



NEUROSURGICAL INTAKE FORM

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Name:	DOB:	Age:	Gender:
Referring Physician:		Primary Care Physician (if different):	

Reason for visit:

Are these symptoms new symptoms? ☐ Yes ☐ No

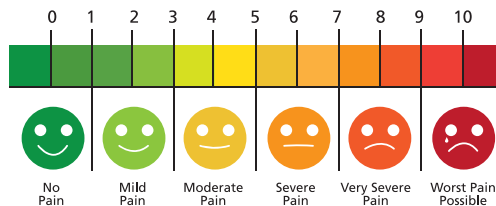
If the symptoms are **new**, when did these symptoms first start? _____

If the symptoms are **old**, how long have they been at their current severity? _____

Were there new symptoms associated with a specific activity or event? ☐ Yes ☐ No

If yes, please describe: _____

Based on this pain scale, how severe are your symptoms on average?



Have you had spine surgery before in the past (cervical, thoracic or lumbar)? ☐ Yes ☐ No

If **yes**, please report the following information to the best of your ability: Type of surgery and spinal level(s), Date of surgery, Location, Surgeon, Helpful (Y/N)

Is this a Workers Compensation injury? ☐ Yes (☐ TX state ☐ TX federal ☐ Other _____) ☐ No

If this injury is related to an MVA or personal injury, is there an active lawsuit? ☐ Yes ☐ No

Have you undergone recent conservative therapy for your primary complaint? ☐ Yes ☐ No

If **yes**, please complete the questions below:

- ☐ structured, physician-supervised pain management (physician: _____)
- ☐ spinal injections (type: _____)
- ☐ narcotic pain medication
- ☐ formal structured physical therapy and/or occupational therapy
- ☐ NSAIDs (Motrin, Aleve or other anti-inflammatory medications)
- ☐ activity and lifestyle modifications
- ☐ chiropractic therapy

Do you have any type of electrical device(s) implanted in your body? ☐ Yes ☐ No

- ☐ thoracic spinal cord stimulator (MRI compatible? ☐ Yes ☐ No ☐ Unknown)
- ☐ cervical spinal cord stimulator (MRI compatible? ☐ Yes ☐ No ☐ Unknown)
- ☐ cardiac pacemaker (MRI compatible? ☐ Yes ☐ No ☐ Unknown)
- ☐ bladder stimulator (MRI compatible? ☐ Yes ☐ No ☐ Unknown)
- ☐ DBS (deep brain stimulator), RNS (epilepsy) or VNS (vagal nerve)
- ☐ other:



Name: _____ DOB: _____

Do you take a daily aspirin? ☐ Yes (☐ 81mg or ☐ 325mg) ☐ NoDo you take frequent NSAID medications? ☐ Yes ☐ NoIf yes, which: ☐ Ibuprofen ☐ Naproxen ☐ Diclofenac ☐ Ketorolac ☐ Etodolac ☐ Indomethacin ☐ Meloxicam ☐ Nabumeton ☐ Oxaprozin ☐ PiroxicamAre you on any anticoagulation or antiplatelets medications? ☐ Yes ☐ No

If yes, please mark:

☐ Warfarin (COUMADIN)☐ Rivaroxaban (XARELTO)☐ Clopidogrel (PLAVIX)☐ Apixaban (ELIQUIS)☐ Prasugrel (EFFIENT)☐ Cilostazol (PLETAL)☐ Dipyridamole (PERSANTINE)☐ Fondaparinux (ARIXTRA)☐ Ticagrelor (BRILLINTA)☐ Dabigatran (PRADAXA)☐ Abciximab (REOPRO)☐ Eptifibatide (INTEGRILIN)☐ Tirofiban (AGGRASTAT)Do you have any known bleeding disorder(s)? ☐ Yes (please list: _____) ☐ NoAre you on any immunosuppressant medications? ☐ Yes ☐ No

