Wyckoff
Wyckoff Heights Medical Center

Wyckoff Heights Medical Center Department of Neurosurgery
Spine Center Intake Form

Demographics

1. **Name:**
2. **DOB:**
3. **Referring Physician Name:**
4. **Primary Care Physician Name:**
5. **Primary Care Physician Contact Number:**
6. **Primary Care Physician Email:**
7. **Additional Physicians name/number**
    1.
    2.
    3.
    4.
    5.

Medical Information

8. Chief Complaint:
9. Past Medical History:
10. Past Surgical History:
11. Medications:
12. Allergies:
13. Onset:
    1. When did symptoms start:
    2. What caused them to start:
    3. Is there any weakness associated with symptom onset:
14. Quality:
    1. *Describe pain*:
        1. constant vs. intermittent:
        2. Does pain radiate/travel: Yes No
            1. if so, where:
    2. *Describe associated symptoms*
        1. Numbness, tingling, cramps:
        2. Balance issues:
        3. Difficulty using buttons/forks/knives/pens/pencils:
        4. Bowel/bladder incontinence:
        5. Other:

15. <u>Provocation:</u>
    1. What makes pain better:
    2. What makes worse:
16. <u>Severity</u>:
    1. Scale 1-10:
    2. How does it influence your life:
17. <u>Treatment</u>:
    1. Have you ever seen a spine surgeon before: *yes* vs. *no*
        1. if so, when:
    2. Have you worked with Physical Therapy: *yes* vs. *no*
        1. if so, when:
        2. How many sessions/weeks:
    3. Have you worked with Pain management: *yes* vs. *no*
        1. if so, when:
    4. Have you ever had an Epidural steroid injection: *yes* vs. *no*
        1. if so, when:
    5. Have you ever had X-rays: *yes* vs. *no*
        1. If so, when:
    6. Have you ever had MRI/CT scan: *yes* vs. *no*
        1. If so, when:

Please circle where pain begins and draw a line where it travels: