# 

New Patient Database  
   
 *(\*Please Complete All Questions\*)*



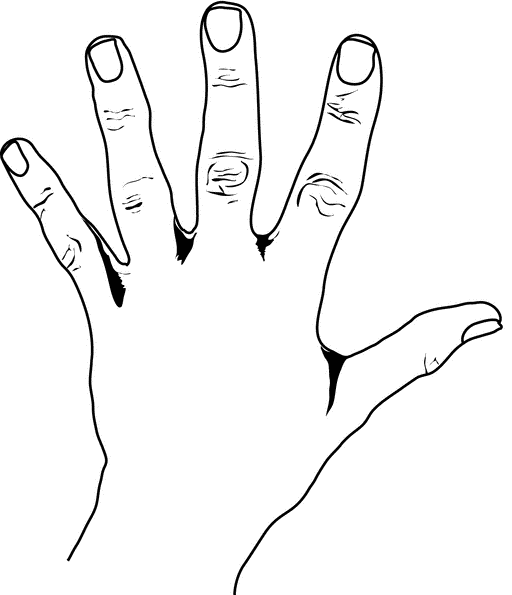
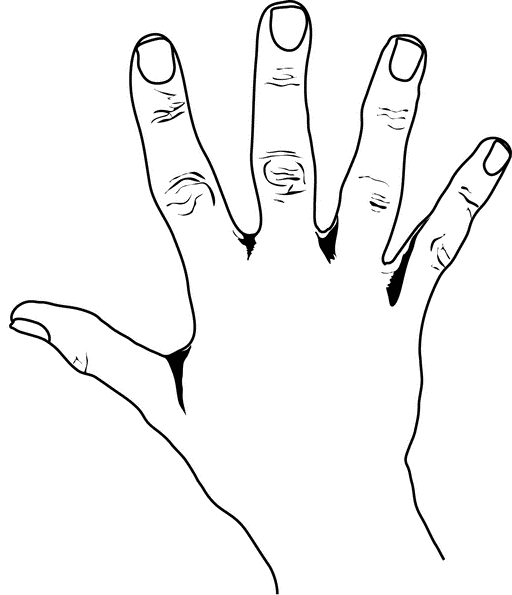
**Patient’s Name: Today’s Date: \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_**

## Part 1. DEMOGRAPHICS

Your *Referring* Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your *Family* Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Birth Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ and Your Age: \_\_\_\_\_\_\_\_\_\_\_

Gender: Male Female **AND** I Am:  Left Handed Right Handed

## Part 2. DESCRIPTION OF SPINE SYMPTOMS

◼ **My** ***major*** **concern(s)** are: (Check all that apply): **\*If you are Experiencing Leg or Arm Please Circle Which One**

Low Back Pain Neck Pain

Leg Pain (Right or Left or Both) Arm Pain (Right or Left or Both)

Leg Numbness/Tingling (Right or Left or Both) Arm Numbness / Tingling (Right or Left or Both)

Leg Weakness (Right or Left or Both) Arm Weakness (Right or Left or Both)

Upper Back Pain Scoliosis (Curved Spine or Spinal Curvature)

Kyphosis (Roundback - Upper Shoulder Area) Difficulty Walking (Prolonged Standing / Distances)

◼ When did your spine problem *First Start – How Long Ag*o? (Approximate Time Frame)

\_\_\_\_\_\_\_\_\_ Days \_\_\_\_\_\_\_\_\_ Months \_\_\_\_\_\_\_\_\_ Years

Please Provide Exact Date, If Known \_\_\_\_\_\_| \_\_\_\_\_\_ | \_\_\_\_\_\_

◼ How was your spine problem first detected / diagnosed?

By a physician / doctor By myself

On a job screening By a family member

On a school screening Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

◼ Does anyone in your family have spine problems?

Yes Relationship(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No

I don’t know

◼ What Things AFFECT Your Symptoms (For Example: Sitting, Standing, Lifting, Bending, Twisting, Walking)

Increase My Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Decrease My Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE:** **Is This Due To A Motor Vehicle Accident or Personal Injury:** **YES or NO**

\* **PLEASE NOTE: “OUR PRACTICE DOES ‘NOT’ DO ANY LEGAL OR PERSONAL TYPE INURY WORK”.** (This Information MUST be disclosed prior to establishing a patient-physician relationship)

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**Medical & Surgical History**

◼ List *ALL* Your **medical Health Problems** (For Example: High blood pressure,

Diabetes, Heart Problems, Lungs, Kidney, Bowel, Bladder, Liver, Spleen, Blood

Conditions, Infectious diseases (e.g. hepatitis), etc.): (\*You may attach written Lists)

#### Medical Problem How Long have you had this?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

◼ List *ALL* ***Surgeries*** that you have had: (\*You may write see attached Lists)

#### Type of Surgery Date(s) of Surgery

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

◼ List *ALL* ***Medications*** you are taking: (\*You may write see attached Lists)

#### Name of Medications Dose How Long have you Taken

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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◼ List *ALL* ***Allergies*** you have**:** Drugs / Medications / Radiographic Dyes / Foods / Seasonal

#### Medication Type of Reaction (e.g. rash, swelling, trouble breathing)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\*IF YOU ARE ALLERGIC to **LATEX** Have You Been Formally Tested ? No Yes

◼ Smoking, e-cigarettes, Vaping or any other tobacco products - Do You **DO ANY OF THESE ?**

1. No I Never Smoked Packs per day # of Years

# 2. \* Cigarettes / Cigars / Pipe: NO YES I Quit \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ 3. \* e-Cigarettes / Vaping: NO YES I Quit \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

# \* (Circle ALL That Apply) \* If You Quit in What Year Did You Quit?: \_\_\_\_\_\_\_\_\_\_\_\_

◼ Do you use **Other Tobacco** products? Chew tobacco Nicotine patch

◼ Do You **Drink**alcoholic beverages? NO YES - About How Much \_\_\_\_\_\_\_\_\_\_\_\_\_ ◼ Have you ever taken any illicit drugs? NO YES

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◼ Have you ***EVER*** received any of the following ***treatment(S) FOR YOUR ‘SPINE’***

**Treatment History**

(Please include dates as best that you can recall them Or Please complete to the best of your ability)

If it Helped What Percent

\***Check** *ALL* When Was It Did It Help You How Long Better Where

that apply (The Month/Year) **Yes** **No** Did It Help You (0-100%)

Bed Rest \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Traction \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Back Exercises \_\_\_\_\_\_\_\_­­\_\_\_\_\_ ­\_\_\_\_ \_\_\_\_

Back School \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Spinal Manipulation \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

(Physician, Chiropractor)

Back Brace \_\_\_\_\_\_\_\_­­\_\_\_\_\_ ­\_\_\_\_ \_\_\_\_

Electrical Stimulation \_\_\_\_\_\_\_\_­­\_\_\_\_\_ ­\_\_\_\_ \_\_\_\_

(TENS, ESO)

Physical Therapy (PT) \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Epidural Steroids (Blocks) \_\_\_\_\_\_\_\_­­\_\_\_\_\_ ­\_\_\_\_ \_\_\_\_

Trigger Point Injections \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Massage Therapy \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Acupuncture \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Oral Steroid Medications \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Steroid Injections \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Nerve Root Blocks \_\_\_\_\_\_\_\_­­\_\_\_\_\_ \_\_\_\_ \_\_\_\_

If you had Physical Therapy (PT):

When was your PT How Long (wks / mos) Where was your PT Done

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WERE YOU EVER IN**: Name of The Program / Center Year(s)

1. Chronic Pain Program\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

\* List the Name of “Current Pain Management Doctor”: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Work Hardening Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

3. Vocational Rehab Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

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**Diagnostic History**

◼ Have you ever had any of the following ***diagnostic tests*** for your ***Spine***:

(\*PLEASE INDICATED ALL THAT APPLY\*)

##### TEST YES NO DATE(s) LOCATION THEY WERE DONE

X-Rays \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CT Scan \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRI \* \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \***Without** Contrast / **With** Contrast / Both \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* (Please Circle ALL That Apply)

Bone Scan \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
 \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Myelogram \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
 \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discogram \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
 \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
EMG \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
   
 \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone Density \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Tests \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### 

