Intracept Patient Intake Form

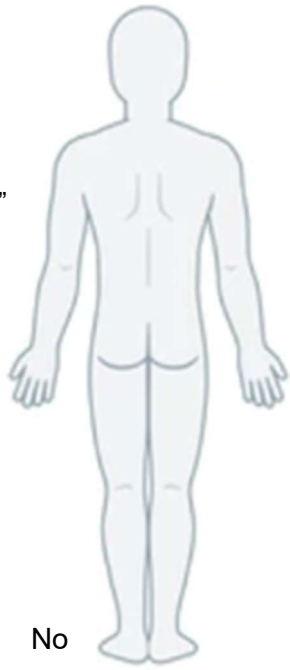
Patient Name: _____ Date of Birth: _____

Duration of low back pain: (circle one)

> 6 months > 1 year > 2 years > 3 years > 5 years

Complete the remainder of the form considering your pain and function over the last 30 days

Please mark an "x" where you are having pain.



Average Pain: _____ Back Pain (%): _____

Worst Pain: _____ Leg Pain (%) _____

Does bending forward/lifting increase your back pain? *(circle one)* Yes or No

Does sitting for long periods (ex. driving) increase your back pain? *(circle one)* Yes or No

Does walking and/or standing improve your back pain? *(circle one)* Yes or No

Does your pain negatively affect your activities of daily living? *(check all that apply)*

☐ Sleep ☐ Work ☐ Leisure Activities

☐ Household Chores ☐ Other: _____

What medications have you taken for your low back pain: _____

Which treatments have your tried to relieve your low back pain? *(check all that apply)*

☐ Physical Therapy ☐ Home Exercise Program ☐ Chiropractic Care

☐ Massage Therapy ☐ Acupuncture ☐ Other: _____

☐ Injections: ☐ Epidural Injections ☐ Facet Injections ☐ SI Joint Injections ☐ Facet Ablations

Pertinent surgical/medical history:

_____

Office Use Only:

MRI Report Included? *(circle one)* Yes No

Signer has reviewed imaging? *(circle one)* Yes No

Modic changes noted at: *(check all that apply)*

Vertebral Body	Location	Modic Type 1	Modic Type 2
☐ **L3**	☐ Superior ☐ Inferior	☐	☐
☐ **L4**	☐ Superior ☐ Inferior	☐	☐
☐ **L5**	☐ Superior ☐ Inferior	☐	☐
☐ **S1**	☐ Superior ☐ Inferior	☐	☐

Diagnosis:

☐ **M54.51** Vertebrogenic low back pain; low back pain vertebral endplate pain	☐ **M54.50** Low Back Pain	☐ **M47.816** Spondylosis w/o myelopathy or radiculopathy, lumbar region
☐ **M47.817** Spondylosis w/o myelopathy or radiculopathy, lumbosacral region	☐ **M51.36** Other intervertebral disc degeneration, lumbar region	☐ **M51.37** Other intervertebral disc degeneration, lumbosacral region

Treatmant Plan:

Intracept	☐ **L3**	☐ **L4**	☐ **L5**	☐ **S1**

Additional comments (why Intracept is the best treatment option): _____

_____

_____

Healthcare Provider Signature: _____

Healthcare Provider Name (Printed): _____

Date: _____