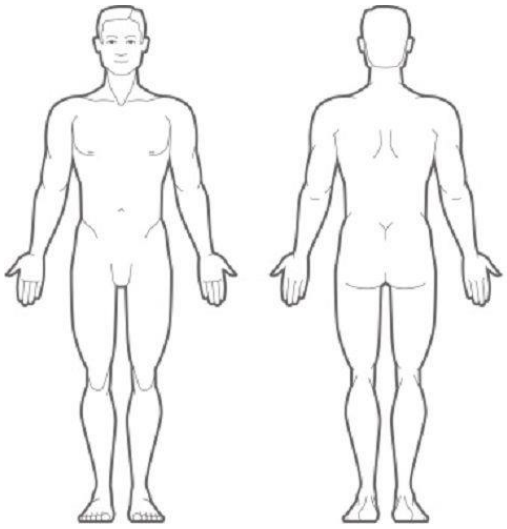
Spine History

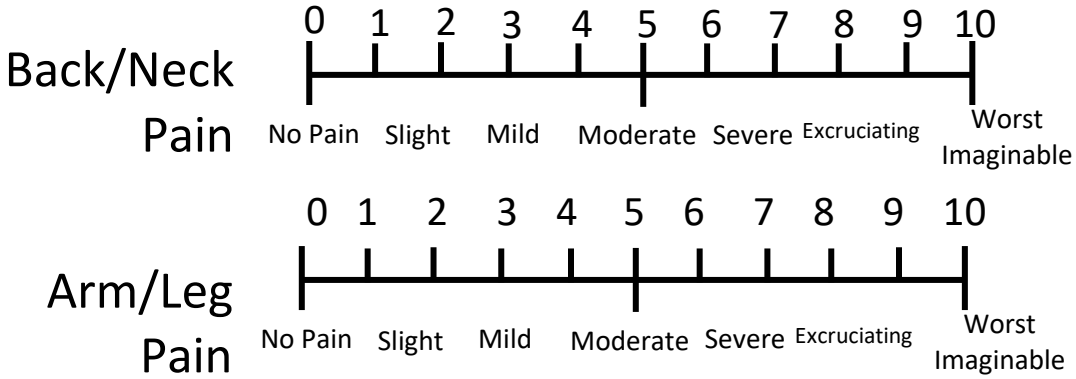
Name:_____ Date:_____
Date of Birth:_____ Sex: M F Preferred Pharmacy:_____
Referring Physician:_____ Primary Physician:_____

1. What is your main area of concern for the provider today?_____
   _____
2. How long has your pain or condition been present?_____
3. Has your pain or condition worsened recently? If yes, how recently?_____
   _____
4. What started your pain or condition?_____
   _____
5. Please use the following markings and diagram to locate your pain or condition:

Stabbing Pain
//////
Burning Pain
OOOO
Aching Pain
XXXXX
Pins/Needles
VVVVV
Numbness
+++++



6. How do you rate your pain?



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7. How much of your pain is in your neck, back, arm, or leg? (Please give a percentage – i.e. 50%)

   Neck:_____ + Arm and which side:_____ = 100%
   Back:_____ + Leg and which side:_____ = 100%

8. Associated symptoms of the pain:
   - □ Headache
   - □ Weakness
   - □ Cramps, spasms, Charlie horse
   - □ Frequent falls
   - □ Loss of bowel control
   - □ Loss of bladder control/inability to empty bladder

9. Is the pain or condition:
   - □ Continuous
   - □ Activity-related
   - □ Night pain
   - □ Other:_____

10. How is your pain limiting your ability to function:
    - □ Not limiting
    - □ Minimally limits
    - □ Partially limits
    - □ Severely limits
    - □ Completely limits

11. Do you have any hobbies that your pain or condition is interfering with?_____
    _____

12. What makes your pain or condition better?_____
    _____

13. What makes your pain or condition worse?_____
    _____

14. Did the pain start at work? If yes, have you filed a worker's compensation claim?____
    _____

15. Have you had spine surgery before? If yes, what surgery did you have and did it help?_____

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16. What treatments are you currently using?_____
_____

