Spine Clinic New Patient Intake (updated 31 July 2023)

room #

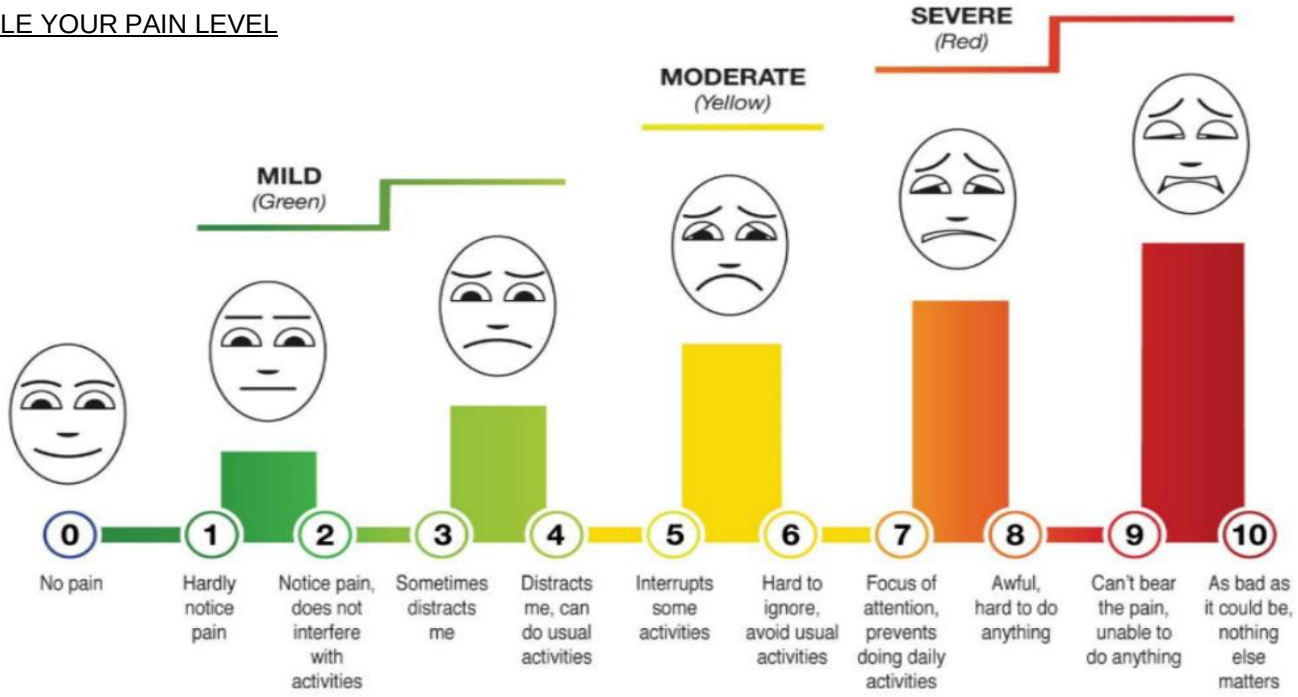
Please complete this form as best you can before Dr. Cleveland sees you.

Name_____ Age_____ Occupation_____

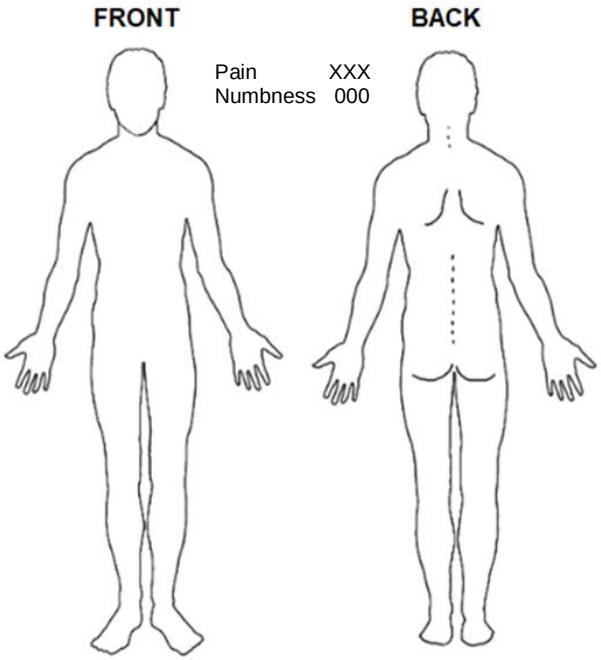
Reason for today's visit? _____

Have you had an MRI? NO YES Where / when? _____

CIRCLE YOUR PAIN LEVEL



DRAW YOUR SYMPTOMS ON THE DIAGRAM



Circle qualities of your symptoms

aching	grinding	catching
locking	throbbing	burning
stabbing	shooting	numbness
tingling	fatigue	weakness

Symptoms are affecting?

[ ] quality of life
[ ] activity of daily living
[ ] ability to work
[ ] ability to exercise
[ ] sleep
[ ] ability to stand upright
[ ] ability to walk normally
[ ] social relationships
[ ] hand function: fine motor tasks
[ ] hand function: gripping or pinching
[ ] hand function: handwriting and utensils

PLEASE COMPLETE BOTH SIDES → → →

Timing of symptoms? 2 months or less 2-6 months more than 6 months

Did you have a specific injury? NO YES _____

Do you use an assist device? NO cane walker wheelchair other

Prior SPINE physical therapy within the last year? NO YES _____

Prior SPINE injections or pain procedures? NO YES _____

Medications for symptoms? NONE Tylenol ibuprofen other NSAIDs/anti-inflammatories

muscle relaxants gabapentin pregabalin / Lyrica tramadol

Tylenol #3/4 (codeine) hydrocodone / Norco oxycodone / Percocet OxyContin (long-acting)

CBD / THC / marijuana other _____

Prior SPINE surgery? NO YES _____

Prior ABDOMINAL surgery? NO hernia C-section hysterectomy laparotomy (open abdomen)

Other _____

Prior radiation? NO YES _____

Prior surgical infection or MRSA? NO YES _____

Are you OK with receiving blood products? YES NO → Why not? _____

OTHER MEDICAL PROBLEMS?

Osteoporosis	Diabetes	Blood thinners	Blood clots, DVT, PE	Immune suppressors
Anxiety	Depression	Hypertension	Cardiac disease	Stroke
Vascular disease	COPD or emphysema	Autoimmune disease	Urinary infection	Bowel or liver disease
Renal / kidney disease	Anemia	Sleep apnea	Neurologic disease	Other

Other _____

OTHER surgeries? NO YES _____

Allergies? NO YES _____

Alcohol use? NO less than once per month monthly weekly daily

Tobacco or Nicotine? NO YES → how much / how often? _____

What is your living arrangement? _____

Who lives with you? _____