BRIGHAM HEALTH
BRIGHAM AND WOMEN'S HOSPITAL

BRIGHAM HEALTH
BRIGHAM AND WOMEN'S Faulkner Hospital

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DEPARTMENT OF NEUROSURGERY

Spine Center

New Patient Intake Form

Today's date: _____ Date of birth: _____

Your name: _____ Email address: _____

CHIEF COMPLAINT (CHECK ALL THAT APPLY):

☐ Neck Pain	☐ Pain	☐ Weakness	☐ Numbness / Tingling / Burning
☐ Back Pain	☐ Pain	☐ Weakness	☐ Numbness / Tingling / Burning
☐ Arm Pain:	☐ Pain	☐ Weakness	☐ Numbness / Tingling / Burning
☐ Leg Pain:	☐ Pain	☐ Weakness	☐ Numbness / Tingling / Burning

☐ Spinal Deformity (Scoliosis, Kyphosis, Flatback Syndrome, etc.)

☐ Other_____

DESCRIBE YOUR PAIN:

Has your pain been:

Improving ☐

Worsening ☐

Staying the same ☐

Have you had pain like this before? ☐ Yes ☐ No

How long have you had your current pain? _____

Please describe each type of pain that you experience:

Achy ☐ Yes ☐ No

Stabbing ☐ Yes ☐ No

Burning ☐ Yes ☐ No

Numbness/Tingling ☐ Yes ☐ No

Please rate your pain below:

Current Overall Pain / Discomfort (1-10, 10 being Severe):

1 2 3 4 5 6 7 8 9 10

Pain/Discomfort at its worst (1-10, 10 being Severe):

1 2 3 4 5 6 7 8 9 10

How long can you sit? _____

How long can you stand? _____

How long can you walk? _____

Do you have weakness in arm(s)? ☐ Yes ☐ No

Do you have weakness in leg(s)? ☐ Yes ☐ No

WHICH TREATMENTS HAVE YOU TRIED FOR THIS CONDITION?

			Length/Time of Treatments
Acupuncture	☐ Yes ☐ No	Was it helpful? ☐ Yes ☐ No	_____
Chiropractic	☐ Yes ☐ No	Was it helpful? ☐ Yes ☐ No	_____
Physical Therapy	☐ Yes ☐ No	Was it helpful? ☐ Yes ☐ No	_____
Other alternative therapy?	☐ Yes ☐ No	Was it helpful? ☐ Yes ☐ No	_____

Which therapies and when? _____

Spine Injections? ☐ Yes ☐ No Was it helpful? ☐ Yes ☐ No How many injections? _____

Which area of the body and when? _____

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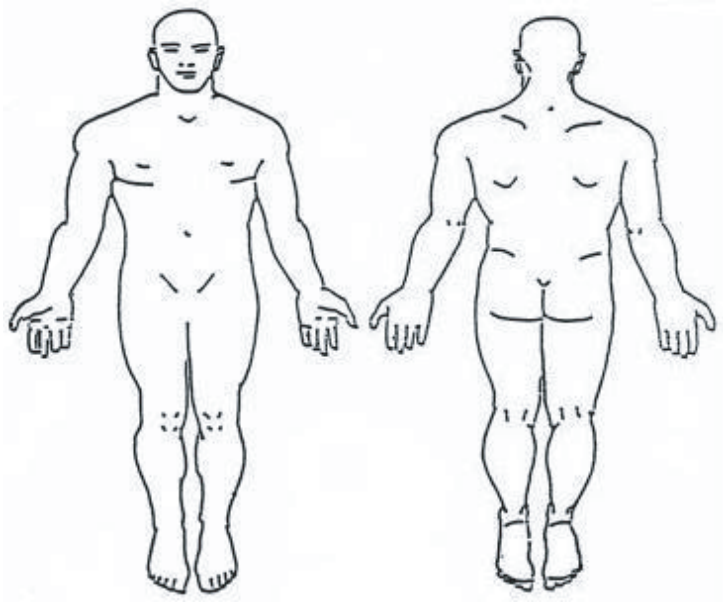
PAIN DIAGRAM:

Using the appropriate symbol, draw on the body diagram ***areas of stabbing or shooting pain with an X***, ***areas of burning pain with a +***, *and* ***areas of numbness with an O*:**

Key
Stabbing/Shooting: X
Burning: +
Numbness: O



PAST SPINE SURGICAL HISTORY:

Please list all surgeries and please bring operative reports of any spine surgeries to your appointment:

Type of surgery/ side Date

PAIN MEDICATIONS:

*Please list **all** of your **current medications**, including over the counter medications:*

Name Dosage Number of times daily

Are you currently taking any blood thinners? ☐ Yes ☐ No
(Coumadin/Warfarin, Plavix, Aspirin, Eliquis, Xarelto, Ticagrelor, etc.
If YES, Please list: _____

ALLERGIES:

Please list all known allergies and your reaction to them, particularly medications and latex:

Allergy Reaction

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REVIEW OF SYSTEMS (please check all that apply):

Constitutional
☐ Unexpected weight loss (more than 10 pounds in past six months)
☐ Fatigue/ tired all over
☐ Fever, chills, or sweats

Eyes
☐ Blurred or double vision

Ears, nose, mouth, throat
☐ Difficulty swallowing
☐ Difficulty hearing

Cardiovascular
☐ Chest pain
☐ Palpitations/ fast heart rate

Gastrointestinal
☐ Nausea or vomiting
☐ Diarrhea
☐ Heartburn

Genitourinary
☐ Frequent or hesitant urination
☐ Bladder accidents / incontinence
☐ Pain with urination
☐ Blood in urine

Respiratory
☐ Wheezing
☐ Shortness of breath

Psychiatric
☐ Anxiety
☐ Depression

Hematological
☐ Too much bruising / bleeding

Musculoskeletal
☐ Back pain
☐ Joint pain / swelling

Neurological
☐ Headaches
☐ Weakness
☐ Numbness
☐ Fainting spells
☐ Dizziness / vertigo

Endocrine
☐ Excessive urination
☐ Excessive thirst

EMPLOYMENT:

Are you currently working? ☐ Yes ☐ No If YES, occupation/title?_____

Is this a work-related injury? ☐ Yes ☐ No
If YES, When did it occur? _____

Are you currently on disability? ☐ Yes ☐ No
If YES, is there a current or upcoming litigation (lawsuit)? ☐Yes ☐ No
Is there a current or upcoming workers' compensation hearing? ☐Yes ☐ No

SOCIAL HISTORY:

☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Do you smoke? ☐ Never ☐ Yes / how much daily: _____ ☐ Former / date quit:_____

Do you drink more than *two* alcoholic beverages on a *daily* basis? ☐Yes ☐ No
Do you use any recreational drugs not prescribed by a doctor? ☐Yes ☐ No

HEALTH CARE PROXY:

Do you have a current Health Care Proxy? ☐ Yes ☐ No

If YES, name of proxy:_____

If no, and you would like more information, please see our front desk staff.

The information on this form is accurate to the best of my knowledge. I understand this form will become part of my medical record:

Patient Signature: _____ Date Completed: _____