

# The Boston Spine Group

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Patient \_\_\_\_\_ Sex M F  
Last First Middle

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Home PH (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work PH (\_\_\_\_)-\_\_\_\_-\_\_\_\_ E-Mail \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Name Address PH

Nearest Friend/Relative \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_  
Name Phone  
Address \_\_\_\_\_ UPIN # \_\_\_\_\_

Current Physician \_\_\_\_\_  
Name Phone  
Address \_\_\_\_\_ UPIN # \_\_\_\_\_

## Primary Insurance

Name \_\_\_\_\_  
ID# \_\_\_\_\_  
Group# \_\_\_\_\_  
Subscriber \_\_\_\_\_  
SSN of Subscriber \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
\_\_\_\_\_

## Secondary Insurance

Name \_\_\_\_\_  
ID# \_\_\_\_\_  
Group# \_\_\_\_\_  
Subscriber \_\_\_\_\_  
SSN of Subscriber \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
\_\_\_\_\_

## Workers' Compensation

Insurance \_\_\_\_\_ Claim # \_\_\_\_\_

Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Last Worked \_\_\_\_/\_\_\_\_/\_\_\_\_

Billing Address \_\_\_\_\_

Adjuster \_\_\_\_\_ PH \_\_\_\_\_ FX \_\_\_\_\_

RN Manager \_\_\_\_\_ PH \_\_\_\_\_ FX \_\_\_\_\_

Attorney \_\_\_\_\_  
Name Address Phone

Pharmacy name: \_\_\_\_\_ Address \_\_\_\_\_

Pharmacy phone number: \_\_\_\_-\_\_\_\_-\_\_\_\_

I hereby assign to the physician for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance(s).

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



**Patient Intake Questionnaire 2 of 3**

Have you had any of the following diagnostic procedures done in evaluation for **this episode** of pain?

(Date/Place)

Bone Scan	____/____/____	_____
CT Scan	____/____/____	_____
Myelogram	____/____/____	_____
EMG	____/____/____	_____
X-Rays	____/____/____	_____
Blood Work	____/____/____	_____
Discogram	____/____/____	_____
MRI	____/____/____	_____

What kind of treatment have you received in this current episode of pain?

Best Rest	Yes___ No___
Medication	Yes___ No___
Brace	Yes___ No___
Physical Therapy	Yes___ No___
Chiropractor	Yes___ No___
Acupuncture	Yes___ No___
Facet Injections	Yes___ No___
Epidural Injections	Yes___ No___
Other Injections	Yes___ No___

What medications are you currently taking (dose) \_\_\_\_\_

Medication Allergies \_\_\_\_\_

Have you had any previous complications with anesthetics? No\_\_\_\_\_ Yes \_\_\_\_\_

Have you had problems with addiction to prescription or non-prescription medications? No \_\_\_ Yes \_\_\_

What type of spine surgeries have you had? \_\_\_\_\_

When\_\_\_\_\_ Where\_\_\_\_\_ By Whom\_\_\_\_\_

When\_\_\_\_\_ Where\_\_\_\_\_ By Whom\_\_\_\_\_

Past surgical history (please include dates): \_\_\_\_\_

Past medical history (please include dates): \_\_\_\_\_

Family medical history: \_\_\_\_\_

Are you married? Single? Divorced? How many children?

Do you smoke? No\_\_\_ Yes, \_\_\_\_\_pack(s)/day How many years?

Do you drink alcohol? No\_\_\_ Yes, \_\_\_\_\_ drink(s)/week

What is your current occupation/work status? \_\_\_\_\_

Are you currently working? Yes\_\_\_\_\_ No\_\_\_\_\_ Are you currently receiving Workers Compensation?

If you are out of work, how long? \_\_\_\_\_

Do you exercise regularly? Yes\_\_\_\_\_ No\_\_\_\_\_ What is your height? \_\_\_\_\_ Weight? \_\_\_\_\_

Are you involved in a personal injury lawsuit because of your pain? Yes\_\_\_\_\_ No\_\_\_\_\_

