COLORADO SPINE INSTITUTE

elite regenerative
stem cell specialists

PATIENT INTAKE

NAME: _____ D.O.B: _____ AGE: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____ HOW DID YOU HEAR ABOUT US: WEBSITE ☐ DEX ☐
ADVERTISEMENT ☐ _____ FRIEND/RELATIVE ☐ _____

OTHER ☐ _____

REFERRING PHYSICIAN_____PRIMARY PHYSICIAN _____

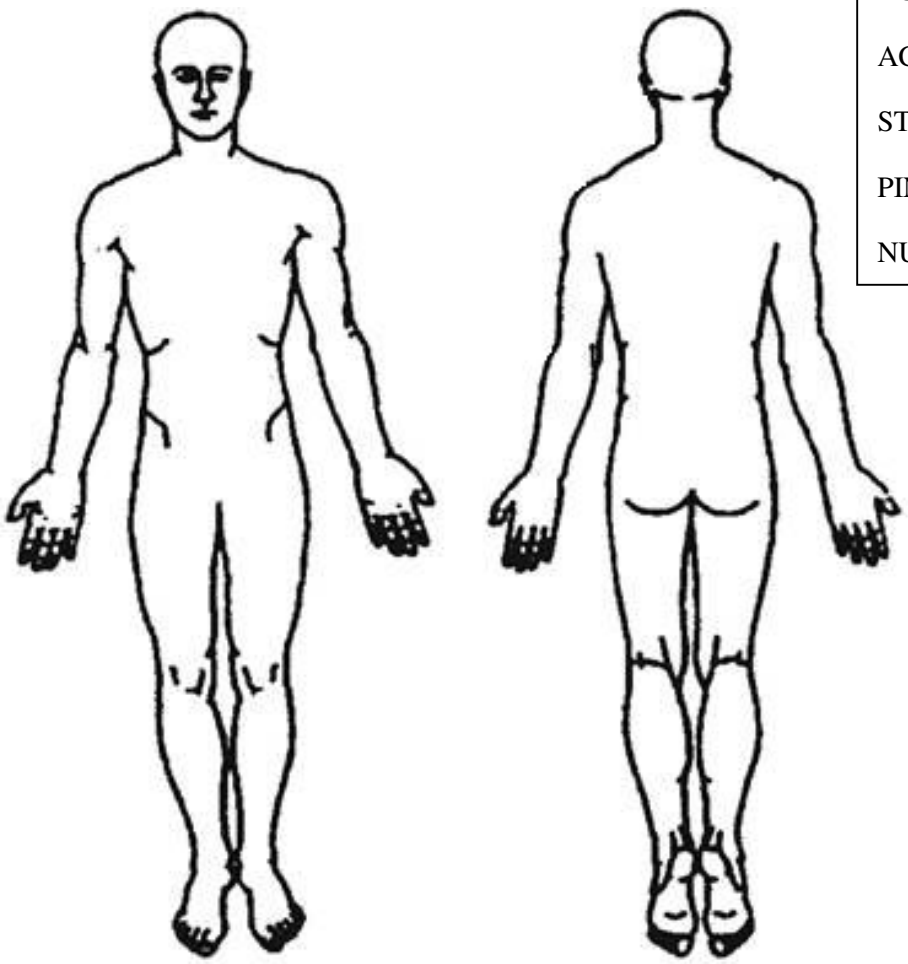
WHAT IS YOUR MAIN CONCERN: (I.E. LOW BACK PAIN…)

_____

How and when did your pain begin: Unknown Auto Accident Trauma or Other cause
(Describe)_____

_____

Where do you have pain? Mark on the pictures with the symbols: Rank your pain on a scale of 1-10 (10 being worst)



BURNING	XXXXX
ACHING	VVVVV
STABBING	///////
PINS & NEEDLES	……..
NUMBNESS	NNNNN

Is your pain worse on the: (circle)
LEFT RIGHT BOTH

What makes your pain better:

_____

_____

What makes your pain worse:

_____

_____

Have you tried: CHIROPRACTIC
PHYSICAL THERAPY
MASSAGE OTHER

Do you have current MRI / X-Ray / or Imaging studies?

When and Where: _____

Patient Name: _____ **DOB:**_____

REVIEW OF SYSTEMS (Mark any of these symptoms you may have had within the past year)

GENERAL: ☐ Poor appetite ☐ weight change
HEAD: ☐ Headaches
EYES: ☐ Blurred vision ☐ Double vision
THROAT: ☐ Chronic sore throats ☐ Difficulty swallowing
LUNGS: ☐ Shortness of breath ☐ Chronic cough
HEART: ☐ Chest pain ☐ Heart pounding ☐ Swollen ankles ☐ Swollen hands
ABDOMEN: ☐ Nausea ☐ Vomiting ☐ Change in bowel habits ☐ Blood in stool ☐ Recurrent indigestion ☐ Abdominal pain ☐ Diarrhea ☐ Constipation

MOUTH: ☐ Loose teeth ☐ False teeth ☐ Dental problems
GU: ☐ Frequent urination ☐ Pain or burning with urinate
HEME: ☐ Easy bruising ☐ Easy bleeding tendency

**** Have you ever had a blood transfusion? YES NO**

PAST MEDICAL HISTORY: (Mark if you have ever had any of the following)

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots in Legs
- ☐ Blood Clots in Lungs
- ☐ Bowel Disease
- ☐ Breast Cysts or Lumps
- ☐ Cancer _____
- ☐ Chronic Bronchitis
- ☐ Depression
- ☐ Diabetes Adult/Child
- ☐ Insulin Dependent
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Hard of Hearing
- ☐ Heart Attack Heart
- ☐ Disease
- ☐ Hepatitis
- ☐ Hernia-Hiatal/Other
- ☐ High Blood Pressure
- ☐ High Cholesterol/Triglycerides
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease/COPD
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Nervous Breakdown
- ☐ Pneumonia
- ☐ Polio
- ☐ Poor Vision
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Skin Disease
- ☐ Sleep Apnea
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcer

CARDIAC HISTORY

Have you ever been treated for a heart problem? ☐ YES ☐ NO
Name and Number of Cardiologist_____Last EKG_____

FAMILY HISTORY

	Maternal	Paternal
Blood Disease		
Heart Disease		
Cancer		
Diabetes		
Tuberculosis		
Problems with Anesthesia		
Lung Disease		
Birth Defects		
Liver Disease		
Kidney Disease		

SOCIAL HISTORY

	Yes	NO
Do you smoke?		
Packs per day		
Are you willing to quit smoking?		
Do you chew tobacco?		
Do you use drugs?		
Do you drink alcohol?		
Have you taken Cortisone?		
Any problems with Anesthesia?		
Are you left or right handed	Right	Left
History of drug alcohol abuse		
Do you use marijuana		

Please list all current medications

Name	Dose	Frequency

Please list all allergies

Allergy	Reaction

Please List all major operations or injuries

Date	Operation / Injury	Treating Provider