Other: _____

□ Back Pain = Leg Pain
□ Back Pain > Leg Pain
□ Back Pain < Leg Pain
□ Back Pain Only
□ Leg Pain Only

Radiation of Pain: □ None

	R	L	BL
Buttock	□	□	□
Back of Thigh	□	□	□
Outside Thigh	□	□	□
Front of Thigh	□	□	□
Back of Calf	□	□	□
Outside Calf	□	□	□
Inside Calf	□	□	□
Ankle	□	□	□
Top of Foot	□	□	□
Bottom of Foot	□	□	□
Outside Foot	□	□	□
Big Toe	□	□	□

□ Other _____

Weakness: □ None

	R	L	BL
Hip	□	□	□
Leg	□	□	□
Knee	□	□	□
Foot	□	□	□
Ankle	□	□	□

□ Other _____

Numbness/Tingling: □ None

	R	L	BL
Buttock	□	□	□
Back of Thigh	□	□	□
Outside Thigh	□	□	□
Front of Thigh	□	□	□
Back of Calf	□	□	□
Outside Calf	□	□	□
Inside Calf	□	□	□
Ankle	□	□	□
Top of Foot	□	□	□
Bottom of Foot	□	□	□
Outside Foot	□	□	□
Big Toe	□	□	□

□ Other _____

Quality of Pain:
□ Severe
□ Aching
□ Shooting
□ Dull
□ Resolved
□ Other _____

Aggravated By: □ None
□ Bending
□ Changing Positions
□ Lifting
□ Sitting
□ Driving
□ Walking
□ Standing
□ Other: _____
□ End of Day
□ Mornings
□ All Activities

Relieved By: □ None
□ Changing Positions
□ Sitting
□ Laying Down
□ Standing
□ Heat
□ Exercise
□ Medication: _____
□ Rest
□ Stretching
□ Other: _____

Associated Symptoms / Pertinent Negatives: □ All No
□ Balance Disturbances
□ Bladder Incontinence
□ Bowel Incontinence
□ Spasms
□ Gait Disturbances
□ Weakness
□ Change in Handwriting
□ Other: _____

Symptoms Improved With:
□ PT □ Time
□ Injections □ Meds
□ **Other:** _____

Symptoms Failed to Improve With:
□ PT □ Time
□ Injections □ Meds
□ **Other:** _____

Other/Notes: _____

_____

OVER

REVIEW OF SYSTEMS

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

Cardiovascular:
- ☐ Chest Pain
- ☐ Cyanosis (blue coloration of skin)
- ☐ Irregular Heartbeats/Palpatations

Integumetary/Skin:
- ☐ Rash

Metabolic/Endocrine:
- ☐ Cold Intolerant
- ☐ Heat Intolerant

HEENT:
- ☐ Headache
- ☐ Vision Loss

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Neurological:
- ☐ Difficulty Walking
- ☐ Dizziness

Hematologic/Blood:
- ☐ Bleeding

Respitory:
- ☐ Cough
- ☐ Dyspnea

Genitourinary:
- ☐ Dysuria
- ☐ Hematuria

Immunological:
- ☐ Enviromental Allergies
- ☐ Food Allergies

☐ **None**

PATIENT'S MEDICAL CONDITION

Height: ___ft **___**in **Weight:** _____lbs **Blood Pressure:**_____/_____ **List details of any diet program:**_____

My Weight in the last 6 months has: ☐ Not Changed ☐ Increased _____lbs. ☐ Decreased _____lbs.

PATIENT'S MEDICAL HISTORY

(Please check all that apply)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimers
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benigin Prostatic Hyertrophy
- ☐ Cancer
- ☐ Cerebrovascular Accident (Stroke)
- ☐ Congestive Heart Failure (CHF)
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Degenerative Joint Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ DVT (Blood Clot)
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Bowel Disease
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyme Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Peptic Ulcer Disease
- ☐ Psoriasis
- ☐ PVD
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ SLE (Lupus)
- ☐ Spinal Stenosis
- ☐ Thyroid Disease
- ☐ Valvular Disease (Heart valve problems)
- ☐ Other: _____
- ☐ **None**

PATIENT'S SURGICAL HISTORY

(Please check all that apply)

- ☐ ACL Surgery
- ☐ Angioplasty
- ☐ Angio w/stent
- ☐ Appendectomy
- ☐ Athroscopy (Scope) Details: _____
- ☐ Back Surgery - Details: _____ _____
- ☐ CABG
- ☐ Cardiac (Heart) Valve Replacement
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Cholecystectomy (gallbladder removal)
- ☐ Colectomy
- ☐ Colostomy
- ☐ Discectomy
- ☐ Gastric Bypass _____
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Laminectomy
- ☐ LASIK
- ☐ Meniscus Surgery
- ☐ Muscle Biopsy
- ☐ Neck Surgery - Details: _____ _____
- ☐ ORIF
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy

Gender Specific

Female
- ☐ Cesarean Section
- ☐ Hysterectomy
- ☐ Mastectomy

Male
- ☐ Prostatectomy
- ☐ TURP
- ☐ Other: _____
- ☐ **None**

PATIENT'S FAMILY HISTORY

Is your Father Living? ☐ Yes ☐ No If no, age deceased _____ cause of death _____

Is your Mother Living? ☐ Yes ☐ No If no, age deceased _____ cause of death _____

Are any of your siblings deceased? ☐ Yes ☐ No If yes: ☐Brother ☐Sister age deceased _____ cause of death _____

Family history of chronic/inherited diseases: _____

PATIENT'S SOCIAL HISTORY

Tobacco Use: ☐Yes ☐No ☐Former/Year Quit _____ **Consume Alcohol**: ☐Yes ☐No ☐Former/Year Quit _____

History of Substance Abuse: ☐Yes ☐No **Age Started:** _____ **Drug Type(s):** _____ _____

Activity Level: ☐Sedentary ☐Moderate ☐Vigorous **Type of Exercise**: _____ _____

SIGNATURE

Date: _____ **Signature of Patient, Parent or Guardian:** _____