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?**

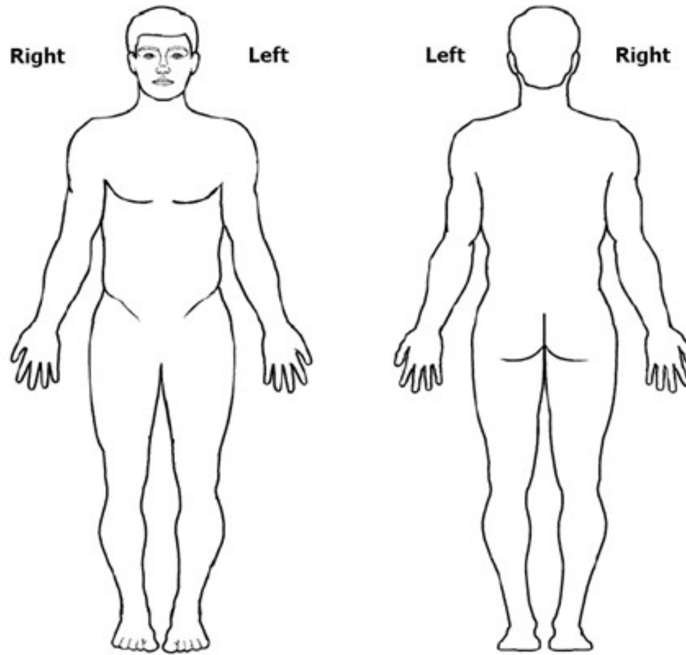
   ☐ **Yes** ☐ **No If yes, please describe:** ____

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
^^^^^	=======	ooooooo	xxxxxxx	//////////	………

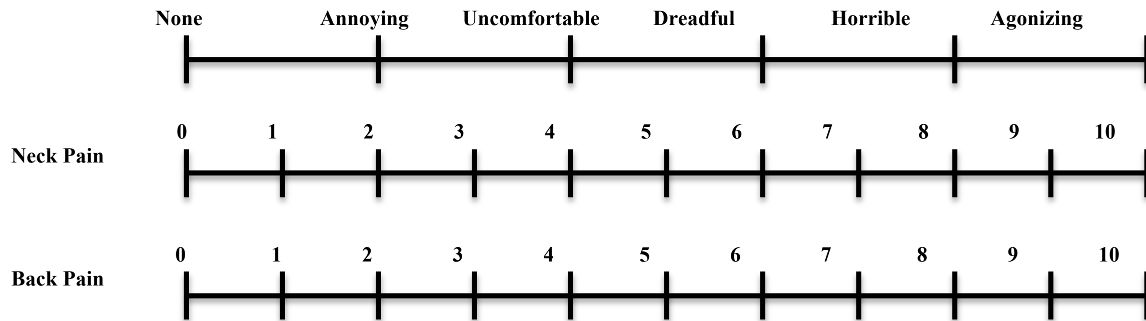


Pain in arm(s) compared with neck________worse__________same__________less

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.