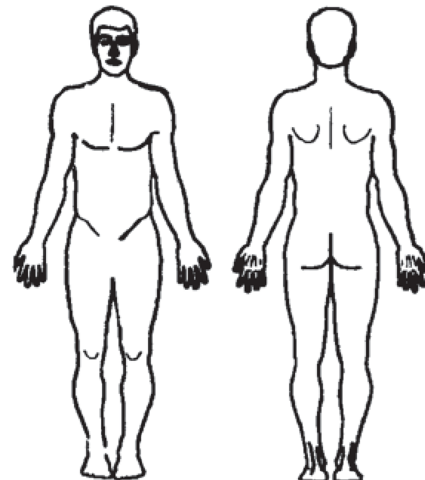
Advanced Spine Care PA
State-of-the-Art Spinal Therapy

Patient Name________________________ Birthdate____/____/____ Sex: ❒ Male ❒ Female



MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

❒ Headache ❒ Neck Pain ❒ Mid-Back Pain ❒ Low Back Pain

❒ Other________________________

Is this? ❒ Work Related ❒ Auto Related ❒ N/A

Date Problem Began:________________

How Problem Began:________________________

Current Complaint—How you feel today (circle one number):

No Pain ------ 0 1 2 3 4 5 6 7 8 9 10 ------ Unbearable Pain

How often are your symptoms present? ❒ 0-25% ❒ 26-50% ❒ 51-75% ❒ 76-100%

Can you perform your daily activities? ❒ Yes ❒ No

Describe any current activity limitations________________________

HAVE YOU HAD SPINAL X-RAYS, MR1, CT SCAN? ❒ Yes (Dates)________________ ❒ No

WHAT AREAS WERE TAKEN?________________________

Please check all of the following that apply to you: ❒ None Apply

Yes	No	Condition	Yes	No	Condition
❒	❒	History of Recent Infection	❒	❒	Prostate Problems
❒	❒	Recent Fever	❒	❒	Frequent Urination
❒	❒	HIV/AIDS	❒	❒	Currently Pregnant: No. of weeks________
❒	❒	Diabetes	❒	❒	Abnormal Weight
❒	❒	Corticosteroid Use	❒	❒	Epilepsy/Seizures
❒	❒	Birth Control Pills	❒	❒	Visual Disturbances
❒	❒	High Blood Pressure	❒	❒	Low/Mid Back Pain
❒	❒	Stroke (Date)	❒	❒	Neck Pain
❒	❒	Dizziness/Fainting	❒	❒	Arthritis
❒	❒	Numbness in Groin/Buttocks	❒	❒	History of Alcohol Use
❒	❒	Urinary Retention	❒	❒	History of Tobacco Use
❒	❒	Aortic Aneurysm	❒	❒	Nocturnal Pain (Pain at Night)
❒	❒	Cancer/Tumor	❒	❒	Surgeries (Type and Date)________
❒	❒	Osteoporosis			________
❒	❒	Recent Trauma	❒	❒	Medications________
					________

Family History: ❒ Cancer ❒ Diabetes ❒ High Blood Pressure ❒ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify Advanced Spine Care immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that Advanced Spine Care may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to Advanced Spine Care to contact my physician, if necessary.

Patient Signature________________________ Date________________

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Non-Surgical IDD Therapy®