CAPRI

CENTRAL ALBERTA PAIN & REHABILITATION INSTITUTE

Intake Form - Spine

We are only accepting patients who reside in Canada

Name:_____

Provincial Health Care Number:_____

Gender

- Male
- Female

Height: _____ft _____in

Weight: _____lbs

Dominant Hand: Right___ Left____ Ambidextrous____

Date of Birth:_____

Profession:_____

Marital Status: _____

Phone:_____

Email:_____

Address:_____

City:_____ Province:_____ Postal Code:_____

Family Physician:_____

Physician's Phone Number:_____

Would you like us to send reports to your family doctor?_____

Areas of Concern (please list site and side)

For example: neck, upper back, lower back...etc.

_____

_____

When did the pain begin?

Please list how long you've been dealing with the pain in each area in months or years

_____

What do you attribute the onset of your pain to? (How did it start?)

If the cause of your pain has been diagnosed, please list it. If not, please give us your best guess. For example, if you think you have osteoarthritis, please indicate so here.

_____

Is your pain constant or does it come and go?

- Constant
- Comes and goes

Since your pain started is it:

- Getting better
- Getting worse
- Staying about the same

How would you describe the pain?

- Burning
- Aching
- Stabbing
- Sharp
- Other:_____

Does the pain radiate?

- No
- Yes, into right arm
- Yes, into left arm
- Yes, into right leg
- Yes, into left leg

Check any of the following that may reduce the pain.

- Sitting or laying down
- Ice
- Heat
- Pain relievers such as Motrin, Aleve, Aspirin, Advil
- Exercise
- Tens machine
- Nothing
- Other:_____

Check any of the following that make the pain worse

- Stairs
- Walking
- Standing
- Bending
- Squatting
- Repetitive movement
- Sitting

Please indicate the following on a scale of 0-10 with 0 = no pain & 10 = worst **spine** pain possible:

- Most Intense Pain _____/10
- Least Intense Pain _____/10
- Average Pain _____/10

What percentage of time are you in **spine** pain, including night time? (Please circle)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Have you been diagnosed with osteoporosis?

Please note: Osteoporosis is a condition where the bone becomes more brittle and fragile (not to be confused with osteoarthritis)

- No
- Yes

Do you have diabetes?

- No
- Yes

Do you have any history of gout or pseudo-gout?

- No
- Yes; which joint(s)_____

Do you smoke?

- No
- Yes, less than ½ pack a day
- Yes, about 1 pack a day
- Yes, 2+ packs a day

Are you taking anti-inflammatories (including natural supplements)?

Note: you will need to discontinue use of these one week prior to and four weeks following your procedure

- No
- Yes

Are you taking statin medication (Statin Medications are used to help control high cholesterol)?

Note: you will need to discontinue these medications for one week prior to and four weeks following your procedure to give you the best chance of success. Please check with your prescribing physician before discontinuing these medications.

- No
- Yes

Have you received a cortisone injection within the last 3 months, and/or do you have an appointment within the next 6 months? Note: if you have had cortisone we will not be able to inject stem cells or PRP for 3 months. If you have had cortisone in a joint that you are not looking for treatment at CAPRI, we will need to wait at least 1 month before a treatment appointment.

- No
- Yes

If yes, please indicate the area of the body and approximate date of the injection

_____

Please list all medications and/or natural supplements you are currently taking (including over the counter and topical medications).

_____

_____

_____

_____

How effective are your pain medications in controlling your pain? (Please circle)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

List any medical conditions you have been diagnosed with

_____

_____

_____

List any past surgeries you have undergone

_____

_____

_____

_____

Do your parents or siblings have spine or chronic pain problems?

- No
- Yes

Do any other serious medical conditions run in your family?

- No
- Yes;

Explain_____

_____

Please check any previous treatments you have tried

- Physical Therapy
- Cortisone Injections
- Massage
- Chiropractor
- Acupuncture

- Other _____

Do you have allergies to any medications or food? (ie. Penicillin, anaesthetics, etc.)

_____

_____

Do you have a latex allergy?

- No
- Yes

Do you have an allergy to x-ray (contrast) dye?

- No
- Yes

Do you work outside the home?

- No
- Yes; How many hours per week? _____

Do you enjoy your work?

- No
- Yes

Have you ever been off work as a result of a spine injury or condition in the past?

- No
- Yes; when and for how long? _____

Do you participate in any fitness or exercise activities on a regular basis?

- No
- Yes; what do you do and how many times per week do you do it?

