

Ithaca Orthopaedic Spine Services

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PRE-SCREENING FORM

Name: _____ Date: _____ Age: _____ DOB: _____

Address: _____ City/State _____ Zip: _____

Phone: _____ Height: _____ Weight: _____ MALE / FEMALE

Where is your pain? (Check all that apply)

Lower Back _____ Upper Back _____ Neck _____ Sciatic _____ Other _____ Body part? _____

Nature of onset of this problem:

Gradually _____ Suddenly _____ Re-Injury _____

Where: Home _____ Work _____ Auto _____ Liability _____ Other _____

How long has your pain been present? _____

Have you had any of the following studies for this problem? (Check all that apply)

X-ray _____ MRI _____ CT Scan _____ NCS/EMG _____ Other _____

Have you had any previous injections for this problem? Yes _____ No _____

If yes when and where? _____

Have you had any of the following treatments for this problem? (Check all that apply)

Surgery? Yes _____ No _____ If yes, When? _____ Where? _____

Physical Therapy? Yes _____ No _____ If yes, When? _____ Where? _____

Chiropractic? Yes _____ No _____ If yes, When? _____ Where? _____

Stimulator or Pain Pump? Yes _____ No _____ If yes, When? _____ Where? _____

Other? Yes _____ No _____ If yes, What? _____

When? _____ Where? _____

Are you currently taking any medications for this problem? Yes _____ No _____

If yes, What? _____

Are you allergic to any medications? Yes _____ No _____

If yes, please list them _____

Who referred you to our practice? _____

**If accepted, we require your previous treatment records including MRI/ X-ray/ Operative reports.
Insurance pre-authorization for all procedures is required.**