First State Orthopaedics
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LUMBAR SPINE INTAKE FORM

□ **Dr. Ginsberg** □ **Dr. Lingenfelter** □ **Dr. Mavrakakis** □ **Dr. Moran** □ **Dr. Newell** □ **Dr. Rudin** □ **Dr. Straight** □ **Dr. Zaslavsky**

PATIENT INFORMATION

Date: _____ **Name:** _____ **Age:** _____ **FSO MR #:** _____

CONCERN

(Describe your back pain, please check all that apply.)

□ **Back Pain** □ **Leg Pain** □ **Right** □ **Left** □ **Bilateral**

Date of Injury/Onset of Pain: _____ □**Auto Accident** □**Work Comp** □**Personal Injury** **Dates off work:** _____

Work Status: □ Currently working _____ hrs/wk

□ Not working □ unemployed □ retired

Severity : □ 0 (no pain) □ 1□ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (excrutiating pain)

Status of Pain: □ Improved □ No change □ Worse □ Resolved

Frequency of Pain: □ Daily □ Constant □ Intermittent □ Occasional

Location of Pain: □ Resolved

	R	L	BL
Back	□	□	□
Leg	□	□	□
Buttock	□	□	□
Groin	□	□	□

Other: _____

□ Back Pain = Leg Pain
□ Back Pain > Leg Pain
□ Back Pain < Leg Pain
□ Back Pain Only
□ Leg Pain Only

Radiation of Pain: □ None

	R	L	BL
Buttock	□	□	□
Back of Thigh	□	□	□
Outside Thigh	□	□	□
Front of Thigh	□	□	□
Back of Calf	□	□	□
Outside Calf	□	□	□
Inside Calf	□	□	□
Ankle	□	□	□
Top of Foot	□	□	□
Bottom of Foot	□	□	□
Outside Foot	□	□	□
Big Toe	□	□	□

□ Other _____

Weakness: □ None

	R	L	BL
Hip	□	□	□
Leg	□	□	□
Knee	□	□	□
Foot	□	□	□
Ankle	□	□	□

□ Other _____

Numbness/Tingling: □ None

	R	L	BL
Buttock	□	□	□
Back of Thigh	□	□	□
Outside Thigh	□	□	□
Front of Thigh	□	□	□
Back of Calf	□	□	□
Outside Calf	□	□	□
Inside Calf	□	□	□
Ankle	□	□	□
Top of Foot	□	□	□
Bottom of Foot	□	□	□
Outside Foot	□	□	□
Big Toe	□	□	□

□ Other _____

Quality of Pain:
□ Severe
□ Aching
□ Shooting
□ Dull
□ Resolved
□ Other _____

Aggravated By: □ None
□ Bending
□ Changing Positions
□ Lifting
□ Sitting
□ Driving
□ Walking
□ Standing
□ Other: _____
□ End of Day
□ Mornings
□ All Activities

Relieved By: □ None
□ Changing Positions
□ Sitting
□ Laying Down
□ Standing
□ Heat
□ Exercise
□ Medication: _____
□ Rest
□ Stretching
□ Other: _____

Associated Symptoms / Pertinent Negatives: □ All No
□ Balance Disturbances
□ Bladder Incontinence
□ Bowel Incontinence
□ Spasms
□ Gait Disturbances
□ Weakness
□ Change in Handwriting
□ Other: _____

Symptoms Improved With:
□ PT
□ Injections
□ **Other:** _____
□ Time
□ Meds

Symptoms Failed to Improve With:
□ PT
□ Injections
□ **Other:** _____
□ Time
□ Meds

Other/Notes: _____

_____

OVER

REVIEW OF SYSTEMS

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

Cardiovascular:
- ☐ Chest Pain
- ☐ Cyanosis (blue coloration of skin)
- ☐ Irregular Heartbeats/Palpatations

Integumetary/Skin:
- ☐ Rash

Metabolic/Endocrine:
- ☐ Cold Intolerant
- ☐ Heat Intolerant

HEENT:
- ☐ Headache
- ☐ Vision Loss

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Neurological:
- ☐ Difficulty Walking
- ☐ Dizziness

