Wasatch Neurosurgery & Spine
1220 East 3900 South, Suite 4E
Salt Lake City, Utah 84124
801-261-8507

Name:_____ DOB:_____ Date: _____

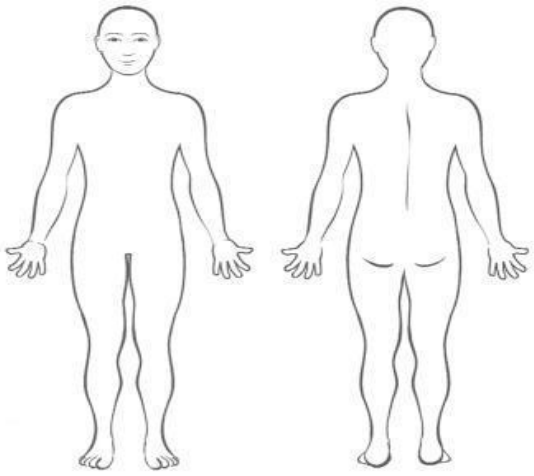
Who is your Primary Care Physician?_____
Who referred you to our Clinic?_____

Please describe the reason for your visit today:
_____
_____

Have you had any imaging or previous treatments and if so, where:
_____

Please indicate where your pain is located and what type of pain you feel at the present time. Use the symbols to describe your pain.

XXX PAIN = = = NUMBNESS



Is this pain (please circle one) NEW RECURRENT CHRONIC

Circle the number that best describes your pain right now:
(One being hardly any pain at all, ten being the most severe pain you have ever felt.)

1 2 3 4 5 6 7 8 9 10

Have you tried any of the following:(Circle all that apply)

Nothing	Chiropractor	Ice	NSAIDS
Analgesics	Heat	Muscle relaxant	Walking
Bed rest	Home exercises		

Improvement on treatment

No relief	Mild relief	Moderate relief	Significant relief

Do you currently exercise? Circle all that apply:
Exercise: Walking Swimming Running None Other: _____
Frequency: Daily # of ____Days/Week Rarely Never

Preferred local and mail order pharmacy: _____
List all allergies to medications, food and environmental and reactions:
_____

List all the **medications and supplements** you are currently taking and **doses**:

1._____	4._____	7._____
2._____	5._____	8._____
3._____	6._____	9._____

List any past medical history such as: (circle all that apply)

Asthma	Headaches
High Blood Pressure	Kidney Problems
High Cholesterol	Heart Attack
Heart Problems	Osteoarthritis
Diabetes	Osteoporosis
Cancer Type:_____	
Other_____	

Do you have any mental health disorders? Yes No
Please describe: _____

List all other previous surgeries and years performed. PLEASE INCLUDE ALL SPINAL SURGERIES:

Type _____	Type _____
Type _____	Type _____
Type _____	Type _____

Family history:

- **Adopted**

Member Living/Deceased	Heart	Diabetes	Kidney Disease	Cancer (Type)	Other
Father L/D					
Mother L/D					
Sibling: M/F L/D					
Sibling: M/F L/D					
Children: M/F					
Children: M/F					
Other/Additional Family:					

Other/Additional Family:					

Social History
Do you smoke? Yes No How many packs per day? _____ Years? _____
If former, when did you quit? _____
Do you use smokeless tobacco? Yes No
Do you use alcohol? Yes No How much and how often? _____
Use of Caffeine Circle all that apply: coffee tea soda
How much of each per day? _____
Do you now or have you ever had a problem with illicit substance abuse?
Yes No If yes, please describe: _____
Are you currently employed? Yes No Retired
Employer and position: _____

Relationship Status: Single Married Divorced Widowed Other: _____
Do you have any children? Yes No **How many? _____**
Do you live alone? Yes No Who lives with you?_____

Review of all other Systems (circle all that apply)

Fever	Blurred vision	Heartburn	Excessive hunger
Chills	Double vision	Nausea	Allergies
Weight loss	Light sensitivity	Vomiting	Excessive thirst
Fatigue	Eye pain	Abdominal pain	Dizziness
Sweating	Eye discharge	Diarrhea	Tingling
Weakness	Eye irritation	Constipation	
		Blood in stool	
Rash	Chest pain	Painful urination	Sensory change
Itching	Palpitations	Urinary urgency	Speech change
Easy bruising	Shortness of breath	Urinary frequency	Focal weakness
Easy bleeding		Blood in urine	Seizures
		Flank pain	Loss of consciousness
			Falls
Headaches	Cough	Neck pain	Depression
Hearing loss	Bloody mucus	Back pain	Suicidal thoughts
Ringing in ears	Sputum	Muscle pain	Substance abuse
Ear pain	Wheezing	Joint pain	Hallucinations
Ear discharge		Leg swelling	Anxiety
Nosebleeds		Gait changes	Insomnia
Congestion		Leg pain R/L	Memory Loss
Sore throat		Arm pain R/L	
Voice changes			