Paul L. Kuflik, M.D.

New Patient Intake Form
Dr. Paul Kuflik

Date of Initial Visit: _____/_____/_______

Last Name ______________________________ **First Name** ______________________________

Age: ________ **Date of Birth** _____/_____/______ **Sex:** ________ **Weight:** ________ **Height:** ________

Phone: Home______________________ **Work** _____________________ **Mobile**________________________

Email:_____________________________________

Who referred you to the Spine Institute?

____ ___________________________________
Referring Physician Name **Referring Physician Telephone #**

____
Referring Physician Address **City** **State** **Zip Code**

Please describe your main problem/complaint. ____

____

____

____

PLEASE PUT AN "X" NEXT TO THE BEST ANSWER FOR EACH QUESTION

SOCIAL HISTORY

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Highest Education Level Completed:
___ (0, 1 2 3 4 5 6 7 8) Grade school ___ (9 10 11 12) High school
___ (13 14 15 16) College, Technical ___ (> 16 YEARS) Graduate, Professional

Do you currently use Tobacco? ___ Yes ___ No **Started Age/Yr.**_______ **Stopped Age/Yr.**_______

Indicate quantity per day: **Cigarettes**_______ **Cigars**_______ **Chewing Tobacco**________

Do you currently consume Alcohol? ___ Yes___ No

Indicate quantity per day: **Beer**_________ **Wine**_________ **Distilled Spirits**_________

WORK STATUS

Occupation ___________________________________

Are you currently?
___ Working Full time ___ Working Part time
___ Unemployed ___ Retired
___ Disabled, Temporarily ___ Disabled, Permanently
___ Housewife ___ Other _______________

If you are currently NOT working:
How long have you been off work due to your back/neck pain? _______________

PAST MEDICAL HISTORY - Check below if you have had any of the following:

___ **Heart Disease**
___ **Asthma**
___ **Migraine Headaches**
___ **Emotional Disorder**
___ **OTHER** ________________
___ **High Blood Pressure**
___ **Kidney Disease**
___ **Hepatitis**
___ **Cancer**
___ **Diabetes**
___ **Tuberculosis**
___ **Epilepsy**
___ **HIV**
___ **NONE**

Current Medications (include Non-Prescription): ____

____

Medicine / Substance Allergies (include Reaction):____

____

CURRENT MEDICAL CONDITION:

Do you have:
___ **Only back pain**
___ **Back and leg pain**
___ **Only shoulder pain/arm pain**
___ **Only leg pain**
___ **Only neck pain**
___ **Neck, shoulder and arm pain**
___ **Other** __________

Which is worse:
___ **Back pain**
___ **Neck pain**
___ **Leg pain**
___ **Shoulder/arm pain**

I have had back/neck pain:
___ **Less than 1 month**
___ **3 - 6 Months**
___ **1 - 3 Years**
___ **Greater than 5 years**
___ **1 - 3 Months**
___ **6 Months - 1 Year**
___ **3 - 5 Years**

My pain came on:
___ **Gradually, over time**
___ **Quickly**

My pain was brought on by:
___ **No specific incident**
___ **Following an accident or incident at work**
___ **Following an accident or incident NOT at work**

Describe the accident/incident: ____

____

Do you have:
___ **NUMBNESS** **Where** ____________________
___ **TINGLING** **Where** ____________________
___ **WEAKNESS** **Where** ____________________

What time of the day is your pain worse: ___ **Morning** ___ **Late in the day** ___ **The middle of the night**

My pain pattern is:
___ **A Single attack of pain**
___ **Attacks of pain with pain free intervals**
___ **Continuous pain**
___ **Continuos pain with attacks of severe pain**

I experience pain:
___ **The entire day**
___ **Most of the day (16-20 HOURS)**
___ **A Good part of the day (8-15 HOURS)**
___ **A Fair amount of the day (2-7 HOURS)**
___ **A Small amount of the day (1 HOUR OR LESS)**
___ **Less than once per day**

How long does a pain attack last: ___ Seconds ___ Minutes ___ Hours ___ Constant

For how long can you walk: ___ Less than 15 minutes ___ 15 - 30 Minutes ___ 30 - 60 Minutes ___ NO Restrictions

How long can you sit: ___ Less than 15 minutes ___ 15 - 30 Minutes ___ 30 - 60 Minutes ___ NO Restrictions

How long can you stand: ___ Less than 15 minutes ___ 15 - 30 Minutes ___ 30 - 60 Minutes ___ NO Restrictions

What position/activity make the pain worse or better?

