Brain and Spine intake form

Main Line HealthCare
Physician Network

Please check or fill in completely.

Name: ______________________ Date: ________

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

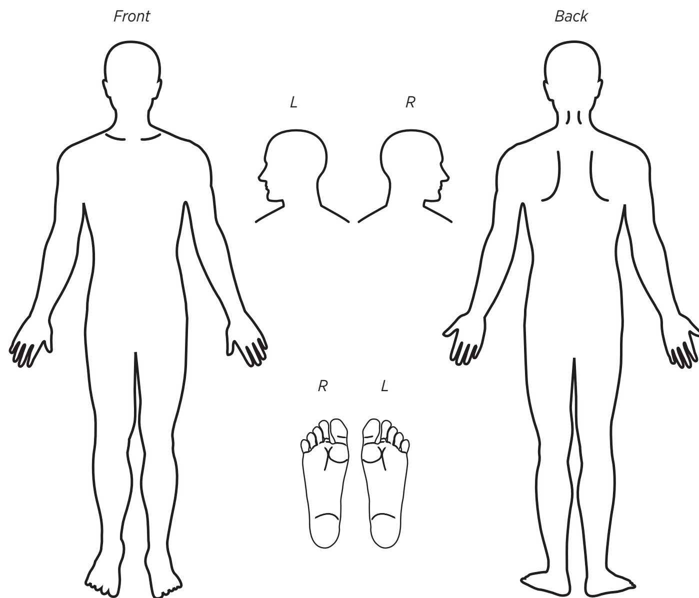
Height: ______________ Weight: ______________

Have you had any of the following?

	Body part	*Date*
Myelogram	______	______
Discogram	______	______
Plain x-rays	______	______
MRI/MRA	______	______
CT/CTA scan	______	______
EMG	______	______
DSA	______	______

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 >

BRAIN AND SPINE CENTER AT LANKENAU MEDICAL CENTER

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

____
Signature Date

____
Scott A. Rushton, MD Date

____
Peter D. LeRoux, 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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