Please List Any Additional Test Here : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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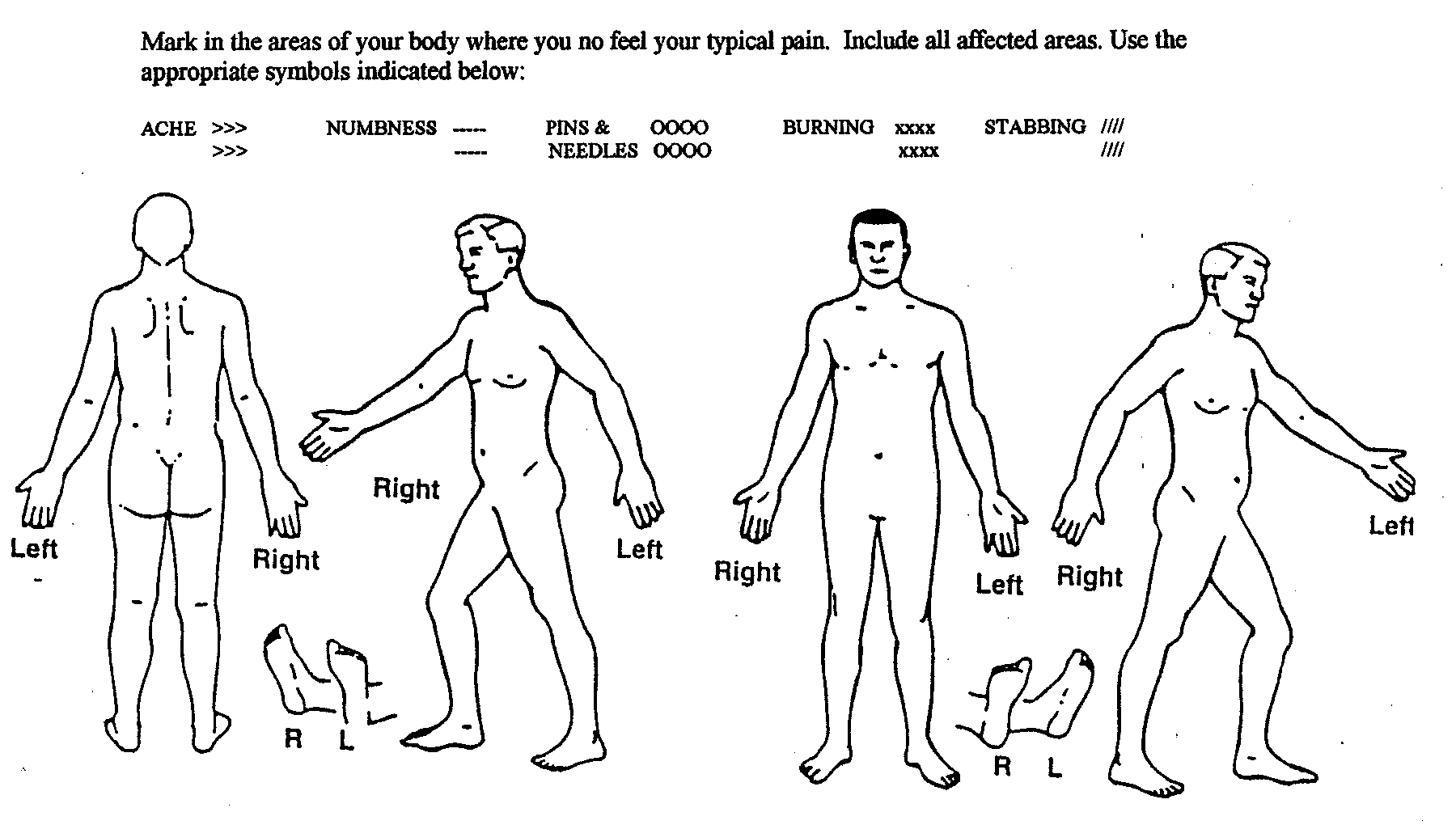
◼ Mark on the line below the point that best represents the severity of your pain ‘Most of the time’.