	Better	Worse	Comments			Better	Worse	Comments
Standing					Bending			
Sitting					Lifting			
Walking					Coughing			
Stairs					General Activity			
Lying Down					Bowel Movement			

Pain Rating Scale: **How would you rate your pain today: (Circle One Number)**

No Pain — 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 — *Worst Possible Pain*

None (0) Mild (2) Moderate (5) Severe (8)

Where have you sought help for your pain: (Check all that apply)

- ___ Family Doctor
- ___ Orthopedic Doctor
- ___ Spine Surgeon
- ___ Physical Therapist
- ___ Neurologist
- ___ Psychiatrist / Psychologist
- ___ Physiatrist
- ___ Chiropractor
- ___ Pain Clinic
- ___ OTHER ______________________

Have any of the above decreased your pain: ___ NO ___ YES Specify__________________________

My pain now seems to be: ___ Getting better ___ Staying the same ___ Getting worse

Have you noticed any change in your bowel or bladder habits:

___ NO ___ YES Describe: ___________________________________

Have you had previous Surgery:

___ YES WHEN: ____/____/____ TYPE: ____________________________________

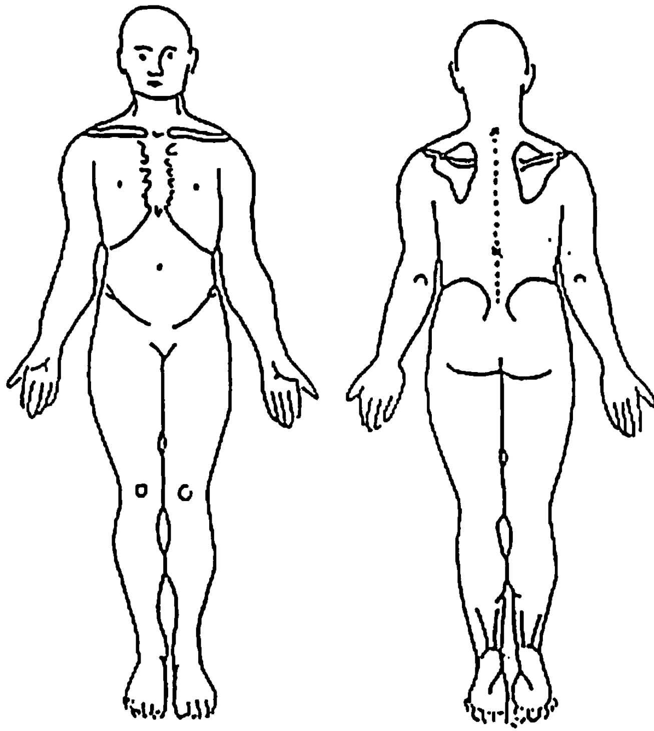
___ NO WHEN: ____/____/____ TYPE: ____________________________________

WHEN: ____/____/____ TYPE: ____________________________________

If you had previous spine surgery, did the surgery make the pain better: ___ YES ___ NO

Have you, or are you planning to apply for disability or workmen's compensation: ___ YES ___ NO

Is there a lawsuit or litigation pending in relationship to your pain? ___ YES ___ NO



PAIN DIAGRAM:
Please use the following diagrams to show us where you are experiencing pain and numbness:

Pain: x x x x x x
Numbness: o o o o o o o
Aching: / / / / / /

Please circle all of the following adjectives which describe your pain:

DULL	BURNING
COLD	SHOOTING
TIGHT	THROBBING
ELECTRIC	TINGLING
OTHER____________________	

Patients with Scoliosis or Kyphosis, please complete the next section.

SCOLIOSIS / KYPHOSIS SECTION

Year deformity was first noticed: ________

Your age at the time deformity was first noticed: ________

Family history of Scoliosis/ Kyphosis: ___ None ___ Parent ___ Brother/ Sister ___ Cousin ___ Other ________________________________

Previous non-operative treatment: ___ None ___ Exercise ___ Brace ___ Observation only ___ Other ________________________________

First operative event: _____/_____/_____ **Second operative event:** _____/_____/_____

Current concerns: ___ None ___ Feel imbalance ___ New or increased back pain ___ Painful rod ___ Unhappy with my appearance

If you have back pain, then where: ___ Upper back ___ Mid back ___ Lower back

Do you feel that your curves have increased or decreased over time: ___ Yes ___ No
Do you feel you have lost height in the last few years: ___ Yes ___ No

***** END OF QUESTIONNAIRE *****