GARRETT SPINE,
NERVE & PAIN CENTER

Patient Intake Form

Patient Information

Name: _____ Date:____/____/_____

DOB: _____/_____/_____ SSN: _____-____-_____

Address:_____

Home Phone: (_____)_____-_____ Mobile Phone: (_____)_____-_____

Email: _____@_____

Occupation:_____ Work Phone: (_____)_____-_____

Pharmacy: _____

Referring Provider: _____

Primary Care Provider: _____

Primary Reason for Visit: _____

Review of Systems *(circle)*

Constitutional: fever, weight change, fatigue, night sweats
Eyes: vision changes, double vision
ENT: hearing loss, vertigo, difficulty swallowing
Cardiovascular: chest pain, palpitations, leg swelling, fainting
Respiratory: cough, wheezing, shortness of breath
GI: nausea, heartburn, constipation, diarrhea, abdominal pain, bowel incontinence
GU: frequency, urgency, incontinence, retention, sexual dysfunction
Musculoskeletal: neck pain, mid-back pain, low-back pain, joint pain, muscle pain, weakness, stiffness, fasciculations, muscle cramps, muscle wasting
Neurologic: tingling, burning pain, weakness, balance difficulty, tremor, headache, falls, difficulty walking, Hand numbness, foot numbness, foot drop, difficulty climbing stairs, difficulty with fine motor tasks, double vision, dysphagia, slurred speech
Psychiatric: anxiety, depression, sleep disturbance
Endocrine: heat intolerance, cold intolerance
Skin: rash, color changes

Autonomic Symptoms

Dizziness on standing, near syncope, syncope, rapid heart rate, palpitations,

brain fog, exercise intolerance, heat intolerance, excessive sweating,

decreased sweating, dry eyes, dry mouth, constipation, diarrhea,

urinary urgency, urinary retention, erectile dysfunction, color changes in hands/feet

Medications / Supplements & Dosage

_____ _____

_____ _____

_____ _____

_____ _____

Allergies *(allergen & reaction)*

_____

_____

Medical History *(circle)*

Anxiety	Migraines	Osteoporosis
Depression	GERD	Seizures
Heart Attack	Edema	Vitamin Deficiency
Stroke	Hypothyroidism	Chemotherapy
COPD	Coronary Artery Disease	Alcoholism
Asthma	Hepatitis	Substance Use Disorder
HTN	Kidney Disease	Autoimmune Disease
Diabetes	Liver Disease	Cancer:_____
Allergies	Neuropathy	Other:_____

Surgical History *(surgery, side, & year)*

_____

_____

_____

Family History *(alive/deceased, diabetes, hypertension, heart disease, cancer, etc.)*

Father: A / D _____

Paternal Grandfather: A / D _____

Paternal Grandmother: A / D _____

Mother: A / D _____

Maternal Grandfather: A / D _____

Maternal Grandmother: A / D _____

Siblings: A / D _____

Children: A / D _____

Social History

Tobacco Use: nonsmoker / former smoker / current smoker
cigarettes / chew / vape

Alcohol Use: Yes / No
If yes: How often?_____ How many? _____

Substance Use: (outside of prescription) Yes / Formerly / No

Dietary Habits: _____

Exercise Habits: _____

Pain Assessment

Pain Score Today (0-10): ____ Worst: ____ Best: ____

Location: _____ Side: _____

Quality: Sharp / Burning / Aching / Stabbing / Electric / Throbbing / Cramping / Pressure

Better with: _____ Worse with: _____

Time: gradual onset, sudden onset, intermittent, constant

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Autonomic System Symptom Questionnaire

Patient Name: _____ Date: _____

1. Symptoms When Standing (Orthostatic)
   - ☐ Lightheadedness
   - ☐ Dizziness
   - ☐ Feeling faint
   - ☐ Passing out (syncope)
   - ☐ Heart racing when standing
   - ☐ Blurred or dim vision
   - ☐ Brain fog when upright
   - ☐ Head pressure when standing
   - ☐ Symptoms improve when lying down

2. Heart Rate Symptoms
   - ☐ Resting heart rate over 100 bpm
   - ☐ Heart rate increases dramatically when standing
   - ☐ Palpitations
   - ☐ Skipped beats
   - ☐ Shakiness with rapid heart rate

3. Blood Pressure Changes
   - ☐ Blood pressure drops when standing
   - ☐ Blood pressure rises when standing
   - ☐ Labile or fluctuating blood pressure
   - ☐ Morning headaches
   - ☐ Symptoms worse after meals

4. Sweating & Temperature Regulation
   - ☐ Sweat less than normal
   - ☐ Sweat excessively
   - ☐ Certain areas do not sweat
   - ☐ Heat intolerance
   - ☐ Cold intolerance
   - ☐ Cold hands or feet

5. Gastrointestinal Symptoms
   - ☐ Early fullness when eating
   - ☐ Nausea
   - ☐ Bloating
   - ☐ Vomiting undigested food
   - ☐ Constipation
   - ☐ Diarrhea

6. Bladder & Sexual Function
   - ☐ Difficulty starting urination
   - ☐ Weak urine stream
   - ☐ Feeling of incomplete emptying
   - ☐ Urinary urgency
   - ☐ Erectile dysfunction (if applicable)

7. Nerve & Sensory Symptoms
   - ☐ Burning pain in feet or hands
   - ☐ Pins and needles
   - ☐ Sensitivity to touch
   - ☐ Reduced sensation to temperature
   - ☐ Dry eyes
   - ☐ Dry mouth

8. Sleep & Fatigue
   - ☐ Non-restorative sleep
   - ☐ Night sweats
   - ☐ Frequent nighttime urination
   - ☐ Excessive daytime fatigue