New Patient - Spine Health History

Patient Name (Print) _____ **DOB** _____ **Referred by** _____ **Today's Date** _____

1. Where is your pain? ___**Neck (see 1a.)** ____**Low Back (see 1b.)** ____**Neck and Back pain (see 1a. and 1b.)**

1a. IF NECK PAIN

Most of my pain is in my neck_____
OR
Most of my pain is in my arm(s) _____
OR
I have equal amounts of pain in my neck and arm(s)
_____

I have also experienced
- Hand/arm numbness/tingling __
- Hand/arm weakness ____
- Hand/arm clumsiness ____
- Headaches ___
- Problems with gait/walking/balance ____
- Problems with handwriting/buttoning ____
- Clumsiness, dropping things more frequently___
- Loss of bladder or bowel control _____

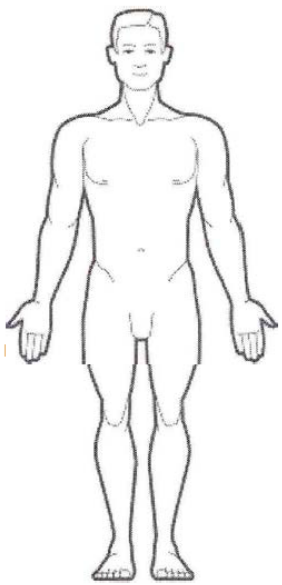
1b. IF LOW BACK PAIN

Most of my pain is in my back _____
OR
Most of my pain is in my leg(s) _____
OR
I have equal amounts of pain in my back and leg(s)
_____

I have also experienced
- Leg/foot numbness/tingling ____
- Leg/foot weakness _____
- Leg/Foot clumsiness of gait ____
- Problems with gait/walking/balance ___
- Loss of bladder or bowel control _____

2. Drawing Pain

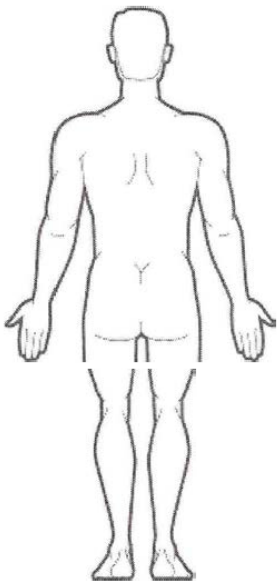
Front



Where is your pain?
Use the body diagram to show where you feel the following sensations .

Ache	AAA
Numbness	000
Burning	XXX
Stabbing	///
Pins and Needles	

Back



On a scale from 0 to 10, with 0 being none and 10 being unbearable, please mark your level of pain/discomfort for each of these areas by placing an "x" in the box of the best answer.
(Mark only one box for each scale)

____ Neck Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

____ Right Arm Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

____ Left Arm Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

____ Back Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

____ Right Leg Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

____ Left Leg Pain
☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10

Office Use Only:
Radiation of Pain: Back vs. Leg (%):
Neck vs. Arm (%):

Please describe characteristics of your pain:
- ☐ Intermittent
- ☐ Constant
- ☐ Burning
- ☐ Dull
- ☐ Sharp
- ☐ Stabbing
- ☐ Throbbing
- ☐ Aching
- ☐ Cramping

Your symptoms worsen with:
- ☐ Sitting/Driving
- ☐ Standing
- ☐ Walking
- ☐ Laying down

Your symptoms improved with:
- ☐ Sitting/Driving
- ☐ Standing
- ☐ Walking
- ☐ Laying down

Please rate your pain
On a bad day ____ (0-10)
On a good day ___ (0-10)

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3. ONSET:

When did your symptoms first start?_____

Was the onset _____Suddenly ____Gradually _____ unknown

What caused your symptoms? (Circle One) Injury don't know other:_____

If an injury, where did it take place?

___Home ___School ___Sports ___Motor Vehicle Accident (see 3a.) ___Work Related (see 3b.)

3a. **If your condition is due to a motor vehicle accident answer the questions below:**

- □ Date of injury: _____
- □ Do you have an attorney representing you? ___ Yes ___ No
- □ If Yes, name of attorney: _____
- □ Where were you when the accident happened? ___ Passenger ___ Driver ___ Pedestrian

3b. **If your condition is due to a work accident or injury answer the questions below:**

- □ Name of the employer where the work injury or accident occurred: _____
- □ Date of injury: _____
- □ Do you have an attorney representing you? ___ Yes ___ No
- □ If Yes, name of attorney: _____

4. Previous Treatment for this Problem

Injections: Yes or No	**Location of injection, Type, & Times**	**How many injections in last 12**	**Date of most recent injections**	**Helped or not?**
Physical therapy : Yes or No	**Part of body, e.g. neck, back or others**	**How many sessions/weeks**	**Date of most recent PT?**	**Helped or not?**
Chiropractor: Yes or No	**Part of body, e.g. neck, back or others**	**How many sessions/weeks**	**Date of most recent treatment**	**Helped or not**
Spinal Surgery? Yes or No	**Type of Surgery**		**Date**	**Surgeon**
Narcotics or other pain killers	**Discontinued? (Yes/No)**	**Dose (how much each time)**	**Frequency (how many times a**	**Helped or not?**
Hydrocodone				
Percocet				
Tylenol with codeine				
Tramadol				
Other				
NSAIDs (Ibuprofen, Aleve, Advil et al) list name of meds below	**Discontinued? (Yes /No)**	**Dose (how much each time)**	**Frequency (how many times a day)**	**Helped or not?**

Other treatments: _____ Acupuncture _____ Exercise _____Massage _____ Brace

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5. Past Medical History: Please tell us whether you now have or have ever had in the past any of these illnesses. Please LEAVE BLANCK spots for any which DO NOT relate to you.

