**PATIENT INFORMATION**

**First Name:** Click here to enter text. **M.I**. **Last Name:** Click or tap here to enter text.

**Date of Birth:** Click or tap here to enter text. Male  Female

**Address City:** Click or tap here to enter text. **State:** **Zip Code:**

**Primary Phone****:** Click here **Type:** Choose an item. **Ok to leave message?**  YES  NO

**Secondary Phone:** Click here **Type:** Choose an item. **Ok to leave message?**  YES NO

**Email:** Click here to enter text.

**Employer:** Click here to enter text.

**Parent/Guardian (if patient is a minor):** Click here to enter text.

**Relation to Patient:** Click here to enter text. **Phone:** Click here to enter text.

**EMERGENCY CONTACT**

**Contact 1:** Click or tap here to enter text. **Phone:** Click here to enter text.

**Contact 2:** Click or tap here to enter text. **Phone:** Click here to enter text.

**PRIVACY/HIPAA**

**Please list any others that you would like to have access to your information. This includes being able to cancel or make appointments for you, as well as information relating to any aspect of your care at Specialized Spine Care, Inc.**

1. **Name** Click or tap here to enter text.**:** **Relation to Patient:** Click or tap here
2. **Name:** Click or tap here to enter text. **Relation to Patient:** Click or tap here to enter text.
3. **Name:** Click or tap here to enter text. **Relation to Patient:** Click or tap here to enter text.

**Release of Information to Providers**

**Referring Provider:** Click or tap here to enter text. **Fax:** Click here to enter text.

**Primary Physician (if different than the referring provider):** Click here to enter text.

**Clinic:** Click or tap here to enter text. **Fax:** Click here to enter text.

**Other providers you would like to receive updates:**

1. **Name** Click or tap here to enter text.**:** **Fax:** Click here to enter text.
2. **Name:** Click or tap here to enter text. **Fax:** Click here to enter text.

**SYMPTOMS**

**Where is the most intense pain located?** Click or tap here to enter text.

**Is there pain, tingling, or numbness in any other areas? If so, explain.** Click or tap here to enter text.

**When did your symptoms originally begin?** Click or tap here to enter text.

**Was it caused by a specific incident or did it come on gradually? Explain.** Click or tap here to enter text.

**When was your most recent flare up and what caused it?** Click or tap here to enter text.

**If this is an ongoing issue, did something change to cause you to seek treatment with us now? If so, what happened?** Click or tap here to enter text.

**What makes your pain increase (certain activities, positions, sleep, etc.)?** Click or tap here to enter text.

**What helps decrease your pain (ice, heat, meds, certain positions, etc)?** Click or tap here to enter text.

**What other types of treatments have you done prior to coming to this clinic?**

Massage  Chiropractic  Meds  Physical Therapy  Injections  Acupuncture

Other Click or tap here to enter text.:

**Have you had a spinal surgery?**  YES  NO **When?** Click or tap to enter a date.

**What type of surgery and which levels?** Click or tap here to enter text.

**Did you have any residual symptoms after surgery? Explain.** Click or tap here to enter text.

**Lifestyle**

**My job involves (check all that apply):**   a lot of travel/driving significant walking

maintaining a static position (sitting, standing, looking down or off to the side, etc.)

heavy lifting awkward positions  reaching overhead

I am currently unable to work my normal job  I am currently not working

**Exercise:**

I work out Choose an item.

My normal workout routine involves (check all that apply): lifting weights walking

cardio (elliptical, running, treadmill, etc.) swimming yoga/pilates

racquetball/pickleball/tennis CrossFit/Peak Physique

Other: Click or tap here to enter text.

**Past Medical History**

**Please put an (x) in all diagnoses that apply to you:**

Osteoporosis/Osteopenia  Diabetes  Asthma

Rheumatoid Arthritis  Osteoarthritis  Epilepsy/Seizures

Heart Issues  Pregnant  Ehlers Danlos Syndrome

Pacemaker  COPD  Vertigo

Claustrophobia  Stroke  Balance Issues

Cancer  Migraines

Other: Click or tap here to enter text.

**List all known allergies:** Click or tap here to enter text.

**Have you noticed any of the following since the onset of your symptoms?**

Changes in bowel/bladder  Weight gain/loss  Nausea/vomiting

Shortness of breath  Loss of appetite  Pain at night

Dizziness/lightheadedness  Difficulty Swallowing

**MEDICATIONS**

**Prescribed Medications**

Medication Dosage Reason for taking

|  |  |  |
| --- | --- | --- |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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**Over the Counter Medications**

Medication Dosage Reason for taking

|  |  |  |
| --- | --- | --- |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**Vitamins, Supplements, Other**

Name Dosage

|  |  |
| --- | --- |
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| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

**How did you find out about Specialized Spine Care, Inc.?** Choose an item.