If yes, please list the medication(s) and indication(s) _____

Are you have a known diagnosis of osteoporosis? ☐ Yes ☐ No

If yes, please list any medications you take for the osteoporosis: _____

Do you currently smoke tobacco? ☐ Yes (how many cigarettes per day? _____) ☐ NoDo you currently use IV drugs? ☐ Yes ☐ NoAny history of drug dependency? ☐ Yes ☐ NoDo you have any of the following? ☐ HIV/AIDS ☐ Hepatitis B ☐ Hepatitis CDo you have any weakness in you arms or hands? ☐ Yes (☐ severe ☐ moderate ☐ mild) ☐ NoDo you have any numbness in your arms/hands? ☐ Yes (☐ severe ☐ moderate ☐ mild) ☐ NoDo you have any weakness in your arms or legs? ☐ Yes (☐ severe ☐ moderate ☐ mild) ☐ NoDo you have any numbness in your arms or legs? ☐ Yes (☐ severe ☐ moderate ☐ mild) ☐ NoDo you have poor coordination of your RIGHT hand? ☐ Yes (☐ severe ☐ moderate ☐ mild) ☐ NoDo you have poor coordination of your LEFT hand? ☐ Yes (☐ severe ☐ moderate ☐ mild) ☐ NoDo you have difficulties walking due to an unsteady and/or wide-based stance? ☐ Yes ☐ NoDo you have RIGHT leg pain primarily when standing or walking? ☐ Yes ☐ NoDo you have LEFT leg pain primarily when standing or walking? ☐ Yes ☐ NoDoes your leg pain go away with sitting or lying down? ☐ Yes ☐ NoDo you have any new peri-anal or peri-genital sensory loss? ☐ Yes ☐ NoDo you have any new significant bladder or bowel incontinence? ☐ Yes ☐ NoDo you get electrical shocks down your neck or arms with neck movements? ☐ Yes ☐ NoDoes your leg pain go away with sitting or lying down? ☐ Yes ☐ NoDoes your leg pain go away with leaning over a shopping cart? ☐ Yes ☐ NoHave you noticed any recent significant muscle atrophy? ☐ Yes (location: _____) ☐ No



Name: _____ DOB: _____

If applicable, which best describes your ratio for neck & arm or back & leg pain?

- ☐ 100% back pain and 0% leg pain 100% neck pain and 0% arm pain
- ☐ 75% back pain and 25% leg pain 75% neck pain and 25% arm pain
- ☐ 50% back pain and 50% leg pain 50% neck pain and 50% arm pain
- ☐ 25% back pain and 75% leg pain 25% neck pain and 75% arm pain
- ☐ 0% back pain and 100% leg pain 0% neck pain and 100% arm pain

If applicable, which best describes the prominence your arm or leg pain?

- ☐ 100% LEFT leg and 0% RIGHT leg 100% LEFT arm and 0% RIGHT arm
- ☐ 75% LEFT leg and 25% RIGHT leg 75% LEFT arm and 25% RIGHT arm
- ☐ 50% LEFT leg and 50% RIGHT leg 50% LEFT arm and 50% RIGHT arm
- ☐ 25% LEFT leg and 75% RIGHT leg 25% LEFT arm and 75% RIGHT arm
- ☐ 0% LEFT leg and 100% RIGHT leg 0% LEFT arm and 100% RIGHT arm

How long can you sit?

- ☐ unable to tolerate ☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hour ☐ indefinitely

How long can you stand?

- ☐ unable to tolerate ☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hour ☐ indefinitely

How long can you walk?

