COLORADO SPINE INSTITUTE

elite regenerative
stem cell specialists

PATIENT INTAKE: New Patient/New Problem

NAME: ______________________ D.O.B: __________ AGE: ______ DATE: __________

HEIGHT: ________ WEIGHT: __________ HOW DID YOU HEAR ABOUT US: WEBSITE ☐ GOOGLE ☐
ADVERTISEMENT ☐ __________________ FRIEND/RELATIVE ☐ ____________________________

OTHER ☐ ____

REFERRING PHYSICIAN____________________PRIMARY PHYSICIAN ______________

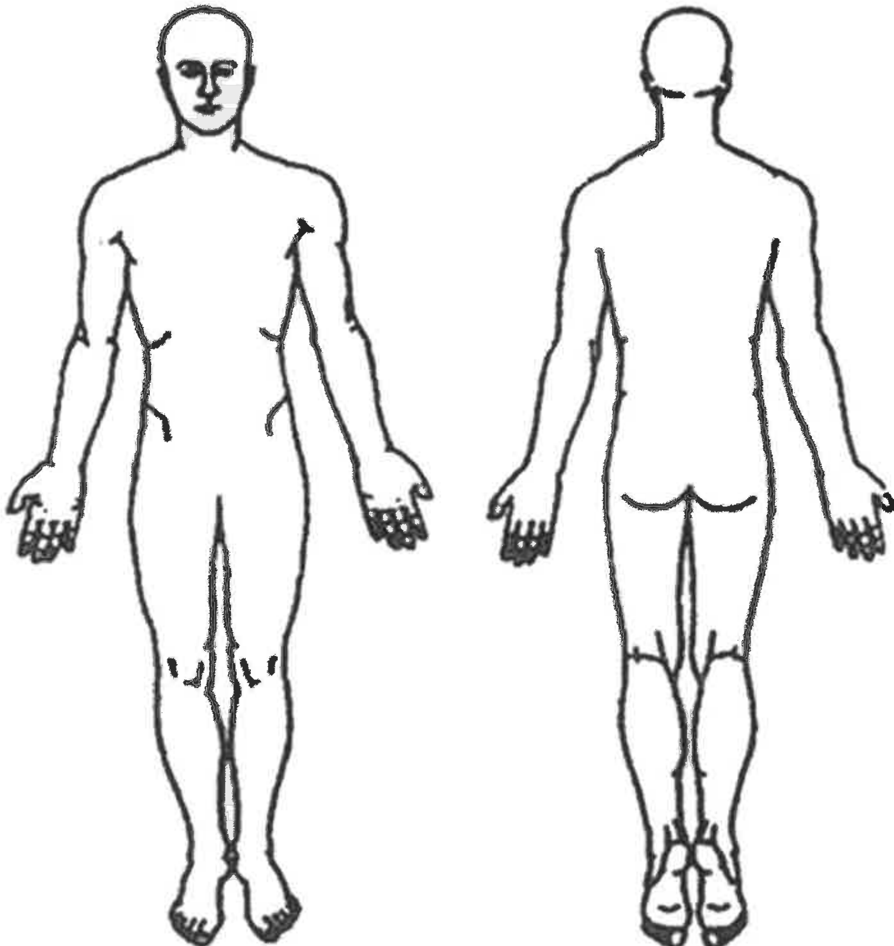
WHAT IS YOUR PRIMARY COMPLAINT: (I.E. LOW BACK PAIN…)

____

How and when did your pain begin: Unknown/Auto Accident/Trauma/Other ______________
(Describe)____
Date of Injury: ____________________ Your *typical* pain on a scale of 1-10 (10 being worst)__________

Mark your pain on the pictures with the symbols ***AND*** label with a number (1-10) indicating the worst pain area:

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



Is your pain worse on the:

LEFT RIGHT BOTH

What makes your pain better:

____
____

What makes your pain worse:

____
____

Have you tried: CHIROPRACTIC

PHYSICAL THERAPY/ MASSAGE

INJECTIONS Other__________

What medication do you take for your pain? ____________________

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

When and Where: ____