BioSpine Institute

NEW PATIENT PAPERWORK

First Name:

Last Name:

Preferred Name:

Date of Birth: / / SSN:
Month Day Year

Email: Occupation:

I am: ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

When did your pain begin? / / Is this Date: ☐ Exact ☐ Approximate
Month Day Year

Is this visit related to a:

☐ Motor Vehicle Accident ☐ Sports or Recreation
☐ Fall ☐ Job Related
☐ Lifting ☐ Other

Date of Accident? / /
Month Day Year

If involved in a motor vehicle accident, please select your position:

☐ Driver ☐ Front Seat Passenger
☐ Rear Passenger (driver's side) ☐ Rear Passenger (front seat passenger side)
☐ Pedestrian

If involved in a MVA or fall, is there an open legal case?

☐ Yes
☐ No

Briefly explain what led to your condition. Include current and prior accidents.
(If involved in a motor vehicle accident, explain how the vehicle was hit and on what side; if you were a pedestrian, explain what happened)

Have you had any other accidents? If yes, please list all prior accidents.

☐ Yes
☐ No

Is this a Workman's Compensation approved visit?

☐ Yes
☐ No

If yes, briefly explain the circumstances that led to your condition:

Your Area of Pain

Please select the areas where you have a complaint. Please select all that apply. We will then ask for specific details on each area

☐ Neck Pain ☐ Lower Back

Neck Pain

Please answer the following questions specifically as they relate to your neck pain.

Radiating pain related to neck pain.

- ☐ Left Arm
- ☐ Right Arm

Left arm pain related to neck pain.

- ☐ Shoulder
- ☐ Fingers
- ☐ Elbow
- ☐ Biceps
- ☐ Hand

Right arm pain related to neck pain.

- ☐ Shoulder
- ☐ Fingers
- ☐ Elbow
- ☐ Biceps
- ☐ Hand

Quality of Neck Pain

- ☐ Ache
- ☐ Burn
- ☐ Deep
- ☐ Diffuse
- ☐ Discomforting
- ☐ Dull
- ☐ Localized
- ☐ Numbness
- ☐ Piercing
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Superficial
- ☐ Throbbing

Frequency of neck pain

- ☐ Occasional
- ☐ Persistent
- ☐ Rare

Overall, since the onset of the neck pain the status is:

- ☐ Improving
- ☐ Stable
- ☐ Worse

Level of neck pain (1 is for minor pain & 10 is for excruciating pain)

	1	2	3	4	5	6	7	8	9	10
What is your pain level **today**?	○	○	○	○	○	○	○	○	○	○
How **high** does your pain go?	○	○	○	○	○	○	○	○	○	○
How **low** does your pain go?	○	○	○	○	○	○	○	○	○	○

What aggravates the neck pain?

- ☐ No Specific Activity
- ☐ Ascending Stairs
- ☐ Bending
- ☐ Bending Backward
- ☐ Bending Forward
- ☐ Changing Positions
- ☐ Coughing
- ☐ Daily Activity
- ☐ Defecation
- ☐ Descending Stairs
- ☐ Jumping
- ☐ Lifting
- ☐ Lying/Resting
- ☐ Pushing
- ☐ Rolling Over in Bed
- ☐ Running
- ☐ Sitting
- ☐ Sneezing
- ☐ Standing
- ☐ Twisting
- ☐ Walking

What makes the neck pain better?

- ☐ No Specific Activity
- ☐ Bending Forward
- ☐ Bending Side-to-Side
- ☐ Brace or Splint
- ☐ Exercise
- ☐ Heat
- ☐ Ice
- ☐ Injection
- ☐ Lying Down
- ☐ Massage
- ☐ Movement
- ☐ Over the Counter Medication
- ☐ Pain Medication
- ☐ Physical Therapy
- ☐ Rest
- ☐ Rotation
- ☐ Sitting
- ☐ Standing
- ☐ Stretching
- ☐ Twisting
- ☐ Walking

Do you have weakness due to neck pain?

☐ Yes ☐ No

Where is the Weakness?

Do you have numbness due to neck pain?

☐ Yes ☐ No

Where is the Numbness?

Do you have tingling due to neck pain?

☐ Yes ☐ No

Where is the Tingling?

Neck Pain (Cont.)

Do you have difficulty sleeping due to the neck pain?

- ☐ Never
- ☐ Occasionally
- ☐ Frequently

Has your neck pain caused difficulty with?

- ☐ Bowel
- ☐ Bladder
- ☐ Sexual Function

Do you have difficulty walking related to your neck pain?

☐ Yes ☐ NO

If yes, how far can you walk before you experience pain and discomfort?

Is walking difficulty related to this condition?

☐ Yes ☐ NO

If no, explain what condition your walking difficulty is related to.

What treatments have you already received for your Neck pain?

☐ Prescription Medications ☐ Epidural Injections ☐ Chiropractic Care ☐ Physical Therapy ☐ Pain Management

Medications

What prescription medication(s) have/ are you been taking for your neck pain?

How long did you or have you been taking medication(s) related to neck pain?

Start:____/____ (month year) ☐ Ongoing

End:____/____ (month year)

Select degree of relief

- ☐ Minimal
- ☐ Moderate
- ☐ Significant

Epidural Injections

What injection facility(ities)?

How many injection(s) related to the neck pain?

Select degree of relief

- ☐ Minimal
- ☐ Moderate
- ☐ Significant

Chiropractic Care

What chiropractic facility(ities)?

How long did you receive your chiropractic care related to the neck pain?

Start:____/____ (month year) ☐ Ongoing

End:____/____ (month year)

Select degree of relief

- ☐ Minimal
- ☐ Moderate
- ☐ Significant

Physical Therapy

What physical therapy facility(ities)?

How long did you receive your physical therapy related to the neck pain?

Start:____/____ (month year) ☐ Ongoing

End:____/____ (month year)

Select degree of relief

- ☐ Minimal
- ☐ Moderate
- ☐ Significant

Pain Management

What pain management facility(ities)?

How long did you receive your pain management related to the neck pain?

Start:____/____ (month year) ☐ Ongoing

End:____/____ (month year)

Select degree of relief

- ☐ Minimal
- ☐ Moderate
- ☐ Significant

Lower Back Pain

Please answer the following questions specifically as they relate to your lower back pain.

Radiating pain due to lower back pain.

- ☐ Left Leg
- ☐ Right Leg

Left leg pain related to lower back pain.

- ☐ Thigh
- ☐ Calf
- ☐ Ankle
- ☐ Foot
- ☐ Toes

Right leg pain related to lower back pain.

- ☐ Thigh
- ☐ Calf
- ☐ Ankle
- ☐ Foot
- ☐ Toes

Quality of your lower back pain?

- ☐ Ache
- ☐ Burn
- ☐ Deep
- ☐ Sharp
- ☐ Superficial
- ☐ Diffuse
- ☐ Discomforting
- ☐ Dull
- ☐ Shooting
- ☐ Throbbing
- ☐ Localized
- ☐ Numbness
- ☐ Piercing
- ☐ Stabbing

Level of lower back pain
(1 is for minor pain & 10 is for excruciating pain)

	1	2	3	4	5	6	7	8	9	10
What is your pain level **today**?	○	○	○	○	○	○	○	○	○	○
How **high** does your pain go?	○	○	○	○	○	○	○	○	○	○
How **low** does your pain go?	○	○	○	○	○	○	○	○	○	○

Frequency of lower back pain

- ☐ Occasional
- ☐ Persistent
- ☐ Rare

Overall, since the onset of the lower back pain status is:

- ☐ Improving
- ☐ Stable
- ☐ Worse

What aggravates the lower back pain?

- ☐ No Specific Activity
- ☐ Ascending Stairs
- ☐ Bending
- ☐ Bending Backward
- ☐ Bending Forward
- ☐ Changing Positions
- ☐ Coughing
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- ☐ Pushing
- ☐ Rolling Over in Bed
- ☐ Running
- ☐ Sitting
- ☐ Sneezing
- ☐ Standing
- ☐ Twisting
- ☐ Walking

What makes the lower back pain better?

- ☐ No Specific Activity
- ☐ Bending Foward
- ☐ Bending Side-to-Side
- ☐ Brace or Splint
- ☐ Exercise
- ☐ Heat
- ☐ Ice
- ☐ Injection
- ☐ Lying Down
- ☐ Massage
- ☐ Movement
- ☐ Over the Counter Medications
- ☐ Pain Medication
- ☐ Physical Therapy
- ☐ Rest
- ☐ Rotation
- ☐ Sitting
- ☐ Standing
- ☐ Stretching
- ☐ Twisting
- ☐ Walking

Do you have weakness due to lower back pain?

☐ Yes ☐ NO

Where is the Weakness?

Do you have numbness due to lower back pain?

☐ Yes ☐ NO

Where is the Numbness?

Do you have tingling due to lower back pain?

☐ Yes ☐ NO

Where is the Tingling?

Lower Back Pain (Cont.)

Do you have difficulty sleeping due to lower back pain?

- ☐ Never
- ☐ Occasionally
- ☐ Frequently

Has your lower back pain caused difficulty with?

- ☐ Bowel
- ☐ Bladder
- ☐ Sexual Function

Do you have difficulty walking?

☐ Yes ☐ NO

If yes, how far can you walk before you experience pain and discomfort?

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If no, explain what condition your walking difficulty is related to.

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Medications

What prescription medication(s) have/ are you been taking for your lower back pain?

How long did you or have you been taking medication(s) for lower back pain?

Start: ____/____ (month year) ☐ Ongoing

End: ____/____ (month year)

Select degree of relief

- ☐ Minimal
- ☐ Moderate
- ☐ Significant

Epidural Injections

What injection facility(ities)?

How many injection(s) related to the lower back pain?

Select degree of relief

- ☐ Minimal
- ☐ Moderate
- ☐ Significant

Chiropractic Care

What chiropractic facility(ities)?

How long did you receive your chiropractic care related to the lower back pain?

Start: ____/____ (month year) ☐ Ongoing

End: ____/____ (month year)

Select degree of relief

- ☐ Minimal
- ☐ Moderate
- ☐ Significant

Physical Therapy

What physical therapy facility(ities)?

How long did you receive your physical therapy related to the lower back pain?

Start: ____/____ (month year) ☐ Ongoing

End: ____/____ (month year)

Select degree of relief

- ☐ Minimal
- ☐ Moderate
- ☐ Significant

Pain Management

What pain management facility(ities)?

How long did you receive your pain management related to the lower back pain?

Start: ____/____ (month year) ☐ Ongoing

End: ____/____ (month year)

Select degree of relief

- ☐ Minimal
- ☐ Moderate
- ☐ Significant

Medical History

If applicable, please list PREVIOUS NECK & BACK SURGERIES (please include date, location and procedure):

If applicable, please list previous surgeries NOT RELATED to the neck and back (please include date, location and procedure):

Are you currently taking any medications?

☐ Yes ☐ No

VERY IMPORTANT Please include dosage (mg, mcg, etc.) and how often you take it.

Do you have allergies?

☐ Yes ☐ No

Please list all allergies:

Do you have a history of any of these medical conditions?

☐ Alzheimer's Disease	☐ Coronary Artery Disease	☐ Fibromyalgia	☐ Heart Attack	☐ Sleep Apnea
☐ Anemia	☐ Crohn's Disease	☐ Fracture	☐ Obesity	☐ Spinal Stenosis
☐ Angina	☐ Deep Venous Thrombosis	☐ Gout	☐ Osteoporosis	☐ Spondyloarthropathy
☐ Arthritis	☐ Degenerative Joint Disease	☐ Headache, Migraine	☐ Peptic Ulcer Disease	☐ Stroke
☐ Asthma	☐ Depression	☐ Hepatitis/Liver Disease	☐ Psoriasis	☐ Systemic Lupus Erythematosus
☐ Cancer	☐ Diabetes	☐ High Blood Pressure	☐ Renal Disease	☐ Thyroid Disease
☐ Congestive Heart Failure	☐ Drug Abuse	☐ Inflammatory Bowel Disease	☐ Scoliosis	☐ Valvular Disease
☐ COPD	☐ Elevated Lipids	☐ Lyme Disease	☐ Seizure Disorder	
☐ Other				

If checked, what type of diabetes do you have?

☐ Type1 ☐ Gestational
☐ Type2 ☐ Mellitus

How do you control your Diabetes?

☐ Insulin
☐ Medication
☐ Diet Only

If checked, what type of cancer do either you and/or your family member have?

Do you have a family history of any of these medical conditions?

☐ ADD/ADHD	☐ CAD	☐ Depression	☐ High Blood Pressure	☐ Osteoarthritis
☐ Alcoholism	☐ CAD-Premature	☐ Developmental Delay	☐ Kidney Disease	☐ Osteoporosis
☐ Allergies	☐ Cancer	☐ Diabetes	☐ Learning Disability	☐ Parkinson's
☐ Alzheimer's Disease	☐ Colitis	☐ Drug Abuse	☐ Liver Disease	☐ PVD
☐ Anemia	☐ Congenital Heart Disease	☐ Gout	☐ Mental Illness	☐ Renal Disease
☐ Asthma	☐ Congestive Heart Failure	☐ Hearing Impairment	☐ Migraines	☐ Seizure Disorder
☐ Blood Disease	☐ COPD	☐ Heart Disease	☐ Muscle Disease	☐ Thyroid Disorder
☐ CA Bone	☐ CVA (Stroke)	☐ Hodgkin's Disease	☐ Obesity	☐ No Relevant Family History
☐ Adopted - No Family History Known		☐ Other		

Have you *ever* used nicotine products?

☐ Yes ☐ No

If yes, which ones?

☐ Cigarettes ☐ Cigarillo
☐ Cigar ☐ Pipe
☐ Chewing ☐ Smokeless
☐ Snuff

If yes, what age did you start?

If yes, which age did you quit?

Do you *currently* use nicotine products?

☐ Yes ☐ No

If yes, which ones?

☐ Cigarettes ☐ Cigarillo
☐ Cigar ☐ Pipe
☐ Chewing ☐ Smokeless
☐ Snuff

How many per day?

How many years have used nicotine?