17. What treatments have you tried in the past?
    - □ Physical therapy, exercise
    - □ Massage or ultrasound
    - □ Traction
    - □ Chiropractor
    - □ Tens Unit
    - □ Brace
    - □ Anti-inflammatory medications
    - □ Narcotic medications
    - □ Epidural injections (If so, how many?___)
    - □ Trigger point injections
    - □ Other:_____

18. Did any of those treatments benefit you?_____
_____

19. Have you seen anyone for a spine problem before? If so, please list who you saw, what you saw them for, and when you saw them._____
_____
_____

20. What are your goals for today?
    - □ Second opinion
    - □ Recommendation for physical therapy
    - □ Medications
    - □ Injection treatments
    - □ Surgery
    - □ Other:_____

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Health History

Past Medical History: Please check all that apply.

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Abnormal heartbeat
- ☐ Heart failure
- ☐ Stroke
- ☐ Blood clots (leg)
- ☐ Blood clots (lung)
- ☐ Poor circulation
- ☐ High cholesterol
- ☐ Stomach ulcers
- ☐ Tuberculosis
- ☐ COPD
- ☐ Thyroid issues
- ☐ Asthma
- ☐ Gastric reflux
- ☐ Hernia
- ☐ Pneumonia
- ☐ Gout
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Bleeding disorder
- ☐ Neuropathy
- ☐ Neurofibromatosis
- ☐ Seizures
- ☐ Migraines
- ☐ Spina bifida
- ☐ Depression
- ☐ Anxiety
- ☐ MRSA
- ☐ Emphysema
- ☐ Cerebral palsy
- ☐ Sleep apnea
- ☐ Anemia
- ☐ Fibromyalgia
- ☐ Liver disease
- ☐ Claustrophobia
- ☐ Cancer: If yes, specify type and treatment: _____
- ☐ Diabetes: If yes, please list Hemoglobin A1C level:_____ Insulin?_____
- ☐ Other:_____

Past Surgical History: Please list all past surgeries.

Operation	Year

Current Medications: Please include over-the-counter and any supplements.

Medication	Dosage	What medication treats

Allergies: Please list.

_____

_____

Social History:

Work Status

□ Currently working (If so, occupation:_____)
□ Homemaker
□ Unemployed
□ Disabled
□ Retired (Occupation:_____)
□ Student

Marital Status

□ Single
□ Married
□ Divorced
□ Widowed

Children

□ No □ Yes (If so, how many?__)

Do you live alone?

□ Yes □ No (If so, who lives with you?_____)

Are you a current smoker or do you use chewing tobacco?

□ No □ Yes (If so, for how long and how many packs per day?_____)

Do you drink alcohol?

□ No □ Yes (If so, how many drinks per week?_____)

Do you drink coffee?

□ No □ Yes (If so, how many cups per day?_____)

Are you a current or past drug user?

□ No
□ In the past (If so, what kind of drugs?_____)
□ Currently (If so, what kind of drugs?_____)

Family History:

Do any bleeding disorders, blood clots, heart diseases, anesthetic complications, or other illnesses or diseases run in your family?

□ No
□ Yes (If so, please explain:_____)

Mother

□ Alive (If so, current age:_____)
□ Deceased (If so, age at death and cause:_____)

Father

□ Alive (If so, current age:_____)
□ Deceased (If so, age at death and cause:_____)

Siblings: Health status or cause of death:

□ Brother(s):_____
□ Sister(s):_____

Review of Systems: Have you experienced any of these in the past 30 days?
Please circle those that apply; if none apply, please check this box □

Constitutional: weight loss weight gain fever chills sweats

Eyes: cataracts glasses/contacts glaucoma blurred vision

Ears, Nose, Throat: hearing difficulty ringing in ears swallowing problems hoarseness

Cardiovascular: chest pain palpitations swelling in hands or lower legs

Respiratory: shortness of breath difficulty breathing cough wheezing

Gastrointestinal: gastric reflux diarrhea constipation abdominal pain

Musculoskeletal: joint pain unsteady when walking frequent falls morning joint stiffness joint swelling soft tissue swelling

Integumentary: skin rashes skin sores/ulcers easy bruising jaundice

Neurologic: recent changes in memory blackouts headaches hallucinations

Do not write below line – For office use only

Height	Weight	BMI

Reviewed and updated by:_____ on _____