# GONSTEAD SPINE INSTITUTE HISTORY UPDATE

| PATIENT NAME | DATE |
|---|---|
| | |

## PATIENT INFORMATION

☐ Check here if your contact information has not changed

Last Name _____ First Name _____ Middle Initial _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-mail _____
Employer _____ Occupation _____

## INSURANCE INFORMATION

☐ Check here if you do not have insurance and will be paying cash for all services
☐ Check here if your insurance information has not changed

Who is responsible for this account? _____ Relationship to patient _____
Insurance Company _____ ID # _____ Group # _____
**Please give the front desk a copy of your insurance card for our records*

## PATIENT CONDITION

**Chief Complaint** and it's location _____

What caused the onset _____

Date of onset _____ Frequency of pain: ____Constant ____ Frequent ____ Intermittent ____ Occasional

On a scale of 0 to 10 with 0 representing no pain and 10 being Excruciating, please rate your pain level below:

Sitting here today, right now, my pain level is:
____ 0 ____ 1 ____2 ____3 ____4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10
What is the least intense the symptom has been:
____ 0 ____ 1 ____2 ____3 ____4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10
What is the most intense the symptom has been:
____ 0 ____ 1 ____2 ____3 ____4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10

How would you best describe the sensation of the pain/symptom
____ Sharp ____ Dull ____ Throbbing ____ Numbness ____ Shooting ____ Burning ____ Tingling ____ Other

**Secondary Complaint** and it's location _____

What caused the onset _____

Date of onset _____ Frequency of pain: ____Constant ____ Frequent ____ Intermittent ____ Occasional

On a scale of 0 to 10 with 0 representing no pain and 10 being Excruciating, please rate your pain level below:

Sitting here today, right now, my pain level is:
____ 0 ____ 1 ____2 ____3 ____4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10
What is the least intense the symptom has been:
____ 0 ____ 1 ____2 ____3 ____4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10
What is the most intense the symptom has been:
____ 0 ____ 1 ____2 ____3 ____4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10

How would you best describe the sensation of the pain/symptom
____ Sharp ____ Dull ____ Throbbing ____ Numbness ____ Shooting ____ Burning ____ Tingling ____ Other

## MEDICAL HISTORY UPDATE

Are you taking any new prescriptions ____ Yes ____ No If yes, please list _____
Have you have any new injuries ____ Yes ____ No If yes, please describe _____
Have you had any surgeries ____ Yes ____ No If yes, please describe _____

Patient Signature _____ Doctor Signature _____