Florida Spine Care and Pain Center

Orange Park Jacksonville St. Augustine Ocean Way

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Specialist in Interventional Pain Management

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FLORIDASPINEPAIN.COM

New Patient Information

Date: _____ **SSN:** _____

LAST NAME | **FIRST NAME** | **DATE OF BIRTH** | **CURRENT AGE**

PRIMARY CARE PHYSICIAN | **PHONE #**

REFERRING PHYSICIAN | **PHONE #**

REASON FOR VISIT (CHECK THE ONE THAT APPLIES TO YOU)

Work comp injury: _____ **Automobile accident:** _____ **Slip and Fall :** _____ **Chronic Pain :** _____

If a specific personal injury was indicated above, please complete this section. (If not skip to next section)
date of injury: _____ state or place of injury: _____ attorney representation: yes or no

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PRIMARY REASON FOR THIS VISIT (DESCRIBE LOCATION OF PAIN)

FACTORS OF COMPLAINT

Explain how your pain or problem began and how it happened

How long have you had this problem? _____

FOR OFFICE USE ONLY

Height: _____ **Weight:** _____

Vitals: _____ **Blood pressure:** _____ **Pulse:** _____

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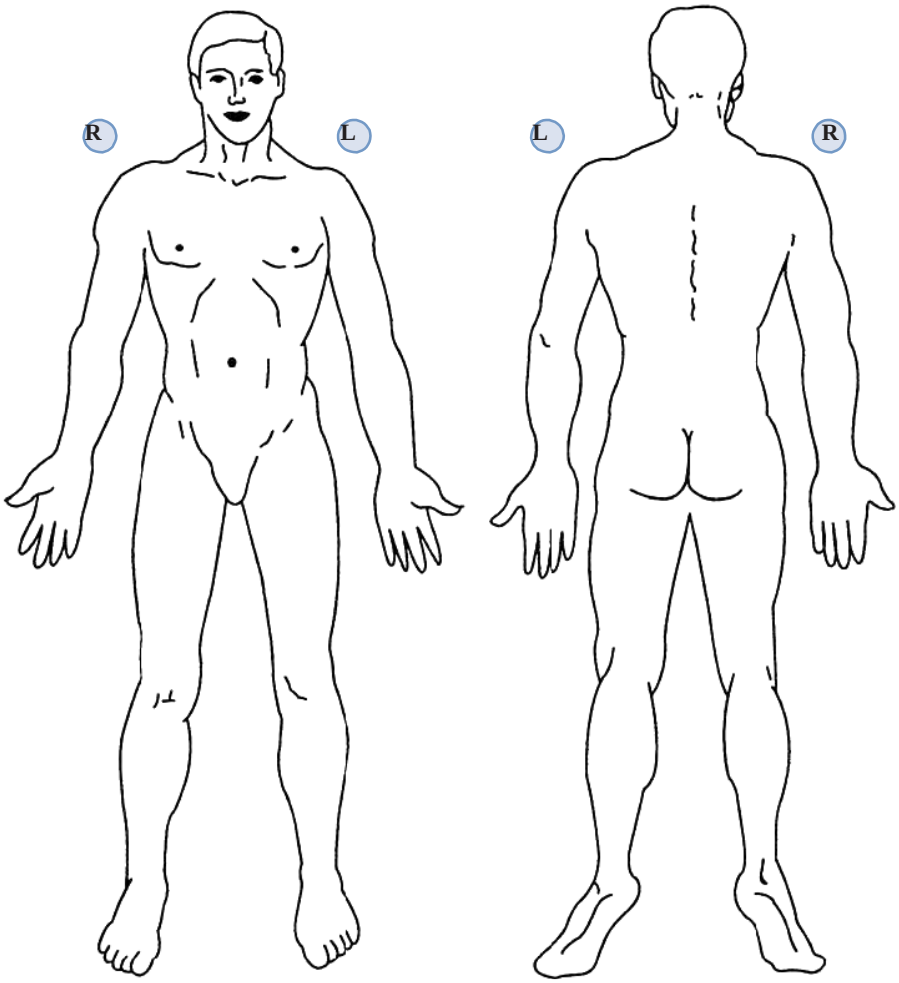
Patient information