***Pain and Symptom History***

**Please Draw Your Pattern of Pain**

###### On the Diagram Below

**Unbearable Pain**



\_\_\_\_\_\_

**Mark in the areas of your body where you now feel your typical symptoms. Include all affected areas. Use the appropriate symbols below to describe your symptoms.**

\_\_\_\_\_\_

**No Pain**

◼ On a scale of 0 to 10 (where ***1*** is ***very*** ***mild*** pain and ***10*** is the ***worst*** ***pain***)   
  
 Please ***Rate* *Your* *Pain*** - (Use a **Single** **Number** (e.g. 2, 5, 9) **OR** A **Range** of **Numbers** (e.g. 3-4, 8-10, 1-3)

(For Example: 2/10, 8/10, 3-5/10, 7-9/10)

(\*Please Check One Below – This is **IMPORTANT**!)

**Would You Characterize Your Pain As Being**?

Mild Mild to Moderate

Moderate Moderate to Severe

Severe Very Severe

\_\_\_\_\_\_ / 10\_ Pain At its ***Best*** (0 – 10)

\_ \_\_\_\_\_/ 10\_ Pain At its ***Worst*** (0 - 10)

\_\_\_ \_\_\_/ 10\_ Pain On ***Average*** (0 - 10)

**AND** - Please Check the One that best describes your pain pattern:

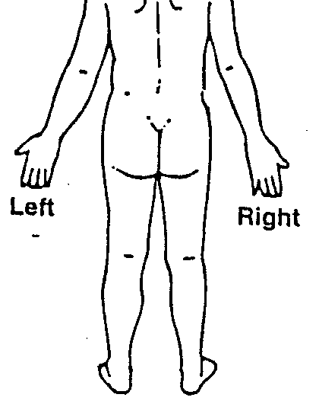
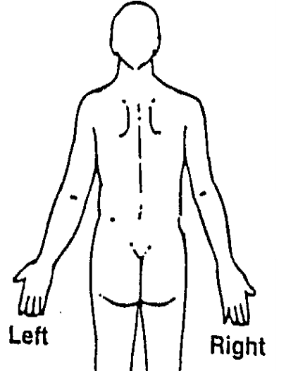
I Am Experiencing: **MORE GOOD** DAYS (Than Bad Days)

I Am Experiencing: **MORE BAD** DAYS (Than Good Days)

I Am Experiencing: **EQUAL GOOD** & **BAD** DAYS

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◼ Does Coughing or Sneezing ‘**Increase’** your ‘**Pain’?**  **YES** **NO**

   
   
 **Back** Pain **Neck** Pain

**‘Circle’**   **Leg** Pain **Arm** Pain

**All That Apply**

**Both Both**

◼ ***If*** you have *BOTH -*  **Back + Leg** Pain (and/or) **Neck + Arm** Pain

What % Percentage (of 100%) is: BACK **v.** LEG **OR** NECK **v.** ARM

(e.g. 30% Back Pain & 70% Leg & Buttock Pain – with the **“Total Adding up to 100%”** (e.g. 60% Neck Pain & 40% Arm & Shoulder Pain – with the **“Total Adding up to 100%”**

Circle – Is your pain on the **R** or **L** or **Both**

\_\_\_\_\_\_\_ % **BACK** Pain vs. \_\_\_\_\_\_\_ % **LEG** → **Right or Left or Both**

\_\_\_\_\_\_\_ % **NECK** Pain vs. \_\_\_\_\_\_\_ % **ARM** → **Right or Left or Both**

◼ Do You have ANY Problems With Control of you BOWEL or BLADDER ( Circle Which Apply):   
  
 1. Bowel NO YES   
 2. Bladder NO YES  
 3. Bowel & Bladder NO YES

4. Did this start: BEFORE (OR) AFTER - your Spine Problems Started?

How Long have you been experiencing Problems In: \_\_\_\_\_ Years / months  
 (Please Indicate)

Do You Have A Urologist: NO YES

Your Urologists Name OR Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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◼ Are you **WORKING** or Have You been ABLE TO WORK despite your spine problem(s)?