**Patient Intake Questionnaire 3 of 3**  
Circle any symptoms you now have:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Fever/Chills        | <input type="checkbox"/> Excessive sweating        | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Significant weight change |
| <input type="checkbox"/> Vision changes      | <input type="checkbox"/> Eye Pain/Redness          | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Insomnia                  |
| <input type="checkbox"/> Hearing loss        | <input type="checkbox"/> Nose bleeds               | <input type="checkbox"/> Oral lesions          | <input type="checkbox"/> Throat Disorder           |
| <input type="checkbox"/> Heart trouble       | <input type="checkbox"/> Chest pain                | <input type="checkbox"/> Heart skipping        | <input type="checkbox"/> Palpitations              |
| <input type="checkbox"/> Swollen ankles      | <input type="checkbox"/> Leg cramps                | <input type="checkbox"/> Swollen glands        | <input type="checkbox"/> High blood pressure       |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cough                     | <input type="checkbox"/> Wheezing              | <input type="checkbox"/> Bloody sputum             |
| <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Abdominal pain            | <input type="checkbox"/> Reflux                | <input type="checkbox"/> Change in bowel habits    |
| <input type="checkbox"/> Incontinence        | <input type="checkbox"/> Urinary frequency         | <input type="checkbox"/> Blood in urine        | <input type="checkbox"/> Menstrual changes         |
| <input type="checkbox"/> Pain in joints      | <input type="checkbox"/> Decreased range of motion | <input type="checkbox"/> Persistent infections | <input type="checkbox"/> Muscle weakness/paralysis |
| <input type="checkbox"/> Skin lesions        | <input type="checkbox"/> Rashes/bumps              | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Easy bruising             |
| <input type="checkbox"/> Numbness            | <input type="checkbox"/> Tremor Dizziness          | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Prolonged bleeding        |
| <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Depression                | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Excessive thirst          |

This part of the questionnaire is designed to give your caregiver information on how your pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realize you may consider two statements in any section may relate to you, but please *mark only one box that most closely describes your problem.*

**Pain Intensity**

- 0 I can tolerate the pain I have without having to use painkillers.
- 1 The pain is bad but I manage without taking painkillers
- 2 Painkillers give complete relief from pain
- 3 Painkillers give moderate relief from pain
- 4 Painkillers give very little relief from pain
- 5 Painkillers have no effect on the pain and I do not use them

**Getting Dressed** (in the past week)

- 0 I can dress myself.
- 1 I can dress myself without increasing pain.
- 2 I can dress myself but pain increases.
- 3 I can dress myself but with significant pain.
- 4 I can dress myself but with severe pain.
- 5 I cannot dress myself due to pain.

**Lifting** (in the past week)

- 0 I can lift heavy objects without pain.
- 1 I can lift heavy objects, but it is painful.
- 2 Pain prevents me from lifting heavy objects off the floor, but I can manage them from a table.
- 3 Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are conveniently positioned.
- 4 I can lift only light objects.
- 5 I cannot lift or carry anything.

**Walking and running** (in the past week)

- 0 I can run or walk without pain.
- 1 I can walk comfortably, but running is painful.
- 2 Pain prevents me from walking more than 1 hour.
- 3 Pain prevents me from walking more than 30 minutes.
- 4 Pain prevents me from walking more than 10 minutes.
- 5 I am unable to walk or can only walk a few steps at a time.

**Sitting** (in the past week)

- 0 I can sit in any chair as long as I want.
- 1 I can only sit in a special chair for as long as I want.
- 2 Pain prevents me from sitting longer than 1 hour.
- 3 Pain prevents me from sitting longer than ½ hour.
- 4 Pain prevents me from sitting longer than 10 minutes.
- 5 Pain prevents me from sitting at all.

**Standing** (in the past week)

- 0 I can stand as long as I want.
- 1 I can stand as long as I want, but it gives me pain.
- 2 Pain prevents me from standing longer than 1 hour.
- 3 Pain prevents me from standing longer than 30 minutes.
- 4 Pain prevents me from standing longer than 10 minutes.
- 5 Pain prevents me from standing at all.

**Sleeping** (in the past week)

- 0 I sleep well.
- 1 Pain occasionally interrupts my sleep.
- 2 Pain interrupts my sleep half of the time.
- 3 Pain often interrupts my sleep.
- 4 Pain always interrupts my sleep.
- 5 I never sleep well.

**Sex Life** (in the past week)

- 0 My sex life is unchanged.
- 1 My sex life is unchanged but causes some pain.
- 2 My sex life is nearly unchanged but it is very painful.
- 3 My sex life is severely restricted because of pain.
- 4 My sex life is nearly absent because of pain
- 5 Pain prevents any sex life at all.

**Social Life** (in the past week)

- 0 My social and recreational life is unchanged.
- 1 My social/rec life is unchanged, but it increases pain.
- 2 My social/rec life is unchanged, but it severely increases pain.
- 3 Pain has restricted my social/recreational life.
- 4 Pain has severely restricted my social/recreational life.
- 5 I essentially have no social/recreational life due to pain.

**Traveling** (in the past week)

- 0 I can travel anywhere.
- 1 I can travel anywhere but it gives me pain.
- 2 Pain is bad but I can manage to travel over 2 hours.
- 3 Pain restricts me to trips of less than 1 hour.
- 4 Pain restricts me to trips of less than 30 minutes.
- 5 Pain prevents me from traveling.