

**SPINE AND PAIN CENTER OF NEBRASKA---NEW PATIENT**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

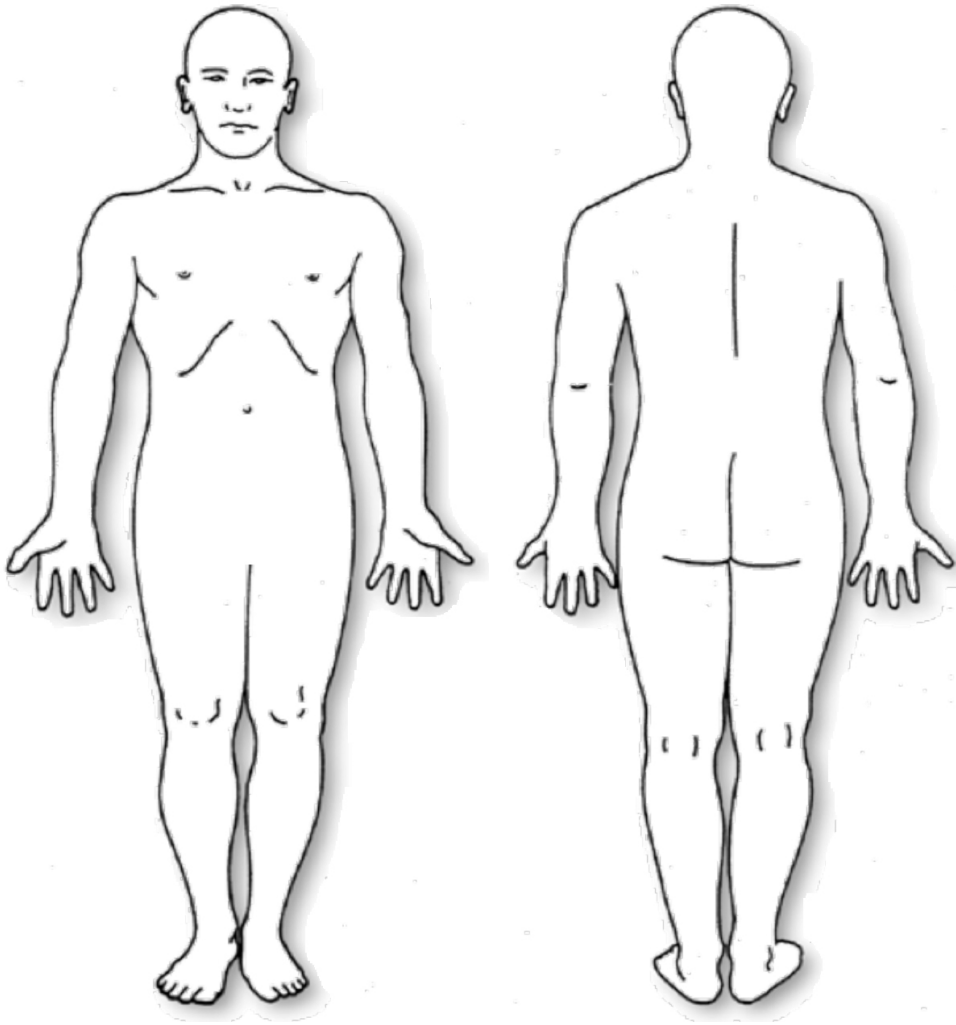
HT: \_\_\_\_\_ WT: \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

WHAT ARE YOUR EXPECTATIONS FOR TODAY'S VISIT? \_\_\_\_\_

**PLEASE SHADE IN ONLY THE AREA OF PAIN THAT YOU ARE BEING TREATED FOR TODAY:**



(place an X on the scale):

NO PAIN ----- WORST PAIN EVER

WHEN DID YOUR PAIN BEGIN? (DATE OF INJURY) \_\_\_\_\_

WORK COMP INJURY: Y\_\_N\_\_

MOTOR VEHICLE ACCIDENT: Y\_\_N\_\_

LITIGATION: Y\_\_N\_\_

DESCRIPTION OF PAIN (please circle):    constant    intermittent    sharp    aching    shooting    burning    numb    tingling    throbbing

WHAT MAKES YOUR PAIN BETTER? \_\_\_\_\_

WHAT MAKES YOUR PAIN WORSE? \_\_\_\_\_

PAIN AT ITS BEST (0-10 SCALE) \_\_\_\_\_ PAIN AT ITS WORST (0-10 SCALE) \_\_\_\_\_

WHAT THERAPIES HAVE YOU TRIED? (please circle):

PT    Aquatherapy    Chiropractor    TENS    Acupuncture    Biofeedback    Psychiatric therapy    Traction

DID YOU RECEIVE RELIEF FROM ANY OF THESE THERAPIES?

EXPLAIN \_\_\_\_\_

\_\_\_\_\_

WHAT MEDICATIONS HAVE YOU TRIED? (please circle):

OPIOIDS: (Hydrocodone, Percocet, Vicodin, Morphine, Oxycodone, Other)                      DID IT HELP? Y\_\_\_ N\_\_\_

ANTIDEPRESSANTS: (Cymbalta, Effexor, Wellbutrin, Savella, Pristiq, Other)                      DID IT HELP? Y\_\_\_ N\_\_\_

NSAIDS: ( Advil, Ibuprophen, Celebrex, Aleve, Naproxen, Other)                      DID IT HELP? Y\_\_\_ N\_\_\_

ANTI-CONVULSANTS: (Gabapentin, Neurontin, Lyrica, Topamax, Other)                      DID IT HELP? Y\_\_\_ N\_\_\_

MUSCLE RELAXERS: (Flexeril, Zanaflex, Skelaxin, Other)                      DID IT HELP? Y\_\_\_ N\_\_\_

ORAL STEROIDS:    DID IT HELP? Y\_\_\_ N\_\_\_

PLEASE LIST ALL OF THE SURGICAL PROCEDURES YOU HAVE HAD:

DATE	SURGICAL PROCEDURE	SURGEON'S NAME
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ILLNESSES AND DIAGNOSES:** (ie; Heart Disease, Diabetes, High Blood Pressure, Stroke, Fibromyalgia, Renal issues, neuropathy, Cancer, Depression, Anxiety, etc) \_\_\_\_\_

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

**ANY FAMILY HISTORY OF ILLNESSES? Please list:**

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

**MARITAL STATUS** (please circle):

Single      Married      Widowed      Divorced

**# of Children:** \_\_\_\_\_

**ARE YOU A SMOKER?** Y\_\_\_ N\_\_\_      **If yes, how many years?** \_\_\_\_\_      **Packs per day?** \_\_\_\_\_

**DO YOU DRINK ALCOHOL?** If yes, how much do you drink? \_\_\_\_\_      **How often?** \_\_\_\_\_

**DO YOU SMOKE MARIJUANA?** Y \_\_\_ N \_\_\_

**DO YOU USE OTHER ILLICIT DRUGS?** Y \_\_\_ N \_\_\_

**PERSONAL OR FAMILY HISTORY OF DRUG OR ALCOHOL ABUSE?** \_\_\_\_\_

**HAVE YOU HAD TREATMENT FOR DRUG ADDICTION OR ALCOHOLISM?** \_\_\_\_\_

**ARE YOU CURRENTLY EMPLOYED?** Y\_\_\_ N\_\_\_      **RETIRED?** Y\_\_\_ N\_\_\_      **DISABLED?** Y\_\_\_ N\_\_\_

**PLACE OF EMPLOYMENT:** \_\_\_\_\_

**POSITION/TYPE OF WORK:** \_\_\_\_\_

**LAST DATE OF EMPLOYMENT:** \_\_\_\_\_

\_\_\_\_\_

**WHAT PHARMACY WILL YOU BE USING?** \_\_\_\_\_

**FAX NUMBER AND ADDRESS:** \_\_\_\_\_