_____

Please circle the one number that best describes how you have been doing **during the past week**:

1. Please indicate your average level of spine pain?
   No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
2. Pain, numbness, tingling or weakness extends from your back to your legs and/or neck to your arms?
   None of the time 0 1 2 3 4 5 6 7 8 9 10 All of the time
3. How would you rate your general health?
   Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent
4. If you had to spend the rest of your life with your current level of pain, how would you feel about that?
   Delighted 0 1 2 3 4 5 6 7 8 9 10 Terrible
5. How anxious (tense, uptight, irritable, fearful, problems concentrating or relaxing) have you been feeling?
   Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely
6. How much have you been able to control (ie. Reduce/help) your pain on your own?
   I can reduce it 0 1 2 3 4 5 6 7 8 9 10 I can't reduce it at all

7. How depressed (feeling down in the dumps, sad, pessimistic, hopeless) have you been feeling?

Not depressed at all 0 1 2 3 4 5 6 7 8 9 10 Extremely depressed

8. How certain are you that you will be doing normal activities or working in 6 months?

Very certain 0 1 2 3 4 5 6 7 8 9 10 Not certain at all

9. I can do light work for an hour.

Completely agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

10. I can sleep at night.

Completely agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

11. An increase in pain is an indication that I should stop what I'm doing until the pain decreases.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

12. Physical activity makes my pain worse.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

13. I should not do my normal activities, including work, with my present pain.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

Have you had a **sudden and dramatic** increase in weakness or numbness in your limbs?

- o No
- o Yes

Do you have any problems controlling your bowel or bladder function?

- o No
- o Yes

Are you experiencing any numbness in your genital/anal area?

- o No
- o Yes

Are you taking any blood thinning medications like Coumadin or Warfarin?

- o No
- o Yes

Do you have a medical condition or take medication that suppresses your immune system?

- o No
- o Yes

Are you using any drugs intravenously?

- o No
- o Yes

Have you experienced any **unexplained** fever, chills or night sweats?

- o No
- o Yes

Do you have a history of malignancy (cancer)?

- o No
- o Yes: still active or in remission for less than a year

- Yes: in remission for more than a year

If yes, please explain

Where was the malignancy? How long ago were you being treated? What is the current status of the malignancy?

_____

_____

_____

Did your spine pain first start after you were 55 years old?

- No
- Yes

Have you experienced any unintentional weight loss of 20lbs or more?

- No
- Yes

Is your spine pain constant AND worse at night?

- No
- Yes

Are you taking any steroid medication like Prednisone?

- No
- Yes

Do you have stiffness in the morning which lasts more than half hour?

- No
- Yes

Do you often awake with back pain during the 2nd half of the night?

- No
- Yes

Have you experienced dramatic pain relief when you have taken anti-inflammatory pills?

- No
- Yes

Do members of your family have ankylosing spondylitis?

- No
- Yes

Do you have Crohn's disease or ulcerative colitis?

- No
- Yes

Have you had frequent recurrent inflammation in your eyes?

- No
- Yes

Have you had frequent problems with tendinitis?

- No
- Yes

Do you have psoriasis?

- No
- Yes

Have you had a sexually transmitted disease in the past?

- No
- Yes

Do you have pain in your arms or legs that goes past your elbows or knees?

- No
- Yes

Do your arms/legs hurt when you cough, sneeze or have a bowel movement?

- No
- Yes

Do you have pain in your arms or legs that bothers you more than the pain in your neck or back?

- No
- Yes

Have you developed weakness in your arms or legs with some of your muscles getting smaller?

- No
- Yes

Do you have leg pain, weakness, numbness that is worse when you stand or walk and improves when you sit?

- No
- Yes

Our doctors need IMAGING REPORTS, CURRENT WITHIN THE PAST 24 MONTHS, FOR ALL OF THE SITES YOU WANT TREATED so they can accurately assess if our regenerative treatments may benefit you. If you do not have these, see your doctor and ask him/her for a requisition to have them done. You will not be booked in for an assessment until we have received these imaging reports.

- I am Albertan. Imaging reports for the sites indicated above are available on netcare
- I am out-of province. I will have these reports faxed to 403-782-6511

Note: please include as many reports as possible for the past 5 years, including reports from any interventional treatments you have had (ie. Injections, surgeries, etc.)

Regenerative procedures are not insured by provincial healthcare. The total cost will be determined at the assessment.

- I understand the pricing and am prepared to pay for the procedure.