- ☐ unable to tolerate ☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hour ☐ indefinitely

Have you had any recent diagnostic studies of the arms or legs? ☐ Yes ☐ No

☐ Upper extremity EMGs/NCVs date: _____ location/clinic: _____

☐ Lower extremity EMGs/NCVs date: _____ location/clinic: _____

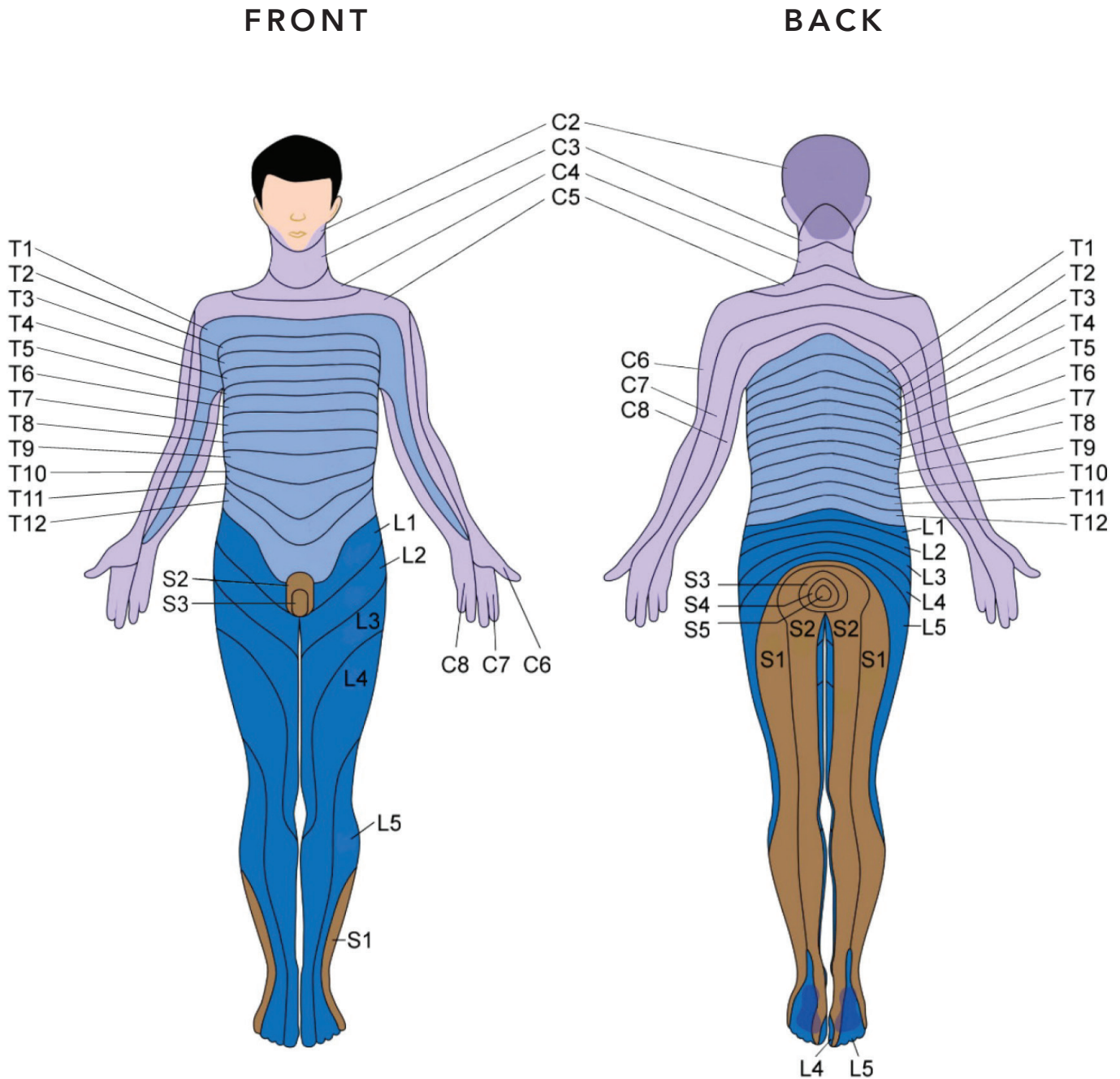
Have you ever had a formal evaluation from a rheumatologist (including lab work)? ☐ Yes ☐ No**Current work status:** ☐ employed full time ☐ employed restricted duty ☐ retired ☐ disabled ☐ student

