THE
SPINE
INSTITUTE

Please complete entire form before submitting.

Ht	Wt

Name	D.O.B.	Sex	R. L. Handed

Symptoms

1.

2.

Length of time:

Aggravating factors:

Relieving factors:

Previous treatment for these symptoms:

Previous testing for these symptoms:

****Drug Allergies:*

SURGERIES: (give type and date)

Have you had any problems with the following - Please check all that apply

☐ Heart	☐ Bladder	☐ Psychiatric	☐ Tingling/prickly sensations	☐ Weakness
☐ Pace-maker	☐ Diabetes	☐ Stroke	☐ Pain	☐ Muscle cramps/Spasms
☐ Lungs	☐ Hepatitis	☐ Seizure	☐ Numnness	☐ Other
☐ Bowels	☐ Blood pressure	☐ Headaches	☐ Tremor	

Please give details of the problems circled:

Marital status: Children: ☐ Yes ☐ No | How many:

How much do you smoke:

How much alcohol do you drink:

"Street Drug" use: Occupation / School:

Date of last period: If pregnant, how far:

Family History:	*Age*	*Living*	*Deceased*	*Health problems / Cause of death*
Mother:		☐	☐	
Father:		☐	☐	
Brothers:		☐	☐	
Sisters:		☐	☐	

Comments:

Signature: Date: