COR Spine and Pain Center
6255 Sharlands Avenue • Reno, Nevada 89523
Office: (775)248-1267 Fax: (775)305-1267
Email: contact@corspine.com Website: www.corspine.com

History Intake Form

Date:_____ Patient Name:_____ DOB:_____

Are your symptoms: ____Better _____Worse _____No Change?
Any new falls, injuries or aggravation? _____
Has there been pain going down arm or leg? ___No ___Yes
If yes, describe pain and location: _____
Have you had any changes to the medications you are taking? ___No ___Yes
If yes, please explain: _____

How is your current pain medication(s) relieving your pain? ___Most of the Time ___Some of the Time ___Not at All ___N/A ___Other, please explain _____
Any new 'medication' allergies or side effects? ___No ___Yes
If YES, please describe: _____

Do any of the following conditions restrict you from using Anti-Inflammatories? ___No ___Yes
Mark all that apply: __Ulcers/GERD/Gastric Bypass/Ulcerative Colitis/Irritable Bowel __Blood Thinners __Bleeding Disorders __Kidney Disease __Blood Pressure (Non-Controlled) __Heart Disease __Liver Disease
Are you Diabetic? __No __Yes, please explain _____

Have there been any changes to your employment? ___No ___Yes
If yes, please explain: _____

Have you had significant functional loss at Work or at Home? (difficulty with prolonged standing or working, bending for vacuum) ___No ___Yes
If yes, please explain: _____

Have you seen another physician for this condition? ___No ___Yes
If yes, please explain: _____

Any new MRI? ___No ___Yes. If yes, where? _____

Have you had any treatment, therapies or other diagnostic testing in the last 30 days? ___No ___Yes
If yes, what & where: _____

Would you like an injection today? ___No ___Yes
When was the last time you had a steroid (medication &/or injection)? _____
Percentage of relief from most recent treatment: ____% Joint Injection ____% Trigger Point ____% Epidural
Length of time you received relief. _____

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Since you last visit, are you now experiencing any of the following? Mark all that apply.
__Incontinence __New hand or foot Numbness/Tingling __New Joint Pain __Fever or Chills

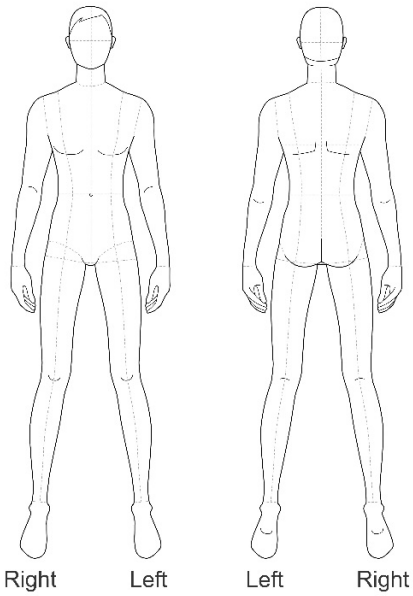
TODAY:
Requesting any medication refills today? ___No ___Yes If yes, what? _____
Pharmacy: _____

Rate your pain:
1 2 3 4 5 6 7 8 9 10
No Pain Intense Pain

Rate general activity:
1 2 3 4 5 6 7 8 9 10

Rate enjoyment of life:
1 2 3 4 5 6 7 8 9 10

Please complete the pain drawing:
===== Numbness
XXXXX Burning
^^^^^ Ache
00000 Pins & Needles
////// Shooting



Chief Complaints

1. Body Part: _____ Left | Right | Both
   Symptom(s): Pain | Instability | Stiffness | Swelling | Numbness | Weakness | Locking/Catching
2. Body Part: _____ Left | Right | Both
   Symptom(s): Pain | Instability | Stiffness | Swelling | Numbness | Weakness | Locking/Catching

Height: ___(Feet) ____(Inches) Weight: _____lbs. Are you claiming this as work related? ___No ___Yes

Current Medical Review: *Circle all that apply within the last 72 hours. **All categories require an answer***

General:	none | good general health lately | fatigue or general weakness | fevers | obesity
Eyes:	none | visual changes
Ears, Nose, Throat (ENT):	none | decreased hearing | difficulty swallowing
Cardiovascular:	none | chest pain/tightness | palpitation
Respiratory:	none | difficult breathing
Gastrointestinal:	none | loss of appetite | heartburn | constipation | diarrhea | nausea | abdominal pain

Genitourinary:	none | urinary urgency | incontinence | blood in urine | painful urination
Musculoskeletal:	none | joint pain | back pain | neck pain | joint swelling | stiffness | muscle weakness
Skin:	none | rash | lumps | ulcers
Neurologic:	none | headaches | numbness | dizziness | seizures | loss of balance
Psychiatric:	none | anxiety | depression
Endocrine:	none | weight gain | weight loss | heat or cold intolerance
Hematologic/Lymphatic:	none | enlarged lymph nodes | abnormal bleeding | abnormal bruising
Allergic/Immunologic:	none | seasonal allergies | persistent infections

Past Medical History: ***Circle ALL previously diagnosed with disease/problem (even if resolved &/or treated for)*

Anemia	Diabetes	Learning disability	Seizure disorder
Anesthesia problems	Drug abuse	Liver disease	Sleep apnea
Arrhythmia	Emphysema	Lupus	Spinal disorder
Arthritis	Fibromyalgia	MRSA	Stomach ulcers
Asthma	GERD/Heartburn	Osteoporosis	Thyroid disease
Blood clots DVT (lungs/legs)	Glaucoma	Other connective tissue disorder	TIA/stroke
Bleeding disorder	Heart disease/Chest pain	Pacemaker	VRE
Chronic lung disease	Hepatitis	Peripheral vascular disease	Cancer(s):
Concussion – prior	High blood pressure	Pulmonary fibrosis	
COPD	HIV	Required home oxygen	
Coronary artery disease	Kidney disease	Rheumatoid arthritis	

Family History: *Circle all that apply. **This section requires an answer.***

Does your biological mother/father/sibling(s) have any of the following?

No known family history | arthritis | stroke | heart disease | anesthesia problems | bleeding disorder

Social History: *Circle all that apply*

- Have you ever smoked/used nicotine? never | current | former
- Do you drink or use caffeine daily? yes | no
- Do you drink alcohol? yes | no
  - Number of drinks? None | 1-2 | 3-4 | 5-6 | 7+
  - How often? daily | weekly
- Do you have an Advanced Care Plan? yes | no
  - If yes, who is your health care agent? _____

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Medication and Allergies Sheet

Patient Name: _____ COR Spine Patient ID#: _____

Preferred Pharmacy & Location: _____

INCLUDE ALL OVER THE COUNTER ANTI-INFLAMMATORIES AND MEDICATIONS ☐ No Medications

Current Medications	Dosage	Frequency

LIST ALL MEDICATION ALLERGIES & WHAT REACTION YOU HAD TO THEM ☐ No Known Medications

Critical Reaction = anaphylaxis **Severe Reaction** = shortness of breath, facial swelling
Moderate Reaction = skin rash, hives **Mild Reaction** = itching

Medication Causing Reaction	Critical	Severe	Moderate	Mild

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-764-8111 (TTY: 1-877-764-8111).
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-764-8111 (TTY: 1-877-764-8111).

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Patient or Guardian Agreement:

☐ I acknowledge that COR SPINE AND PAIN CENTER may disclose protected health information for the purpose of payment, treatment and healthcare operations (please refer to COR SPINE AND PAIN CENTER's Notice of Privacy Practices for additional information).

All Patients:

☐ CONSENT TO TREATMENT: I consent to receive services and any ancillary services that are deemed medically necessary or appropriate by my treating physician.

☐ I understand that: I was provided with an option to receive a copy of the Privacy Practices for COR SPINE AND PAIN CENTER and have waived that option. This is posted in the practice waiting area and is also located on the website.

Family & Friends Release of Information

List family and friends, *if any*, whom we may inform about your general medical condition and your diagnosis.

Name	Relationship	Date of Birth

This Authorization will remain in effect for one year or I provide written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE