SPINE CENTER AT LANKENAU MEDICAL CENTER

Spine intake form

Main Line HealthCare
Physician Network

Please check or fill in completely.

Name: ______________________________

Pain: ☐ Neck ☐ Back ☐ Arms ☐ Legs

Pain in which side? ☐ Left ☐ Right ☐ Both

If all your pain equals 100%, assign each area a percentage:
Arm:_____ Leg:_____ Back:_____ Neck:_____

Worse when: ☐ Standing ☐ Sitting ☐ Walking ☐ All

How far can you walk? ______________________________

Better when: ☐ Standing ☐ Sitting ☐ Walking ☐ Lying down ☐ No different

What position give least amount of pain? ______________________________

Pain aggravated by: ☐ Coughing ☐ Sneezing ☐ Straining ☐ Bending (Forward / Backward *circle one*)

How long have you had the present pain? ______________________________

What do you think started your pain? ______________________________

IMAGING

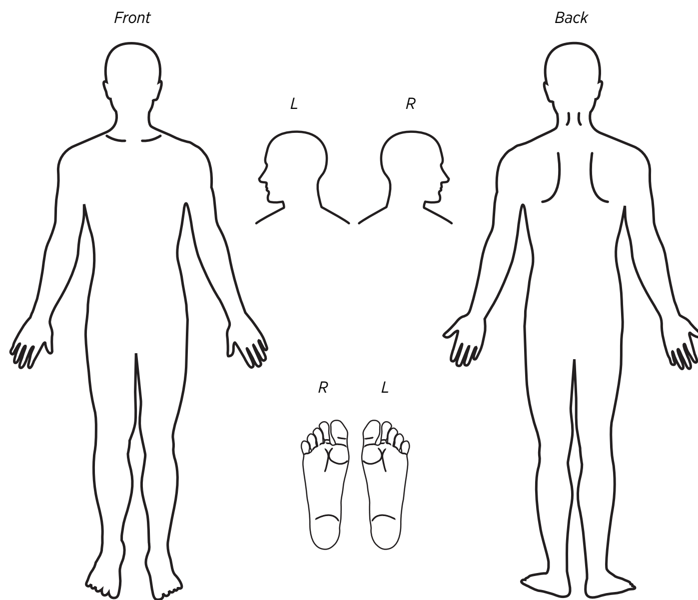
Height: ____________________ Weight: ____________________

Have you had any of the following?

	Body part	*Date*
Myelogram	____________	____________
Discogram	____________	____________
Plain x-rays	____________	____________
MRI	____________	____________
CT scan	____________	____________
EMG	____________	____________

Is this a second opinion? ☐ Yes ☐ No

On diagram, please SHADE IN the location of your pain.
Please CIRCLE the one most painful area.



Check all that describes pain:

☐ Sharp ☐ Shooting ☐ Throbbing ☐ Stabbing
☐ Burning ☐ Aching ☐ Sickening ☐ Punishing

Place an "X" on the line below to indicate the level of your pain in the following:

Average level of pain you have every day...

No pain |————————————| *Worst possible pain*

Level of pain you have now...

No pain |————————————| *Worst possible pain*

Previous treatments:

Acupuncture	☐ Effective	☐ Not effective
Chiropractor	☐ Effective	☐ Not effective
Biofeedback	☐ Effective	☐ Not effective
Anti-inflammatories	☐ Effective	☐ Not effective
Injections	☐ Effective	☐ Not effective
Anti-depressants	☐ Effective	☐ Not effective
Sedatives/Narcotics	☐ Effective	☐ Not effective
Physical therapy	☐ Effective	☐ Not effective

Over >

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Please check or fill in completely.

Date of birth: ______________________________

Social Security #: ______________________________

Age: _________ Sex: ☐ Male ☐ Female

List all surgeries (with date and surgeon's name):

____
____
____
____
____

Previous hospitalizations:

____
____
____
____
____

Social history:

Do you drink alcohol? ☐ No ☐ Yes (Number per day _______)
Do you smoke cigarettes? ☐ No ☐ Yes (Number per day _______)

Current or recent occupation: ______________________________

Disabled? ☐ No ☐ Yes
Any litigation in process? ☐ No ☐ Yes

____

Scott A. Rushton, MD Date

Do you have significant problems with these other areas?

Weight loss	☐ No	☐ Yes
Loss of appetite	☐ No	☐ Yes
Fever/chills	☐ No	☐ Yes
Double/blurred vision	☐ No	☐ Yes
Ringing in ears	☐ No	☐ Yes
Bloody nose/gums	☐ No	☐ Yes
Sore throat	☐ No	☐ Yes
Chest pain	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Cough	☐ No	☐ Yes
Speech	☐ No	☐ Yes
Leg/arm weakness	☐ No	☐ Yes
Blood in stool	☐ No	☐ Yes
Constipation/diarrhea	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Abdominal pain	☐ No	☐ Yes
Change in bladder habits	☐ No	☐ Yes
Rashes	☐ No	☐ Yes
Bruises	☐ No	☐ Yes
Headache	☐ No	☐ Yes
Dizziness	☐ No	☐ Yes
Blackouts	☐ No	☐ Yes
Numbness/tingling	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Pain in other joints?	☐ No	☐ Yes

If yes, please list: ______________________________
____

Past medical history includes:

High blood pressure	☐ No	☐ Yes
Peptic ulcer	☐ No	☐ Yes
Frequent infections	☐ No	☐ Yes
Bleeding problems	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Anesthesia problems	☐ No	☐ Yes
Liver disease	☐ No	☐ Yes
Rheumatoid arthritis	☐ No	☐ Yes
Cardiac disease	☐ No	☐ Yes
Angina	☐ No	☐ Yes
Thyroid	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Sleep apnea/c-pap	☐ No	☐ Yes
Blood clot	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Emphysema	☐ No	☐ Yes
Depression/anxiety	☐ No	☐ Yes
Asthma	☐ No	☐ Yes

Other medical conditions: ______________________________
____
____

Family history of:

Rheumatoid arthritis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Heart disease	☐ No	☐ Yes

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