Regional Brain & Spine

New Patient Appointment Form

Please list your Care Team Providers:

Family Physician:_____
Cardiologist: _____
Pulmonologist: _____

Females Only

Are you or could you be pregnant?
Yes / No

Have you recently..(check all that apply)

- ☐ Been hospitalized
- ☐ Diagnosed with cancer
- ☐ Diagnosed with a new disease
- ☐ Had any changes in your medical history
- ☐ Had a cardiac stent placed
- ☐ Lost bowel or bladder function

If yes to any of these, explain: _____

Are today's symptoms due to a Work related injury? Yes / No

Describe your main problem to be addressed at today's appointment:

Please list any surgeries you have had in the past: _____

_____

Have you completed physical therapy or chiropractic care in the last 6 months? Yes / No

If yes, when and where? _____

If yes, approximately how many sessions have you attended in the last 6 months? _____

How bad is your pain now?

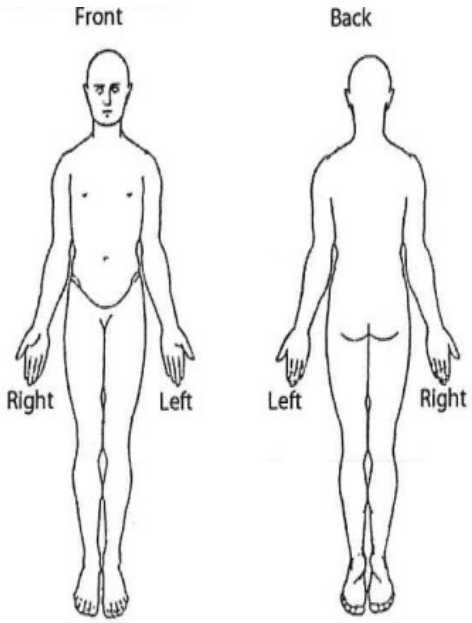
- ☐ 0 No pain at all
- ☐ 1 Like an itch
- ☐ 2 Very minor (band aid)
- ☐ 3 Kind of annoying
- ☐ 4 Concerning but can still function
- ☐ 5 Like a tooth ache or bee sting
- ☐ 6 Serious - interferes with concentration
- ☐ 7 Distressing - can't live alone
- ☐ 8 Can't move as it hurts too bad
- ☐ 9 Like being mauled by a bear
- ☐ 10 Unimaginable - passed out due to pain

If you have pain, is it:

- ☐ Stable
- ☐ Improved
- ☐ Worsening

Please mark the body diagram where you feel:

Ache
^^^^
^^^^
Burning
xxxx
xxxx
Numbness
0000
0000
Pins & Needles
////
////
Stabbing
====
====



How does the following affect your pain?

	Worse	Better	No Effect
Sitting	☐	☐	☐
Standing	☐	☐	☐
Lying Down	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Walking	☐	☐	☐
Coughing/Sneezing	☐	☐	☐

Have you tried these treatments for your current problem?

	Yes	No	
Bed Rest	☐	☐	
Home Exercises	☐	☐	
Medications	☐	☐	
Heat	☐	☐	
Ice	☐	☐	
Injections	☐	☐	_____
Other	☐	☐	_____

Patient Signature: _____ Today's Date: _____