Vanderbilt Orthopaedic Institute

Vanderbilt Spine Center

Dan M. Spengler, M.D.
Rick A. Davis, M.D.

New Patient Intake Form

Date:________________________________

Name:_______________________________

Address:_____________________________

City:________________________________

State:__________ Zip:__________________

Phone:_______________________________

Sex:_____________ Age:_______________

Height:_________ Weight:______________

Referring Physician Name:

____

Physician's Address:

____

____

Chief Complaint:

Do you have? (circle):

Back Pain Yes/No
Leg Pain Yes/No

Which is worse? Back/Leg

Neck Pain Yes/No
Arm Pain Yes/No

Which is worse? Neck/Arm

Rate your pain on a scale from 1-10 (10 being the most severe)_________________________

How long have you had these symptoms? ____

Is this problem resulting from:

Work Injury Yes/No
Car Accident Yes/No

Do you have an attorney for your problem? Yes/No

Have you ever had a work related spine injury? Yes/No

Did you miss work as a result of your problem? Yes/No

Have you had back/neck surgery? Yes/No

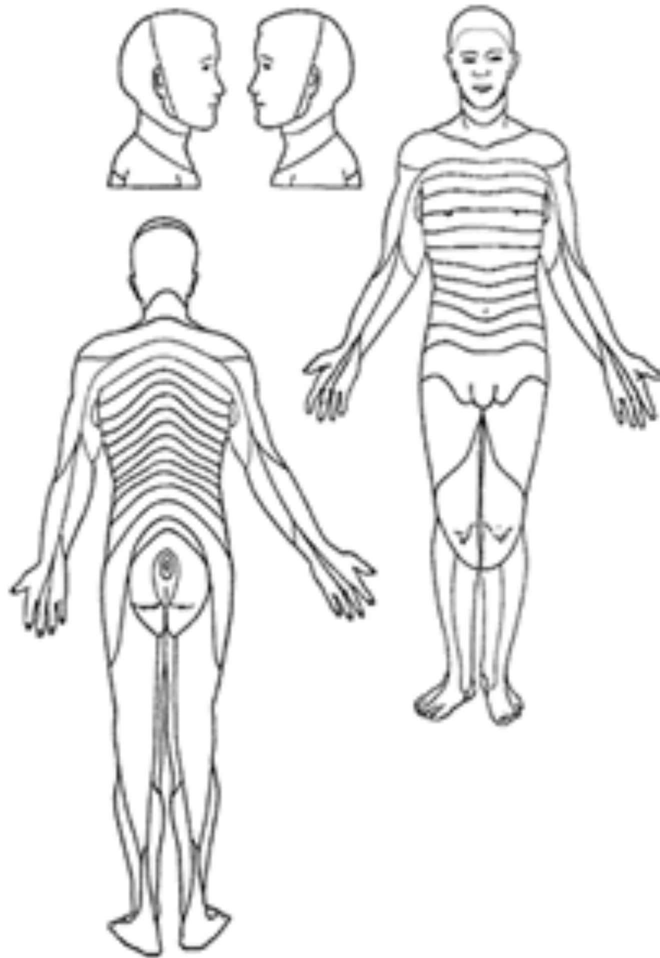
Year: _______________________ Operation:____

Did your symptoms improve after surgery? Yes / No

If so, how long? ___________________________

Pain Diagram

Mark the area where you now feel your typical pain



Diagnostic Studies

	Most Recent Dates
MRI	____________________
CT	____________________
EMG	____________________

Previous Treatment

Physical Therapy	Yes / No	
Chiropractor	Yes / No	
Epidural Steroid Injections	Yes / No	If so, how many? ____________
Acupuncture	Yes / No	

Medical History

Have you ever been diagnosed with the following: (check all that apply)

Diabetes	_____	Fatigue Syndrome	_____
Asthma	_____	Cancer	_____
Heart Attack	_____	Arthritis	_____
Blood Clots	_____	Thyroid nodule	_____
Stroke	_____	Kidney infection	_____
Ulcers	_____	Migraine Headaches	_____

Review of Symptoms

Constitutional

Fever O YES O NO

Chills O YES O NO

Loss Appetite O YES O NO

Musculoskeletal

Joint Stiffness/Swelling O YES O NO

Muscle Pain/Swelling O YES O NO

Fatigue O YES O NO

Fractures O YES O NO

Gastrointestinal

Heartburn O YES O NO

Constipation O YES O NO

Diarrhea O YES O NO

Skin

Rash O YES O NO

Hives O YES O NO

Eczema O YES O NO

Neurologic

Paralysis O YES O NO

Seizures O YES O NO

Double Vision O YES O NO

Respiratory/CV

Shortness of Breath O YES O NO

Irregular Heartbeat O YES O NO

Cough O YES O NO

Chest Pain O YES O NO

Allergy/Immune

Drug Allergy O YES O NO

Food Allergy O YES O NO

Seasonal Allergy O YES O NO

Hematologic

Anemia O YES O NO

Excessive Bleeding O YES O NO

Easy Bruising O YES O NO

Lymphoma O YES O NO

Endocrine

Menopause O YES O NO

Obesity O YES O NO

Pelvic Pain O YES O NO

Genitourinary

Sexual Difficulties O YES O NO

Pain Urinating O YES O NO

Blood in Urine O YES O NO

HEENT

Eye Redness O YES O NO

Ear Ringing O YES O NO

Glaucoma O YES O NO

Psychiatric

Poor Sleep O YES O NO

Depression O YES O NO

Anxiety O YES O NO

Allergies (list drug allergies)

____

Medications (list current medications/doses)

____
____
____
____

Family History (circle all that apply)

Spine problems
Bleeding Disorder
Diabetes
Heart Disease
Cancer

Social History (circle all that apply)

Level of Education:	*High School*	*Technical School*	*College*	*Post Graduate*
Marital Status:	*Single*	*Married*	*Divorced*	*Widowed*
Children:	Yes / No	If so, how many?	______________	
Work Status:	*Working*	*Not Working*	*Student*	*Disabled*
	Retired			

Occupation: ________________________ Employer: ________________________________

Do you Smoke Cigarettes/Cigars/Pipe or Chew Tobacco
Yes / No If so, how much? _________________

Amount of beer/alcohol consumed in a week: ______________________________________

How often do you exercise each week?

____

What type of exercise?

____

This questionnaire has been reviewed and confirmed with the patient:

Dan M. Spengler, M.D. ____________________________________Date_____________________

Rick A. Davis, M.D. _______________________________________ Date_____________________