DISC CENTERS of AMERICA STOCKTON

Stockton Spine Center

Patient Intake Form

Welcome to Stockton Spine Center. To accurately assess you and to determine if you are a qualified candidate for our care, it is important that you fill out this form as thoroughly as possible. Thank You. *– Dr. Le & Staff*

Today's Date _____ Time _____ am pm

Name _____ **Sex** ____ **Birthday** _____ **Age** _____

Marital Status (Single Married Divorced Separated) Spouse Name _____

Address_____ City_____ State ____ Zip Code _____

Cell #_____ Work #_____ Email _____

Employer _____ Occupation_____

How did you hear about us? _____

What/Where Is Your Main Problem/Pain Prompting Your Request With The Doctor Today?

_____

How Long Have You Been Like This?_____

How Serious Do You Think Your Problem Is?_____

Would You Consider This Problem? (circle one)
- MINIMAL (Annoying but causing NO limitations)
- SLIGHT (Tolerable but causing a little limitation)
- MODERATE (Sometimes tolerable but definitely causing limitations)
- SEVERE (Causing Significant limitations)
- EXTREME (Causing near constant (>80% of the time) limitations)

In Reference To Your MAIN PROBLEM
- How Often Are You Aware of This Problem? (circle one)
- Occasionally (25% of the time)
- Intermittently (50% of the time)
- Frequently (75% of the time)
- Constant (90-100% of the time)

On a Scale of 0-10 (10 - being unbearable, 0 - being No Pain or Discomfort)
Please rate the following...
- The HIGHEST your pain gets WITHOUT medication _____
- The LOWEST your pain gets WITHOUT medication _____
- The HIGHEST your pain gets WITH medication _____
- The LOWEST your pain gets WITH medication _____

Please describe the quality of the pain.
(sharp, dull, achy, stabbing, shooting, tingling, numbness, burning, etc...)

Although you are not a doctor or specialist, you are in fact the person who knows more about your back than anyone else. In your own words and in your own opinion what do you think the real problem is?

Since your pain became this severe what THREE things/activities has it caused you to miss the most?

How has your life changed since your pain became a problem?

What kinds of treatments have you received?

Epidural: How Many _____ When(approx) _____
Dr's Name: _____Clinic Name: _____
Chiropractic: How Many _____ When(approx) _____
Dr's Name: _____Clinic Name: _____
Physical Therapy: How Long _____ When(approx) _____
Medication, OTC:_____
Injection:_____

List ANY past major surgeries that you have had and the corresponding dates.

Did any of these treatments work? If so which one(s)? For how long?

If you cannot find a solution to this problem, what do you think will happen to you?

List OTHER health problems/concerns NOT including your main problem above.

What are you hoping happens today because of your consultation with the Doctor?

Patient / Guardian Signature: _____Date:_____