Alabama Spine and Pain
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NEW PATIENT REGISTRATION FORM

DATE OF VISIT ___/___/____

Please fill this form **COMPLETELY** before your appointment. ☐CP ☐ MRI LS / CS

FIRST	MI	LAST NAME	GENDER ☐MALE ☐ FEMALE / DATE OF BIRTH
STREET ADDRESS			
CITY , STATE & ZIP CODE			
HOME PHONE		CELL PHONE	WORK PHONE
SOCIAL SECURITY NUMBER :			MARITIAL STATUS ☐Single ☐ Married ☐ Divorced ☐ Widow (Er)
EMAIL:			DISABILITY: ☐FULL ☐ PARTIAL
EMPLOYER:			OCCUPATION
WORK ADDRESS:			
RACE: ☐WHITE ☐AFRICAN AMERICAN ☐HISPANIC ☐ASIAN/PACIFIC ISLANDER ☐AMERICAN INDIAN			ETHNIC GROUP: ☐AFRICAN AMERICAN ☐ ASIAN ☐ LATINO/HISPANIC ☐NON HISPANIC

INSURANCE INFORMATION

PRIMARY INSURANCE	POLICY HOLDER	POLICY HOLDER SSN #
PRIMARY INSURANCE HOLDER'S DATE OF BIRTH:		
SECONDARY INSURANCE	POLICY HOLDER	POLICY HOLDER SSN #
SECONDARY INSURANCE HOLDER'S DATE OF BIRTH:		
WORKER'S COMPENSATION BENEFITS ☐ NO ☐YES		IF YES – PLEASE SEE RECEPTIONIST ASAP
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE NUMBER:

OTHER INFORMATION

REFERRING PHYSICIAN'S NAME :		PHONE:
PRIMARY PHYSICIAN'S NAME:		PHONE:
PHARMACY NAME:		PHONE:
HEIGHT:	WEIGHT:	SMOKER: ☐NO ☐ YES

ALLERGIES: ☐None - No Known Drug Allergy

☐Iodine/shellfish ☐Latex ☐ Adhesive Tape ☐X ray Dye or Contrast Media ☐ Lidocaine or Novocain ☐ Steroids
☐Other, Please List :

ARE YOU TAKING **BLOOD THINNERS** : ☐NO ☐ YES If Yes, Name of the Medication:

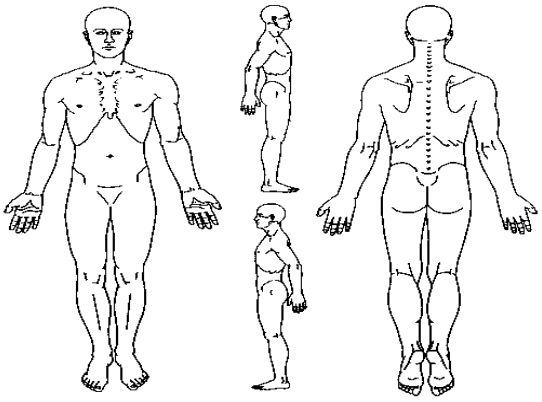
Have you been prescribed a Pain Medication in the past 6 months: ☐NO ☐ YES

Please list name of Medication:

Do you have any PRESENT OR PAST HISTORY OF SUBSTANCE ABUSE OR ADDICTION : ☐NO ☐ YES

PAIN HISTORY

Mark "X" the areas that hurt the most.



Please describe your pain?

- ☐ Constant
- ☐ Intermittent

- ☐ Sharp / Shooting
- ☐ Dull Aching
- ☐ Pins and Needles
- ☐ Numbing
- ☐ Tingling
- ☐ Burning
- ☐ Throbbing
- ☐ Aching

Please list ALL pain medications

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please CIRCLE one number below that best describes your pain:

0 =No pain	**8 = Need to be in the hospital for treatment of SEVERE PAIN**										**10 = Worst pain of your life**
Worst pain in the past 10 days	0	1	2	3	4	5	6	7	**8**	9	10
Least Pain in the past 10 days	0	1	2	3	4	5	6	7	**8**	9	10
Average Pain in the past 10 days	0	1	2	3	4	5	6	7	**8**	9	10
Pain you have **RIGHT NOW**	0	1	2	3	4	5	6	7	**8**	9	10

Please CIRCLE one number below that best describes how pain interferes with the following activity (0=Pain Free)

	Does not Interfere										Completely Interferes
General Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Work at home and outside	0	1	2	3	4	5	6	7	8	9	10
Relationships with other people	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

DURATION: How long have you had the pain _____

PAIN LOCATION: Where do you hurt?

- ☐ Low Back
- ☐ Right Side of Back
- ☐ Left Side of Back
- ☐ Other Area: _____

Neck

- ☐ Right Side of Neck
- ☐ Left Side of Neck
- ☐ Other Area: _____

PAIN RADIATION: Where does pain radiate?

- ☐ Both Legs
- ☐ Right Leg
- ☐ Left Leg
- ☐ Below the Knee
- ☐ Side of the Thigh
- ☐ Top of the Foot
- ☐ Sole of the Foot

- ☐ Both Arms
- ☐ Right Arm
- ☐ Left Arm
- ☐ Shoulder
- ☐ Forearm
- ☐ Fingers

What eases the pain?? _____

What makes the pain worse?? _____

Do you have any: Weakness ☐NO ☐ YES Numbness? ☐NO ☐ YES Loss of bowel or bladder function: ☐NO ☐ YES

I certify that I have tried the following treatments for Pain relief before this visit:

- ☐ Rest and Home Exercises
- ☐ Heat or Ice
- ☐ NSAID medications: Tylenol / Ibuprofen / Aleve / Mobic/ Diclofenac etc.
- ☐ Neurontin / Gabapentin/ Lyrica/ Cymbalta
- ☐ Muscle relaxants: Flexeril / Zanaflex / Robaxin / Baclofen / Skelaxin etc.
- ☐ OPIOID MEDICATIONS
- ☐ TENS unit
- ☐ **Physical Therapy**: ☐NO ☐ YES if yes, Where _____ When _____
- ☐ **Chiropractic / Osteopathic manipulation** ☐NO ☐ YES if yes, Where _____ When _____
- ☐ Surgery_____

DIAGNOSTIC TESTS: Which of the following tests have you had to establish the cause of your pain?

MRI Scan ☐NO ☐ YES Where_____
CT Scan ☐NO ☐ YES Where_____
X-ray ☐NO ☐ YES Where _____
Nerve Conduction ☐NO ☐ YES Where_____

PAST SURGICAL HISTORY (Please check (✓) Surgeries you currently have or have had in the past)

- ☐ Back Surgery - Laminectomy
- ☐ Back Surgery – Rods
- ☐ Back Surgery - Discectomy
- ☐ Neck Surgery_____Fusion
- ☐ Other _____
- ☐ Other _____
- ☐ Knee Surgery
- ☐ Hip Surgery
- ☐ CABG
- ☐ Heart Stents
- ☐ Brain Surgery
- ☐ _____
- ☐ Appendix Surgery
- ☐ Gall Bladder
- ☐ Hysterectomy
- ☐ C - Section
- ☐ Breast Surgery
- ☐ _____

PAST MEDICAL HISTORY (Please check (✓) conditions you currently have or have had in the past)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Attacks
- ☐ Heart Stents / CABG surgery
- ☐ Other Stents in the body, Leg Stents
- ☐ Peripheral Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Problems with heart valves
- ☐ Pacemaker/Automatic Defibrillator
- ☐ Asthma / COPD
- ☐ Sleep Apnea
- ☐ Blood Clots in Legs / DVT
- ☐ Blood Clots in Lung
- ☐ _____
- ☐ Blood transfusion
- ☐ Bleeding Disorder
- ☐ Easy bleeding or bruising
- ☐ Hepatitis A B C
- ☐ HIV Infection/AIDS
- ☐ Liver Disease or Jaundice
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Chronic back problems
- ☐ Scoliosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Joint Pain
- ☐ _____
- ☐ Currently/possible pregnant
- ☐ Abuse (Physical/Sexual/Verbal)
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Blood in Urine or Stool
- ☐ Nausea or Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Anemia
- ☐ Stroke
- ☐ TIA (Transient Ischemic Attack)
- ☐ Epilepsy/seizures
- ☐ Weakness or paralysis
- ☐ History of Polio
- ☐ Cancer – where _____

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	AGE OF DEATH	CAUSE OF DEATH	Circle if you have family history of the following diseases Other:	
Father					Hypertension	Addiction / Chemical Dependency
Mother					Diabetes	Psychiatric conditions
Brother					Heart Disease	Kidney Disease
Sister					Rheumatoid Disorder	Stroke / Bleeding Disorder/ Cancer

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name Signature Date