JACKSONVILLE
BRAIN & SPINE

NEW PATIENT INTAKE AND HISTORY FORM

Today's Date: _____

Name: _____ **Date of Birth:** _____

Local Pharmacy: _____
(Name/City/Phone#)

Mail Order Pharmacy: _____
(Name/City/Phone#)

Are you currently under the care of a Cardiologist? ☐ Yes ☐ No
If you answered "Yes", please give your cardiologist's name: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____
Timing/Onset: Date of first symptoms / injury? _____
Associated Signs and Symptoms: What are your symptoms? _____

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___ A-fib	___ Diabetes – Type 1	___ Hepatitis	___ Neuropathy
___ Anemia	___ Diabetes – Type 2	___ High blood pressure	___ Pacemaker
___ Anxiety	___ DVT	___ Anesthesia reaction	___ Pregnancy
___ Asthma	___ Emphysema	___ MRSA infection	___ Seizure
___ Cancer	___ GERD	___ HIV/AIDS	___ Stroke
___ COPD	___ Heart Attack	___ Kidney disease	___ Thyroid disease
___ Depression	___ Heart disease	___ Liver disease	

___ Other: _____

PAST SURGICAL HISTORY:

Please list any procedure(s) you have had in the past. Then write the year, reason, and hospital on the line to the right of it.

☐ **None**

_____
_____
_____
_____
_____

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition,

	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Anemia						
Aneurysm						
Anxiety Disorder						
Asthma						
Cancer						
COPD						
Depression						
Diabetes Mellitus						
DVT						
Emphysema						
GERD						
Heart Disease						
Hepatitis						
High Blood Pressure						
HIV – Positive						
Kidney Disease						
Liver Disease						
Pacemaker						
Peripheral Neuropathy						
Pulmonary Embolism						
Seizure Disorder						
Stroke						

Other: _____

MEDICATION HISTORY:

☐ **I am not currently taking any medications**

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Dosage	How Often

ALLERGY HISTORY:

☐ **No Known Allergies (NKA)** ☐ **No Known Drug allergies (NKDA)**

___ Codeine/Codeine Derivatives ___ Latex ___ Penicillin(s)

___ Iodinated Contrast Media ___ Morphine Derivatives ___ Sulfa Drugs

Other: _____

_____

SOCIAL HISTORY:

Most recent primary occupation: _____

Dominant hand: ☐ Right-Handed ☐ Left-Handed ☐ Ambidextrous

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Widowed ☐ Separated ☐ Divorced

Current household members: ☐ Patient lives alone

Or list who you live with: _____

Please describe your current tobacco use:

☐ Smoker, current status unknown ☐ Light Tobacco smoker ☐ Heavy tobacco smoker

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never Smoker

☐ Unknown if ever smoked

If yes please explain what type of tobacco used and number of cigarette packs per day: _____

_____

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: _____

_____

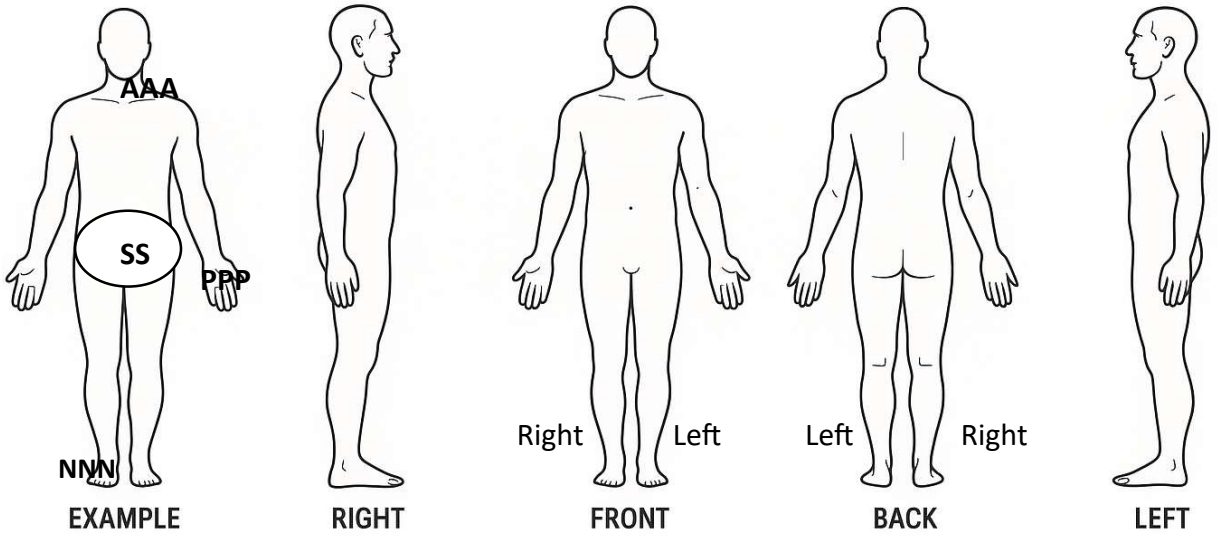
Vitals:

Height: _____ **Weight:** _____

SHOW US WHERE IT HURTS

Please mark area(s) of injury of discomfort as shown in the example below. Mark all area(s) with appropriate symbols and indicate the degree of pain using a scale of 1 (discomfort) – 10 (extreme pain). (circle any area of pain, not represented by a symbol below)

Description -	**Numbness**	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
Symbol to use -	**"N"**	**"P"**	**"B"**	**"A"**	**"S"**



Describe what caused the onset of your pain: _____

_____

What causes the pain to increase? _____

What causes the pain to decrease? _____

Is the pain related to a motor vehicle accident? ☐ Yes ☐ No **If yes, when was the accident?** _____

Pain compared to one month ago? ☐ Better ☐ Same ☐ Worse **Increases with sneezing or coughing?** ☐ Yes ☐ No

Have you tried:	**Yes or No**	**Has that helped?**	**Facility and Year Completed**
Traction:	☐ Yes ☐ No	☐ Yes ☐ No	_____
Chiropractic:	☐ Yes ☐ No	☐ Yes ☐ No	_____
Spine injection	☐ Yes ☐ No	☐ Yes ☐ No	_____
Physical Therapy	☐ Yes ☐ No	☐ Yes ☐ No	_____

Have you had:	**Yes or No:**	**When/Explanation**
Spine X-ray(s):	☐ Yes ☐ No	_____
CT scan:	☐ Yes ☐ No	_____
MRI:	☐ Yes ☐ No	_____
Bone Scan:	☐ Yes ☐ No	_____
EMG:	☐ Yes ☐ No	_____
Myelogram:	☐ Yes ☐ No	_____
Bowel control changes:	☐ Yes ☐ No	_____
Blader control changes:	☐ Yes ☐ No	_____
Weakness of extremities:	☐ Yes ☐ No	_____
Numbness of extremities:	☐ Yes ☐ No	_____

The above information is true, to the best of my knowledge.

Patient: _____ **Date:** _____

(Signature)