Interventional Spine & Pain Rehab Center, ltd

Mansfield Shelby Columbus

165 N. Trimble Rd., Mansfield, OH 44906

New Patient Intake Questionnaire

Feel free to attach any List(s)

Name:________________________________Date of Birth____/____/___

Reason for Visit:____

Where does it Hurt?____

When did it first start?____

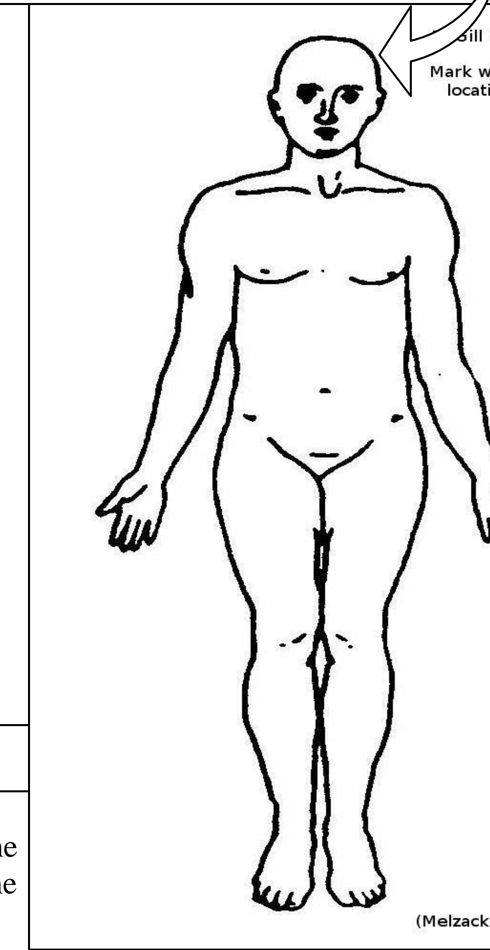
What makes it better?__________________worse?___________________

Were you in the ER for this Problem? _____When and here______________

What has been done so far?_____________________________________

Have you had → Physcial Therapy Injections MRI/Cat Scan EMG

In the Diagram Below
Shade in any Area (s) of pain, tingling, burning or other sensations



Please Circle any known Past Medical Conditions

Diabetes High-Blood-Pressure Angina Thyroid-Disease Asthma
Depression/Anxiety Bipolar Disorder Sleep-Apnea Cancer OxygenUse
High Cholesterol/ High Lipds Stroke Pacer-Maker Insertion COPD
Dependence-on-Habit-Forming-Drugs

Other Not Listed:____

Have your sleep or job been effected?______________________________
For when and for what your last Hospital Admission?___________________

____

What Are Your Allergies?__________Allergy-Related Hospital Admissions?________

Past Surgical History

Spinal Surgery? __________when?_________Are you Better, Worse or the Same
Head or Neck Surgery?____ when?_________Are you Better, Worse or the Same

Joint or other Surgeries?_________________ Are you Better, Worse or the Same

Heart, Lung or Abd/Pelvic Surgery,____________________________________

What Medications do you take on a Regular Basis? Attach separate sheet if necessary

____

____

Include use of any other over-the-counter medications or Herbal Remedies

System Review: Circle All that Apply

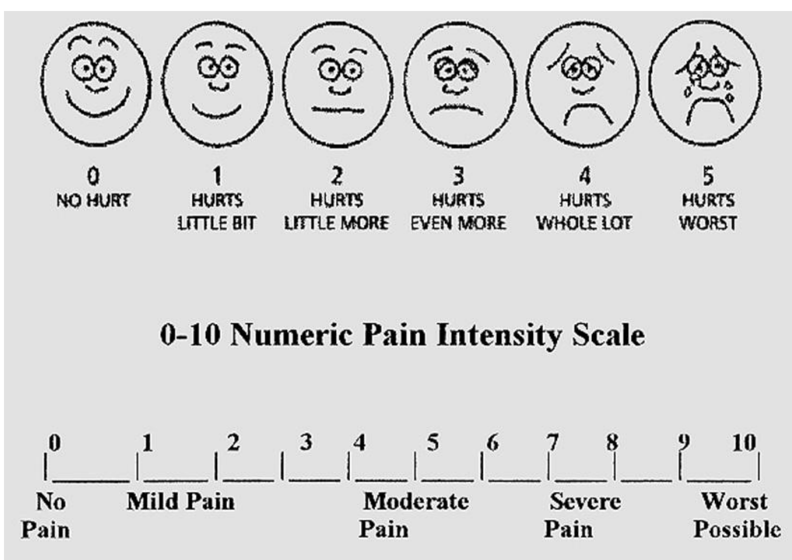
Weight loss/Gain, Fatigue, Poor Sleep, Fever Chills, Night Sweats, Leg Swelling
Chest Pain, Coughing, Snoring, Shortness of Breath, Dental Issues, Frequent Urination
Stomach pain, Dark Stools, Nausea, Vomiting, Constipation, Heart Burn, Rapid Heart Beat
Double/Blurry Vision, Loss of Vision, Headache, HeadPain, New Lumps/Bumps
Numbness, Weakness, Burning, Balance Trouble, Vertigo, Tremor, Leg Buckling
Anxiety, Depression, Memory Trouble, Confusion, Difficulty Swallowing, Easy Bruising
Joint Pain, Muscle Pain, Joint Swelling, Joint Redness, Hair Loss, Skin Eruptions

Do You Smoke?__________Packs per day?_____ Chewing Tabacco or Snuff?
Do you drink Alcohol?___How many drinks per week?_____Prior Drug or Alcohol Treatment?_____
With Whom do you live?_________How many People living in the home?_____________________
Stairs to Enter Your Home?________ How many Floors?___________ Do you feel safe there?_____
Do You Use a? Cane, Walker, Wheelchair, Crutches? How long have you needed them?__________

Are you able to: Bathe/Dress Yourself? **Yes or No** Upper Body? Lower Body? Shoes/Socks?
Go to the Bathroom By Yourself? **Yes or No** Handle Your Affairs **Yes or No**
Drive? **Yes or No** Eat without Assistance **Yes or No**
Complete HouseWork? **Yes or No** Handle Stairs by Yourself? **Yes of No**

Are there any common Medical Conditions in the family?_____________________________________

Mother, living or deceased, at Age____from ______ your Father living or deceased at age_____ from ______
Brother(s)________Health__________. Sister(s)_______Health__________



Check/circle how your pain makes you feel most of the time on the left.

Is there anything else you would like the doctor to know?_____________________

____

X__________________________**Date:**______/_____/**2015** ___________________________

Patient/Guardian Signature **reviewed, M.F. Stretanski, DO**