- ❑ AIDS or positive HIV
- ❑ Anemia
- ❑ Anxiety/Depression
- ❑ Arthritis
- ❑ Asthma
- ❑ Addictive disorders (drugs/alcohol)
- ❑ Bleeding Disorder
- ❑ Blood clots in legs/lungs
- ❑ Blood transfusion
- ❑ Cancer (type) _____
- ❑ Coronary Artery Diseases
- ❑ Chronic pulmonary disease (COPD)
- ❑ Enlarged prostate/urine flow problem
- ❑ Diabetes
- ❑ Gout
- ❑ Gallbladder problems
- ❑ Heart attack
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Heart problems
- ❑ Hernia
- ❑ Herpes
- ❑ Kidney failure
- ❑ Kidney stones
- ❑ Kidney/bladder infection
- ❑ Lung diseases
- ❑ Lupus
- ❑ Liver disease/Hepatitis
- ❑ Migraine
- ❑ MRSA infection of skin
- ❑ Neuropathy
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Peripheral Vascular Disease
- ❑ Rheumatoid arthritis
- ❑ Seizures/epilepsy
- ❑ Stroke/TIA
- ❑ Sickle cell disease
- ❑ Sleep Apnea
- ❑ Sexually transmitted disease
- ❑ Sepsis
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Ulcers/GI bleeding

Other medical conditions (please list):

Food/Medicine Allergies (please list):

6. Social History

Did you have unexplained weight loss in the past year? ___Yes___No How much?_____

Did you have unexplained weight gain in the past year? ____Yes___No How much?_____

Do you use tobacco? ____Yes ____No; If yes, how much?_____
____ Quit How long ago?_____

Do you drink alcohol? ____Yes ____No If yes, how much?_____
____ Quit How long ago?_____

Recreational drug use? ____Yes ____No If yes, how much?_____
____ Quit How long ago?_____

7. Surgical History: Please list all surgeries and hospitalizations you have had and the year they took place.

Have you ever had a blood transfusion?_____Yes_____No When_____

Have you had any anesthetic problems:

____ Difficulty inserting breathing tube
____ High fever during or after anesthesia
____ Significant nausea or vomiting after surgery
_____ Difficulty waking up after anesthesia

8. Family History: Please circle any health problems diagnosed in your immediate family and note who:

Condition	Who	Condition	Who	Condition	Who
Arthritis/Rheumatism		Liver problems		Hypertension	
Sciatic/back problems		Cancer		Heart Attack	
Breathing problems		Diabetes		Angina	
Bleeding problems		Kidney Disease		Other	

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9. Review of System:
In the past month, have you had any of the following problems?

General
❑ Fatigue
❑ Weakness
❑ Fever
❑ Night Sweats

Cardiovascular
❑ Chest Pain
❑ Palpitations/irregular heartbeats
❑ Problems with Circulation

Respiratory
❑ Shortness of Breath
❑ Wheezing
❑ Cough

Eyes
❑ Pain
❑ Double or Blurred Vision
❑ Contact lens
❑ Redness
❑ Loss of Vision

Genitourinary
❑ Frequent or Painful Urination
❑ Blood in Urine
❑ Incontinence
❑ Frequent UTI
❑ Date of last menstrual period_____

Other Problems:

Neurological
❑ Headaches
❑ Dizziness
❑ Fainting or Loss of Consciousness
❑ Numbness or Tingling
❑ Memory Loss
❑ Dementia
❑ Tremor

Gastrointestinal
❑ Nausea
❑ Heartburn
❑ Stomach Pain
❑ Vomiting
❑ Yellow Jaundice
❑ Increasing Constipation
❑ Persistent Diarrhea
❑ Blood in Stools
❑ Black Stools

ENT
❑ Ringing in Ears
❑ Loss of Hearing
❑ Frequent Sore Throats
❑ Hoarseness
❑ Difficulty in Swallowing
❑ Denture
❑ Pain in Jaw

Muscle/Joints/Bones
❑ Numbness
❑ Joint Pain
❑ Muscle Weakness
❑ Limb Swelling
❑ Joint Swelling
❑ Limb Stiffness
❑ Limb cramps

Endocrinology
❑ History of high or low blood sugar
❑ Thyroid problems

Hematology/Lymphatic
❑ Bleeding tendencies/bruising
❑ Frequent nose bleeds
❑ Enlarged lymph nodes

Psychiatric
❑ Depression
❑ Anxiety

Integumentary/Skin
❑ Redness
❑ Rash
❑ Nodules/Bumps
❑ Rash

10. Medication List: List all tablets, patches, drops, ointments, injections etc. Include prescription, over-the-counter, herbal, vitamin, diet supplements, and any medicine you take only on occasion (Viagra, nitroglycerin, albuterol)

Medication	Dose	How often you take the medication	Reason for taking	Date started	Prescriber