Utah Spine Medicine Intake Form

Name_____ Date _____ MRN _____

Birthdate _____ Age _____ Sex _____

Referring Provider _____ Primary Care Provider _____

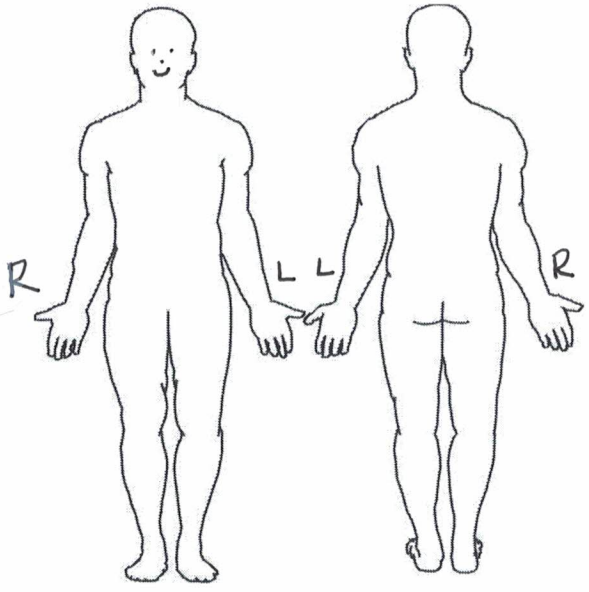
What are you here to see Dr. Cheng about? _____

Work related? *Yes No* Motor vehicle accident? *Yes No* Legal Representation? *Yes No*

Date of Injury _____ How did your pains start? _____

_____

Please indicate the location of your pains:



Front Back

(Please DO NOT write in the box)

For Dr. Cheng

Duration

Quality

Numbness

Weakness

Bowel/Bladder

Fevers/chills/night sweats/wt loss

What level is your pain (0= No Pain, 10 = Worst pain in the world)

Today (0-10) _____ Best (0-10) _____ Worst (0-10) _____

Do you have trouble sleeping at night? *Yes No*

What makes your pains increase? _____

What makes your pain decrease? _____

What **pain medicines** are you taking? *None* _____

_____

What **medications** do you take for your other medical issues? *None* _____

_____

What medical **allergies** do you have? *None* _____

Please continue to the other side....

Who have you seen for these problems? *Primary Care ER Urgent Care PT Chiro*

What treatments have you tried for these pains? *PT Chiro Acupuncture Massage yoga pilates ice heat*

Have you had imaging studies of your spine? *X-ray MRI CT Bone Scan*

Have you had any spine injections? _____ With X-ray guidance? *Yes No Don't know*

What **medical issues** do you have? *None* _____

What **spine surgeries** have you had in the past? *None* _____

What **non-spine surgeries** have you had? *None* _____

Social History

Marital status: *Single Married Partner Divorced Widowed*

Occupation: _____ Last day worked? _____

Tobacco	*Yes*	*No*	# packs/# years _____
Recreational drugs	*Yes*	*No*	
Alcohol	*Yes*	*No*	Amount _____

Family History of medical problems: *None* _____

Review of Systems (please check all that apply)

O Fevers	O Ringing in ears	O Wheezing	O Joint pain or swelling	O Anxiety
O Chills	O Hearing changes	O Belly pain	O Loss of joint motion	O Depression
O Night sweats	O Earache	O Heartburn	O Skin rash	O Abnormal bleeding
O Weight loss/gain	O Chest pain or pressure	O Diarrhea	O Skin growth	O Bruising
O Fatigue	O Arrhythmias	O Constipation	O Itching	O Recurrent infections
O Headaches	O Heart palpitations	O Loss of bowel control	O Hair/nail changes	O Breast lumps
O Dizziness	O Leg swelling	O Bloody stool	O Skin dryness	O Breast discharge
O Difficulty swallowing	O Blood clots	O Urinary frequency	O Balance difficulty	O Breast feeding
O Visual changes	O Shortness of breath	O Urinary urgency	O Walking difficulty	O None
O Eye redness	O Cough	O Loss of urinary control	O Other _____	

I attest that the above information accurately represents my symptoms and medical history.

_____

Your Signature

Thank you very much for your efforts in completing this form!