Are you aware nicotine usage decreases the body's ability to heal after surgery?

☐ Yes ☐ No ☐ I am now

Do you consume alcohol?

☐ Yes ☐ No

If yes, which ones? Check all that apply

☐ **Beer** ☐ **Rum**
☐ **Liquor** ☐ **Scotch**
☐ **Wine** ☐ **Vodka**
☐ Gin ☐ Whiskey
☐ Hard Liquor

If yes, how frequently

☐ Daily ☐ Yearly
☐ Weekly ☐ Socially
☐ Rarely ☐ Occasionally
☐ Monthly

If yes, when was your *last* alcohol consumption?

If yes, what is the amount of alcohol consumption?

☐ Cups ☐ Oz

Do you consume caffeine?

☐ Yes ☐ No

If yes, which ones? Check all that apply

☐ Coffee ☐ Soda
☐ Tea ☐ Tablets
☐ Chocolate ☐ Energy Drinks

If yes, how much do you consume per day?

☐ Cups ☐ Oz

Do you exercise regularly?

☐ Yes ☐ No

If yes, how often?

How does your condition affect the activities of your daily living?

What is your current work status?

☐ Full Time
☐ Part Time
☐ Not Working

Is your condition impacting your work life?

☐ Yes
☐ No

If yes, how does your condition impact your work life?

Review of Systems

Consitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise *(general weakness)*
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Head, Ears, Eyes, Nose & Throat
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Dysphagia *(difficulty/ discomfort swallowing)*
- ☐ Ear Drainage
- ☐ Facial Pain
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Nasal Congestion
- ☐ Ringing in Ears
- ☐ Vertigo
- ☐ Vision Loss

Respiratory
- ☐ Asthma
- ☐ Chest Pain
- ☐ Cough
- ☐ Dyspnea *(shortness of breath)*
- ☐ Known TB Exposure
- ☐ Recent Infection
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Cyanosis *(bluish discoloration in skin)*
- ☐ Heart Murmur
- ☐ Leg Swelling
- ☐ Syncope (fainting)
- ☐ Irregular Heartbeat/ Palpitations

Immunological
- ☐ Bee Sting Allergies
- ☐ Contact Allergy
- ☐ Contact Dermatitis
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Black Tarry Stools
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Jaundice
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Dysuria *(painful or difficult urination)*
- ☐ Frequent Urination
- ☐ Hematuria *(blood in urine)*
- ☐ Urge Incontinence
- ☐ Urinary Incontinence

Metabolic/ Endocrine
- ☐ Cold Intolerant
- ☐ Hair Loss
- ☐ Heat Intolerant

Neurological
- ☐ Difficulty Walking
- ☐ Dizziness
- ☐ Poor Coordination
- ☐ Memory Impairment
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Paresthesia *(pins & needles)*
- ☐ Seizures
- ☐ Tremors

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Integumentary
- ☐ Itchy Skin
- ☐ Rash
- ☐ Skin Infections
- ☐ Skin Lesion

Hematologic
- ☐ Bleeding
- ☐ Bruising

Your Current Medical Providers

Do you have a:

- ☐ Primary Care Physician
- ☐ Pain Management Physician
- ☐ Cardiologist

Primary Care Physician: First Name _____ Last Name _____

Primary Care Physican Ph#: Area Code _____ Phone Number _____

Pain Management Doctor: First Name _____ Last Name _____

Pain Management Doctor Ph#: Area Code _____ Phone Number _____

Cardiologist: First Name _____ Last Name _____

Cardiologist Ph #: Area Code _____ Phone Number _____

Preferred Pharmacy: _____

Preferred Pharmacy Ph#: Area Code _____ Phone Number _____

Demographic Information

Note: We are not trying to be nosy. The government requires us to collect this information, but if you feel uncomfortable disclosing the requested information, please select the "Decline to Specify" check box

Race

- ☐ Decline to Specify
- ☐ Alaskan Native
- ☐ American Indian or Alaska Native
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Black / African American (Not Hispanic)
- ☐ Greek
- ☐ Hawaiian
- ☐ Hispanic
- ☐ Hispanic or Latino (All Races)
- ☐ Indian
- ☐ Multi-racial
- ☐ Multiracial
- ☐ Native American Indian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Pacific Islander (Not Hawaiian)
- ☐ Pacific Islander
- ☐ White
- ☐ White (Not Hispanic/Latino)

Ethnicity

- ☐ Decline to Specify
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Language

- ☐ Decline to Specify
- ☐ Arabic
- ☐ Bulgarian
- ☐ Central Khmer
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ German
- ☐ Hatian: Hatian Creole
- ☐ Hebrew
- ☐ Hindi
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Somali
- ☐ Spanish: Castilian
- ☐ Swahili
- ☐ Thai
- ☐ Urdu
- ☐ Vietnamese