☐ unemployed ☐ other: _____

Occupation (if applicable): _____**Physical activity:** ☐ Light ☐ demanding**Sedentary:** ☐ Yes ☐ No

Name: _____ DOB: _____

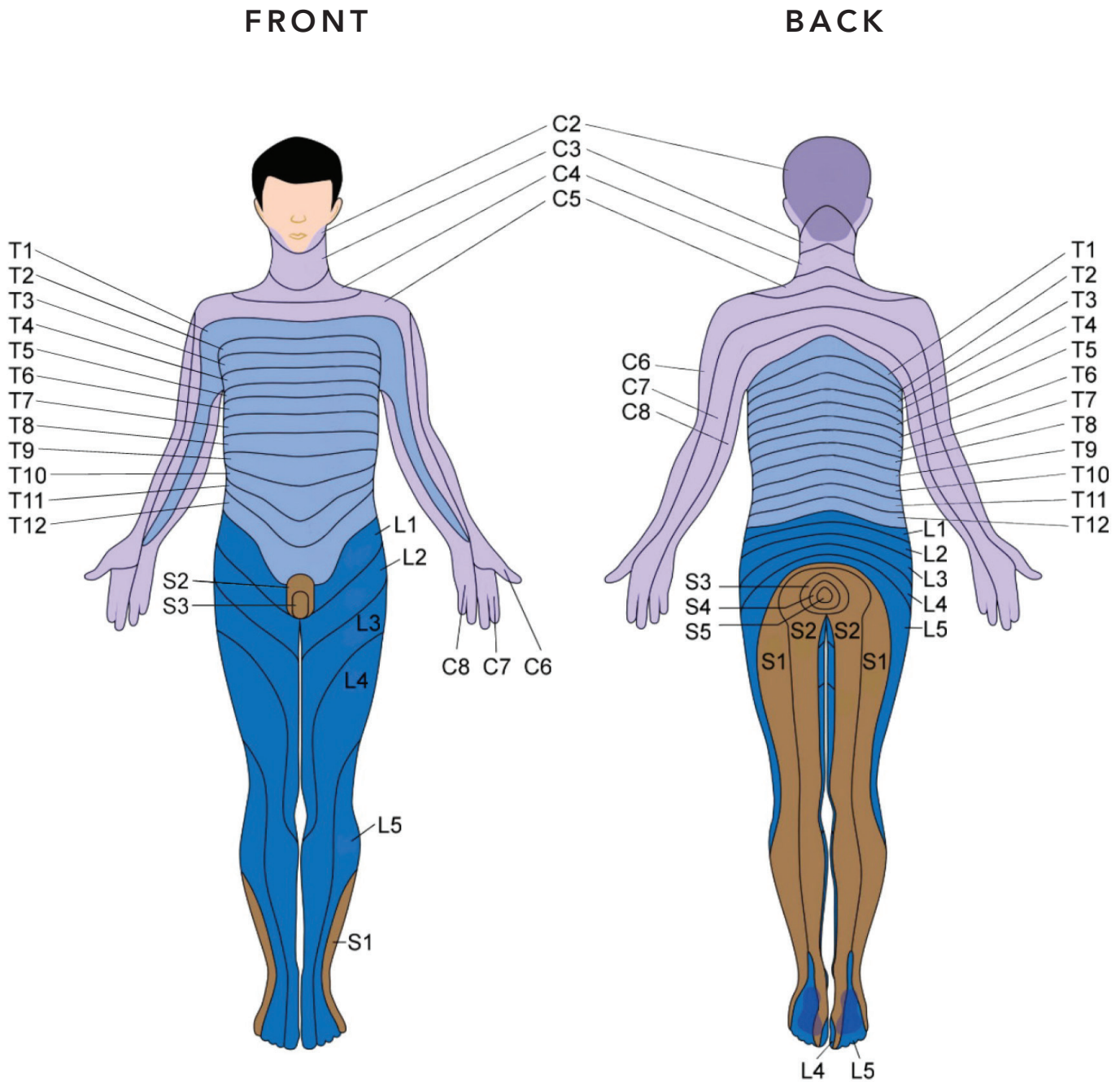
***Please use the diagram below to list your area(s) of
SIGNIFICANT PAIN***



Please list the pain area followed by either "right", "left" or "bilateral". Such as: L5 right, C7 left, T3 bilateral.
If none of those apply, please describe the distribution otherwise.