ORTHO PAIN CHART

Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

numbness	= = =
pins & needles	o o o
burning/aching	x x x
stabbing	/ / /



FUNCTIONAL HISTORY

PLEASE CHECK ALL THE ACTIVITIES THAT YOU REQUIRE ASSISTANCE PERFORMING:

___Driving
___Walking
___Ambulating up or down stairs
____Standing
____Lifting
Other: _____

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FAMILY HISTORY

WHAT ILLNESSES RUN IN YOUR CLOSE FAMILY (CHECK ALL THAT APPLY)

____ Scoliosis ____Spine Disease ____Arthritis ____Cancer ____Other:_____

TESTS & TREATMENT YES OR NO

Any previous tests (examinations) or treatments for your current condition you are being seen for today
(If yes, please complete the following, if no, please skip to "medical history" section)

PREVIOUS TREATMENTS FOR THIS CONDITION

MEDICATIONS

Anti- Iinflammatories	_____	**Temporary relief**	**Lasting relief**	**No relief**
Muscle relaxants	_____	**Temporary relief**	**Lasting relief**	**No relief**
Pain medications	_____	**Temporary relief**	**Lasting relief**	**No relief**
Other(s)	_____	**Temporary relief**	**Lasting relief**	**No relief**

THERAPIES

Chiropractic care	_____	**Temporary relief**	**Lasting relief**	**No relief**
Physical therapy	_____	**Temporary relief**	**Lasting relief**	**No relief**
Other(s)	_____	**Temporary relief**	**Lasting relief**	**No relief**

INJECTIONS

(i.e. epidural steroid injections, nerve-root blocks)

Date _____ **Injection type** _____		**Temporary relief**	**Lasting relief**	**No relief**
Date _____ **Injection type** _____		**Temporary relief**	**Lasting relief**	**No relief**

Previous treating doctors _____

Specialty(s) (i.e. surgeon) _____

SPINE IMAGING HISTORY

PLEASE INDICATE WHETHER YOU HAVE HAD ANY OF THE FOLLOWING STUDIES AND WRITE WHEN & WHERE THE MOST RECENT WAS

Yes	**No**	**Regular x-ray of spine**	**When**	_____	**Where**	_____
Yes	**No**	**CT scan of spine**	**When**	_____	**Where**	_____
Yes	**No**	**EMG**	**When**	_____	**Where**	_____
Yes	**No**	**Bone scan**	**When**	_____	**Where**	_____
Yes	**No**	**Myelogram**	**When**	_____	**Where**	_____
Yes	**No**	**Discogram**	**When**	_____	**Where**	_____
Yes	**No**	**MRI of spine**	**When**	_____	**Where**	_____

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MEDICAL HISTORY

PLEASE CHECK ALL CURRENT & PAST MEDICAL CONDITIONS

___No medical problem	__High Blood Pressure	__Heart attack	__Lung disease
___Cancer *where?* _____	__Asthma	__Bronchitis	__Stroke
___Other:_____			

Are you under a doctor's care for any other medical condition Yes No

If yes, please explain _____

SURGICAL HISTORY

PLEASE CHOOSE ALL SPINAL SURGERIES YOU HAVE HAD

Spine-neck **Type of surgery** _____ **Date(s)** _____

Spine-lower back **Type of surgery** _____ **Date(s)** _____

Other _____ **Type of surgery** _____ **Date(s)** _____

Current medications ***(may attach a list)***

NAME	DOSE	# PER DAY

Allergies ***(may attach a list)*** **No known medical allergies**

SUBSTANCE	REACTION

SOCIAL HISTORY

Married Divorced Separated Single Widow/Widower

Number of children ____ At home Away Other dependents _____