Hematologic/Blood:
- ☐ Bleeding

Respitory:
- ☐ Cough
- ☐ Dyspnea

Genitourinary:
- ☐ Dysuria
- ☐ Hematuria

Immunological:
- ☐ Enviromental Allergies
- ☐ Food Allergies

☐ **None**

PATIENT'S MEDICAL CONDITION

Height: ___ft ___in **Weight:** _____lbs **Blood Pressure:**_____/_____ **List details of any diet program:**_____

My Weight in the last 6 months has: ☐ **Not Changed** ☐ **Increased** _____**lbs.** ☐ **Decreased** _____**lbs.**

PATIENT'S MEDICAL HISTORY

(Please check all that apply)

☐ AIDS/HIV	☐ COPD (Emphysema)	☐ High Blood Pressure	☐ Parkinson Disease	☐ Other:
☐ Alcoholism	☐ Coronary Artery Disease	☐ Hyperthyroidism	☐ Peptic Ulcer Disease	
☐ Alzheimers	☐ Crohn's Disease	☐ Hypothyroidism	☐ Psoriasis	_____
☐ Anemia	☐ Degenerative Joint Disease	☐ Inflammatory Bowel Disease	☐ PVD	
☐ Angina	☐ Depression	☐ Juvenile Rheumatoid Arthritis	☐ Renal Disease	_____
☐ Arthritis	☐ Diabetes	☐ Kidney Disease	☐ Rheumatoid Arthritis	
☐ Asthma	☐ Drug Abuse	☐ Liver Disease	☐ Scoliosis	_____
☐ Atrial Fibrillation	☐ DVT (Blood Clot)	☐ Lyme Disease	☐ Seizure Disorder	
☐ Benigin Prostatic Hyertrophy	☐ Fibromyalgia	☐ Migraine Headaches	☐ Sleep Apnea	_____
☐ Cancer	☐ Gallbladder Disease	☐ Multiple Sclerosis	☐ SLE (Lupus)	
☐ Cerebrovascular Accident (Stroke)	☐ GERD	☐ Myocardial Infarction	☐ Spinal Stenosis	_____
	☐ Gout	☐ Obesity	☐ Thyroid Disease	
☐ Congestive Heart Failure (CHF)	☐ Hepatitis	☐ Osteoarthritis	☐ Valvular Disease (Heart valve problems)	☐ **None**
	☐ High Cholesterol	☐ Osteoporosis		

PATIENT'S SURGICAL HISTORY

(Please check all that apply)

☐ ACL Surgery	☐ CABG	☐ Hip Replacement	☐ Pacemaker	☐ Other:
☐ Angioplasty	☐ Cardiac (Heart) Valve Replacement	☐ Knee Replacement	☐ Small Bowel Resection	_____
☐ Angio w/stent		☐ Laminectomy	☐ Thyroidectomy	
☐ Appendectomy	☐ Carpal Tunnel Release	☐ LASIK	☐ Tonsillectomy	_____
☐ Athroscopy (Scope) Details:	☐ Cataract Extraction	☐ Meniscus Surgery	**Gender Specific**	
	☐ Cholecystectomy (gallbladder removal)	☐ Muscle Biopsy	**Female**	_____
_____		☐ Neck Surgery - Details:	☐ Cesarean Section	
☐ Back Surgery - Details:	☐ Colectomy		☐ Hysterectomy	_____
	☐ Colostomy	_____	☐ Mastectomy	
_____	☐ Discectomy		**Male**	_____
	☐ Gastric Bypass	_____	☐ Prostatectomy	
_____	☐ Hernia Repair	☐ ORIF	☐ TURP	☐ **None**

PATIENT'S FAMILY HISTORY

Is your Father Living? ☐ Yes ☐ No If no, age deceased _____ cause of death _____

Is your Mother Living? ☐ Yes ☐ No If no, age deceased _____ cause of death _____

Are any of your siblings deceased? ☐ Yes ☐ No If yes: ☐Brother ☐Sister age deceased _____ cause of death _____

Family history of chronic/inherited diseases: _____

PATIENT'S SOCIAL HISTORY

Tobacco Use: ☐Yes ☐No ☐Former/Year Quit _____ **Consume Alcohol**: ☐Yes ☐No ☐Former/Year Quit _____

History of Substance Abuse: ☐Yes ☐No **Age Started:** _____ **Drug Type(s):** _____ _____

Activity Level: ☐Sedentary ☐Moderate ☐Vigorous **Type of Exercise**: _____ _____

SIGNATURE

Date: _____ **Signature of Patient, Parent or Guardian:** _____