



### Florida Hospital Spine Center Patient Intake Form

Today's Date\_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Street Address \_\_\_\_\_ DOB \_\_\_\_\_  
(Address, City, State, Zip Code)

First Contact # \_\_\_\_\_ Please Circle: Home Cell Other

Second Contact # \_\_\_\_\_ Please Circle: Home Cell Other

Social Security # \_\_\_\_\_ Email Address: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Contact # \_\_\_\_\_

Nearest Friend or Relative (Name and Phone #) \_\_\_\_\_

Primary Care Physician (Name and Phone #) \_\_\_\_\_

Specialty Physician (Name, Phone # and Specialty) \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Ethnicity:  Hispanic or Latino  Non-Hispanic or Latino  Declined

Race:  American Indian/Alaska Native  Asian  White  Black/African American  
 Native Hawaiian/Pacific Islander  Other  Do Not Wish to Disclose

Primary Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insured Person's Name \_\_\_\_\_

Insured Person's Social Security # \_\_\_\_\_ Insured Person's DOB \_\_\_\_\_

Relationship to Insured Person \_\_\_\_\_ Group # \_\_\_\_\_

Policy/ID # \_\_\_\_\_ Copayment Amount \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insured Person's Name \_\_\_\_\_

Insured Person's Social Security # \_\_\_\_\_ Insured Person's DOB \_\_\_\_\_

Relationship to Insured Person \_\_\_\_\_ Group # \_\_\_\_\_

Policy/ID # \_\_\_\_\_ Copayment Amount \_\_\_\_\_

Is this an injury related to an auto/vehicular accident? Yes No  
Is this an injury related to a Worker's Compensation case? Yes No

**Symptoms: Please place a check next to all the symptoms you have had in the past 6 months**

<b>Constitutional</b>		<b>Ears, Nose and Throat</b>	
Fatigue		Recent Head Injury	
Body Aches		Thyroid Mass	
Fever		Vertigo	
Weight Loss		Sinus Pain	
Chills		Sore Throat	
Loss of Appetite		Nasal Congestion	
<b>Eyes</b>		<b>Cardiovascular</b>	
Eye Pain		Chest Pain	
Blurred Vision		Syncope	
Floaters		Lightheadedness	
Visual Hallucinations		Irregular Heart Beats	
Double Vision		Lower Extremity Edema	
Peripheral Vision Changes		Orthostatic Symptoms	
Sudden Vision Loss		Rapid Heart Rate	
Changes in Vision		Claudication	
Transient Visual Loss		<b>Respiratory</b>	
<b>Integument</b>		Shortness of Breath	
Rash		Hoarseness	
Itching		Wheezing	
Hair Growth Change		Cough	
<b>Gastrointestinal</b>		<b>Genitourinary</b>	
Nausea		Urgency	
Constipation		Urinary Retention	
Heartburn		Impotence	
Vomiting		Frequency	
Loss of Appetite		Difficulty Voiding	
Diarrhea		Possible Pregnancy	
Difficulty Swallowing		Incontinence	
Abdominal Pain		Skipped Menstrual Cycle	
<b>Endocrine</b>		<b>Psychiatric</b>	
Loss of Hair		Anxiety	
Heat Intolerance		Feeling Confused	
Constipation		Depression	
Decreased Libido		Excessive Anger	
Increased Libido		<b>Heme-Lymph</b>	
Cold Intolerance		Easy Bleeding	
Nipple Discharge		Lymph Node Enlargement	
<b>Neurologic</b>		<b>Musculoskeletal</b>	
Muscular Weakness		Joint Pain	
Difficulty Concentrating		Limitation of Motion	
Seizures		Back Pain	
Falls		Joint Swelling	
Incoordination		Muscular Weakness	
Memory Difficulties		Muscle Pain	
Tremors		Muscle Cramps	
Head Injuries		Neck Pain	
Tingling or Numbness		<b>Other</b>	
Speech Difficulties		Difficulty Sleeping	
Loss of Balance			

Please explain any current symptoms not listed above : \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have pain?      Yes                      No

If yes, where is your pain located? \_\_\_\_\_

Does it radiate?      Yes                      No

Describe your pain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please Circle One**

Are you Right Handed or Left Handed?                      Right                      Left                      Ambidextrous

Are you pregnant?                      Yes                      No

Could you be pregnant?                      Yes                      No

Current Height: \_\_\_\_\_

Current Weight: \_\_\_\_\_

**Past Medical History: (Please check all applicable boxes)**

Anemia, Iron Deficiency		Hyperthyroidism	
Angina (Ischemic Chest Pain)		Hypothyroidism	
Arthritis		Increased Cholesterol	
Asthma		Irritable Bowel Syndrome	
Bleeding Disorders		Murmurs	
Brain Mass: Intracranial Mass		Peripheral Neuropathy	
Cardiovascular Disease		Peripheral Vascular Disease	
Congestive Heart Failure		Seizures	
COPD		Stroke	
Diabetes		Ulcers	
Gastric Reflux		Fibromyalgia	
High Blood Pressure		Gout	
		Cancer (Please list details)	

Please explain all boxes checked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgical History : (please complete all applicable boxes)

Past Tests/Treatments	Yes/No	Date	Facility or Physician
Physical Therapy			
Chiropractic Treatment			
EMG/Nerve Conduction			
Traction			
Epidural Injections			
Facet Blocks			
Facet Rhizotomies			
Trigger Point Injections			

Have you taken any NSAIDs (Non steroidal anti inflammatory medications like Advil, Aleve, Tylenol, etc.)? If so, please list:

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**Please list all surgeries and major hospitalizations: (Date/Procedure)**

If none, please check

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If spine related, have you seen a spine specialist in the past?      Yes                  No

If yes, physician name?----- Phone No. -----

Have you previously seen a pain management doctor?                          Yes                  No

If yes, physician name?----- Phone No. -----

**Medications: List name, strength, and how often taken.**

If none, please check

Medication (Prescription + Over the Counter)	Dose	Frequency # Times/Day	Reason/Condition Treated	Prescribing Doctor	Current or Previous

\*\*Attach list if you need additional space

## Family Medical History

Please list and explain any family illness(es).

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## Past Scans/Tests

	Date		Date
X-Rays		PET Scan	
MRI		CT Scan	
Sonogram		Nerve Tests	
Angiogram		Myelogram	
Fluid Analysis		Cisternogram	
Bone Scan		Laboratory Tests	
Vestibular Testing			

Date of Most Recent Scan: \_\_\_\_\_ Facility: \_\_\_\_\_

Do you have CD/Films?    Yes        No

## Social History

Do you smoke?    Yes        No

If so, how long have you smoked? \_\_\_\_\_

How much do you smoke and how often? \_\_\_\_\_

If you quit smoking, when did you quit? \_\_\_\_\_

Do you drink alcohol?    Never        On Occasion        Moderately

Do you drink caffeinated beverages?    Yes        No

Frequency:    Daily        Weekly        Monthly