Princeton Neurological Surgery

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## Spine Pain Management Intake Form

Today's date:_____/_____/_____
*Month Day Year*

Patient name:_____ DOB:_____/_____/_____
*Last First Middle* *Month Day Year*

| Pain Management | Provider | Provider Address | Provider Phone/Fax | Date Started | Date Completed |
|---|---|---|---|---|---|
| ☐ Y ☐ N | | | | | |
| **Epidural Injection(s):** ☐ Y ☐ N How many: _____ Relief: ☐ Y ☐ N | | | | | |
| **EMG:** ☐ Y ☐ N | | | | | |
| **Physical Therapy:** ☐ Y ☐ N Relief: ☐ Y ☐ N | | | | | |
| **Chiropractic:** ☐ Y ☐ N Relief: ☐ Y ☐ N | | | | | |
| **Acupuncture:** ☐ Y ☐ N Relief: ☐ Y ☐ N | | | | | |