INOVA
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INOVA SPINE PROGRAM INTAKE QUESTIONS

DATE____/____/_____

Name _____ Date of Birth ___/___/_____ Gender ☐ M ☐ F
Mailing Address_____
Phone Numbers _____(home) _____(work) _____(cell)
Insurance Information _____
Height___ft___in Weight _____Lbs Email address _____
Smoking Status _____No history of tobacco use _____Former tobacco use (no longer actively using tobacco products) _____Current tobacco use

Primary Care Provider Information
Name_____ _____Phone Number_____
Address_____
How did you hear of our spine program? _____
Preferences:
Spine Specialist (by name)_____ Type of Spine Specialist_____
Location_____

Spine History

Describe your current symptoms related to spine problem

_____

_____

What diagnosis has your doctor/physician given you, if any?

_____

Was there a specific event that caused your symptoms? ____YES _____NO
Please Describe (include information about work injuries or motor vehicle accidents, if applicable)

_____

_____

Have you ever filed a Worker's Compensation claim related to a neck or back injury? _____YES _____NO
How long have your symptoms been present? (Estimated month/year) _____/_____

Pain Information

_____Pain (include present pain intensity on zero to ten numeric pain scale where zero is no pain and ten is the worst pain you can imagine _____ Additional pain information _____
Please list any medications you are presently taking for this spine problem:

_____

_____

Please check any of the following symptoms you are presently experiencing?

_____Numbness/Tingling Location_____
_____Muscular weakness Location_____
_____Recent onset of bladder incontinence (dribbling, leaking or having urinary accidents)
_____Recent onset of bowel incontinence (lose control of bowels/stools)
_____Recent onset of numbness, particularly between legs, perineum area or between buttocks
_____Recent onset of stumbling, falling or losing control of your feet when walking
_____Resent onset of dropping items, inability to grasp objects

Have you had any of the following?
Chiropractor Appointments_____YES _____NO Physical Therapy_____YES _____NO
Steroid Injections_____YES _____NO
Radiology Tests related to present spine problem _____MRI _____X-Rays _____ CT Scan
Previous surgeries _____Neck surgery _____ Back surgery

Fax Completed Form to: 703-391-3710