Name: _____ DOB: _____

***Please use the diagram below to list your area(s) of
NUMBNESS / SENSORY DISTURBANCE***



Please list the numbness/sensory disturbance area followed by either "right", "left" or "bilateral". Such as: L5 right, C7 left, T3 bilateral. If none of those apply, please describe the distribution otherwise.

Name: _____ DOB: _____

Please complete if you have low back pain

PAIN INTENSITY

- ☐ pain is mild to moderate, no painkillers needed
- ☐ the pain is bad, but I manage without taking painkillers
- ☐ painkillers give complete relief from pain
- ☐ painkillers give moderate relief from pain
- ☐ painkillers give me very little relief from pain
- ☐ painkillers have no effect on the pain

PERSONAL CARE

- ☐ I can look after myself without causing pain
- ☐ I can look after myself normally, but it causes pain
- ☐ it is painful to look after myself, and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty, bedbound

LIFTING

- ☐ I can lift heavy weights without causing pain
- ☐ I can lift heavy weights but it causes extra pain
- ☐ pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned
- ☐ pain prevents me from lifting heavy weights, but I can lift light weights if conveniently positioned
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

WALKING

- ☐ I can walk as far as I wish
- ☐ pain prevents me from walking more than 1 mile
- ☐ pain prevents me from walking more than ½ hour
- ☐ pain prevents me from walking more than ¼ mile
- ☐ I can walk only if I use a cane, crutches or walker
- ☐ I am in bed or in a chair for most of the day

SITTING

- ☐ I can sit in any chair for as long as I like
- ☐ I can sit in my favorite chair only, for as long as I like
- ☐ pain prevents me from sitting for more than 1 hour
- ☐ pain prevents me from sitting for more than ½ hour
- ☐ pain prevents me from sitting for more than 10 minutes
- ☐ pain prevents me from sitting at all

STANDING

- ☐ I can stand as long as I want to without extra pain
- ☐ I can stand as long as I want but in pain
- ☐ pain prevents me from standing more than 1 hour
- ☐ pain prevents me from standing more than 30 minutes
- ☐ pain prevents me from standing more than 10 minutes
- ☐ pain prevents me from standing at all

SLEEPING

- ☐ pain does not prevent me from sleeping
- ☐ I sleep well, but only when taking medication
- ☐ even when I take medication, I sleep less than 6 hours
- ☐ even when I take medication, I sleep less than 4 hours
- ☐ even when I take medication, I sleep less than 2 hours
- ☐ pain prevents me from sleeping at all

SOCIAL LIFE

- ☐ my social life is normal and causes me no extra pain
- ☐ my social life is normal but increases the degree of pain
- ☐ pain effects my social life by limiting only my more energetic interests such as sports and dancing
- ☐ pain affects my social life, and I do not go out as often
- ☐ pain has restricted my social life to my home
- ☐ I have no social life because of pain

TRAVELING

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere, but it give me extra pain
- ☐ pain is bad, but I manage journeys over 2 hours
- ☐ pain restricts me to journeys less than 1 hour
- ☐ pain restricts me to journeys less than ½ hour
- ☐ pain prevents traveling except to the doctor/hospital

CHANGING DEGREE OF PAIN

- ☐ my pain is rapidly getting better
- ☐ my pain fluctuates but overall is definitely getting better
- ☐ my pain seems to be getting better but very slowly
- ☐ my pain is neither getting better nor worse
- ☐ my pain is gradually getting worse
- ☐ my pain is rapidly getting worse