***Work History***

\_\_\_\_\_ **Yes, I Am Working -** Who is your ***Employer***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Describe your ***Employment***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your job involve heavy manual labor ? Yes No

Does your job require heavy or repetitive lifting/bending/twisting ? Yes No

\_\_\_\_\_ **No, I am NOT Working**

\_\_\_\_\_ **I Am Retired** (If retired, please skip the rest of this form)

\_\_\_\_\_ **I Am on Disability** - My Disability Is: A. Temporary Permanent I don’t know

B. Partial Total I don’t know

**If WORKING -**  Are you working: Full Time or Part Time

**If WORKING -** Have you had to change the type of work you do *or* your place of

employment as a result of your spine problem(s)? Yes or No

**If WORKING -** How long have you worked at your present job? \_\_\_\_\_ Year(s) \_\_\_\_\_ Month(s)

**If WORKING -** How many hours a week do you work? \_\_\_\_\_ Hours

**If WORKING -**  How many hours a day do you work? \_\_\_\_\_ Hours

**If WORKING**, Is your current work physically demanding?

\_\_\_\_\_ Extremely \_\_\_\_\_ Some what

\_\_\_\_\_ Very much \_\_\_\_\_ A little

\_\_\_\_\_ Quit a bit \_\_\_\_\_ Not at all

**If You Are NOT WORKING -** Approximately How Long have you been UNABLE to

work Because of your back or neck problems?

\_\_\_\_\_ Less than one month

\_\_\_\_\_ One month

\_\_\_\_\_ Between one and three months

\_\_\_\_\_ Between three and six months

\_\_\_\_\_ More than six months

What is the Date you Last Worked? \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

(Month) (Day) (Year)

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***Current Pain Medications & Health Screening***

◼ I am using the following ***Pain Medications*** to treat my pain:

Tylenol products Tylenol #3 Flexaril

Aspirin products Norco Robaxin

Ultram/Tramadol Vicodin Zanaflex

Celebrex Vicodin ES Lortab

Mobic Vicodin HS Soma

Naprosyn Percocet Tramadol

Motrin Oxycontin Nucynta

Relafen MS Contin Pain Stimulator

Daypro Other Narcotics Pain Pump

LIST ANY ADDITIONAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

◼ In the *last month* how frequently have you taken the following ***pain medications***?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 3 – 4  Times a day | 1 – 2  Times a  day | 1 – 2  Times a week | 3 – 5  Times a month | 1 - 2  Times a month | Not At  All |
| *Narcotics*  (T3, Codeine, Darvocet,  Vicodin, Percocet, etc.) |  |  |  |  |  |  |
| *Non-Narcotics*  (Aspirin, Advil, Motrin,  Relafen, Vioox, etc.) |  |  |  |  |  |  |

◼ ***Health*** ***Screening***: Do you have *or* have you been treated for any of the Following?

|  |  |  |  |
| --- | --- | --- | --- |
| **CONDITIONS** | **YES** | **NO** | **NOT SURE** |
| *High Blood Pressure* / Hypertension |  |  |  |
| *Heart Problems* (Angina, Heart Attack, Blocked Arteries, ect.) |  |  |  |
| Breathing / Lung Problems  (Asthma, Emphysema, ect) |  |  |  |
| Kidney / Bladder / Urinary |  |  |  |
| Stomach / Intestine problems  (Ulcers, Polyps, Cancer, Reflux, ect) |  |  |  |
| Ear / Eye problems |  |  |  |
| Nose / Throat problems |  |  |  |
| Skin conditions |  |  |  |
| Headaches |  |  |  |
| Stroke |  |  |  |
| Blood Clots / Phlebitis |  |  |  |
| Bleeding / Blood Disorders |  |  |  |
| Cancer |  |  |  |
| Diabetes |  |  |  |
| Arthritis |  |  |  |
| *Osteoporosis* |  |  |  |

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◼ **PLEASE** feel free to **ADD** any additional information **BELOW** that you feel or believe may be pertinent or relevant to your spine care and treatment (if it was not covered above). Also, please be prepared to provide copies of all previous diagnostic studies  
(X-Ray, MRI, CT Scan, ect), along with their associated reports. Any relevant studies and associated reports, tests and test results as well as all operative reports will be required to provide complete care. If these are not available for us today, it will be your responsibility to obtain and provide copies of all relevant information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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