



Spinal Decompression New Patient Form

Name: Date: Address: City/State/ZIP: Home Phone: Work Phone: Cell Phone: Birth date: Age: Social Security #: Marital Status: M W D S E-mail address: Your Employer: Occupation: Spouse's Name: Spouse's Employer: Children's Names and Ages: Favorite Hobbies or Interests: Emergency Contact Person and Phone #:

Current Health concerns/reason for consulting our office:

- 1.
2.
3.

Who may we thank for referring you?

Surgeries you have had with corresponding dates:

Medications you currently take:

Is there any chance you are pregnant? Y N

Have you ever been diagnosed with cancer? If so, what kind?

Have you had similar problems before? Y N

If so, for how long?

In terms of severity, how would you rate it on a scale of 0-10 (10 being the worse)?

What does it feel like when you wake up compared to the rest of the day?

Other doctors you have seen for this problem?

Have you had imaging?

Has surgery been recommended for this problem? Y N

What treatments have you received (i.e., PT, surgery, injections, pharmaceuticals) for this lower back/neck issue?

Did any of these treatments seem to work? If so, which ones and for how long?

What changes or modifications have you had to make to your life since this problem?

What actions or activities do you have trouble with or limitations to?

On a scale of 1-10 (10 being unbearable, 0 being no pain/discomfort) Please rate the following:

The HIGHEST your pain gets WITHOUT medication

The LOWEST your pain gets WITHOUT medication

The HIGHEST your pain gets WITH medication

The LOWEST your pain gets WITH medication

Due to your condition....

Have you lost any time from work? Y N

How much time?

Have you lost any time from your obligations at home? Y N

How much and what chores have been limited?

Have you lost any time enjoying leisure activities? Y N

How much time and what tasks have been limited?

How long has your problem been this severe?



Stress Test

The following areas of stress can cause misaligned vertebrae (Subluxation).

Which of these stresses do you recognize?

Please circle when you experienced these stresses:

Child=C, Teenager=T, Adult=A

Physical/ Emotional/ Chemical Stress:

Comments:

Birth Trauma	C			
Slips or Falls	C	T	A	
Automobile Accidents	C	T	A	
Sports Injuries	C	T	A	
Physical Abuse	C	T	A	
Poor Posture	C	T	A	
Work Injuries		T	A	
Extensive Computer Work		T	A	
Sleeping on Stomach		T	A	
Sitting on a Wallet		T	A	
Carrying a Heavy Purse/ Bookbag/ Child		T	A	
Repetitive Lifting/ Bending		T	A	
Driving for Many Hours		T	A	
Continuous Hours Sitting/ Standing		T	A	
Children Stress		T	A	
Career Stress			A	
Relationship Stress	C	T	A	
Concealed Feelings	C	T	A	
Quick Tempered	C	T	A	
Smoker/ 2 nd Hand Smoke	C	T	A	Amount: _____
Poor Diet/ Excessive Sugar	C	T	A	Amount: _____
Caffeine	C	T	A	Amount: _____
Artificial Sweeteners	C	T	A	
Prescription Drugs	C	T	A	
Over The Counter Drugs (eg. Tylenol, Motrin, etc.)	C	T	A	

Which do you feel are your primary stresses? _____.

The above information is true and accurate to the best of my knowledge.	
Patient or Guardian Signature: _____	Date: _____



AUSTIN DISC & SPINE

Dr. Ross Coccimiglio • Dr. Mary Elder • Dr. Tom Neblett

Phone: (512) 345-WELL (9355) • Fax: (512) 345-9357

10815 FM 2222 Bldg. 3C- Ste. 100 • Austin, TX 78730 • (Located in River Place Medical Plaza)