Patient Intake Form

Welcome to Dallas Spine Center. To accurately assess you and to determine if you are a qualified candidate for our care, it is important that you fill out this form as thoroughly as possible. Thank You.

Today's Date ____________________________ **Time** _______________ am pm

Name ____________________________________ **Sex** ____ **Birthday** ____________ **Age** ______
Driver's License # ________________________ **SS#** ____________________________________
Marital Status (Single Married Divorced Separated Widowed) Spouse Name _______________________
Address___________________________ **City**________________ **State** ____ **Zip Code** _________
Cell #__________________ **Work #**________________ **Email** ______________________________
Work Status (Employed Unemployed Retired Disability) **Type** __________________________________
How did you hear about us? ____

Your Main Complaint/Problem/Pain Prompting Your Request with The Doctor Today (circle)?

Neck Upper Back Mid Back Lower Back Lt Arm Rt Arm Lt Leg Rt Leg Other…

____

Describe the Type/Quality of Pain (Circle)
(dull, achy, sharp, stiffness, tightness, stabbing, burning, shooting, tingling, numbness, etc...)

____

How Long Have You Been Suffering & What Happened? ____________________________________
____

How Often Are You Aware of This Problem? (circle one)
- Constant (90-100% of the time)
- Frequently (75% of the time)
- Intermittently (50% of the time)
- Occasionally (25% of the time)

On a Scale of 0-10 (10 - being unbearable, 0 - being No Pain or Discomfort)
Please rate the following...
The HIGHEST your pain gets WITHOUT medication ___________
The LOWEST your pain gets WITHOUT medication ___________

In your own words and/or opinion what do you think the real problem is (the root cause)?

____

Since your pain became this severe what THREE things/activities has it caused you to miss the most?

____

How has your life changed since your pain became a problem?

____

What kinds of treatments have you received?

Epidural: How Many ____________ When(approx) ________________________
Dr's Name: ________________________________Clinic Name: __________________________
Chiropractic: How Many ____________ When(approx) ________________________
Dr's Name: ________________________________Clinic Name: _____________________________
Physical Therapy: How Long ____________ When(approx) ________________________
Medication, OTC: ____
Injection: ____

List ANY past major surgeries that you have had and the corresponding dates.

____
____

If you cannot find a solution to this problem, what do you think will happen to you?

____

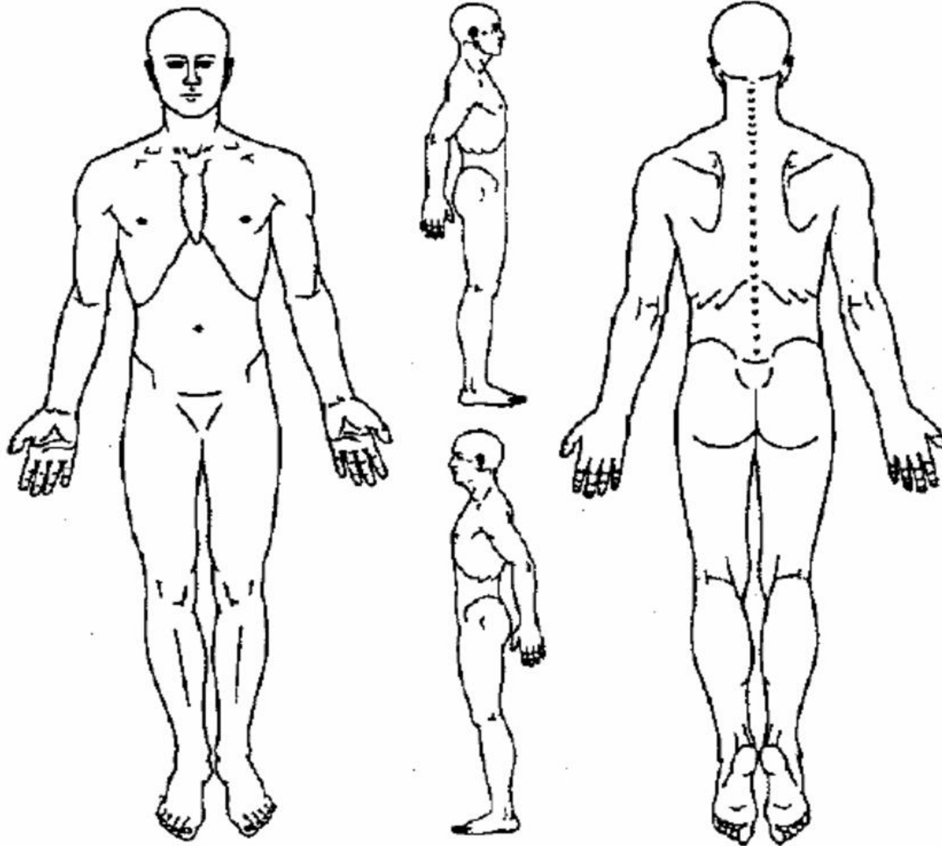
Patient / Guardian Signature: ____**Date:**______________

DALLAS SPINE CENTER
Excellence In Advanced Pain Relief

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗



NAME ______________________________ DATE __________________

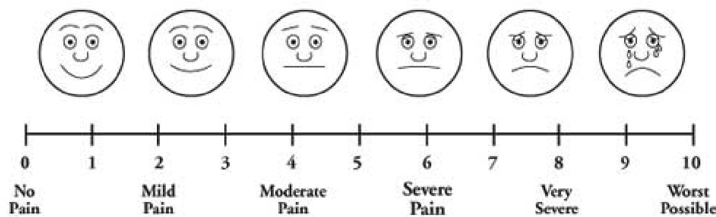
No Pain |——————————————————————————| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

____

Patient Signature

HOW MUCH DOES IT HURT?



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