



## USC Center for Spinal Surgery New Patient History Form

*Please take the time to answer all questions that apply to your problem as completely as possible. Thank You.*

Date \_\_\_\_\_ Referring Doctor/Primary Doctor \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Chief Complaint \_\_\_\_\_ Date of Injury \_\_\_\_\_

Injured at \_\_\_\_\_ County of \_\_\_\_\_ Time of Injury \_\_\_\_\_

When did the symptoms originally begin? \_\_\_\_\_

Did your pain start gradually? \_\_\_\_\_ Suddenly? \_\_\_\_\_

Are your symptoms now worse? \_\_\_\_\_ Better? \_\_\_\_\_ No Change? \_\_\_\_\_

What is the degree of pain that you are currently experiencing:  
\_\_\_none \_\_\_mild \_\_\_moderate \_\_\_severe

What is your pain on a scale of 1-10, with 10 being the worst pain? \_\_\_\_\_

How often do you experience the pain: \_\_\_intermittent \_\_\_constant

Describe the quality of your pain (i.e. dull, burning, sharp, etc.) \_\_\_\_\_

What is your back pain to leg pain ratio? (i.e. 100% back/0% leg)?  
\_\_\_100/0 \_\_\_90/10 \_\_\_80/20 \_\_\_70/30 \_\_\_60/40 \_\_\_50/50  
\_\_\_40/60 \_\_\_30/70 \_\_\_20/80 \_\_\_10/90 \_\_\_0/100

What is your neck pain to arm pain ratio? (i.e. 100% neck/0% arm)?  
\_\_\_100/0 \_\_\_90/10 \_\_\_80/20 \_\_\_70/30 \_\_\_60/40 \_\_\_50/50  
\_\_\_40/60 \_\_\_30/70 \_\_\_20/80 \_\_\_10/90 \_\_\_0/100

Where is your pain located?

\_\_\_neck \_\_\_neck and arm(s) R or L \_\_\_Arm(s) only- R or L

\_\_\_back \_\_\_back and leg(s) R or L \_\_\_Leg(s) only- R or L

What aggravates your pain? (standing, sitting, etc.) \_\_\_\_\_

What relieves your pain? (lying down, sitting, etc.) \_\_\_\_\_

Do you have night pain? \_\_\_\_\_ Does it wake you up from sleep? \_\_\_\_\_

Do you have numbness? If so, where? \_\_\_\_\_

Do you have weakness? If so, where? \_\_\_\_\_

Do you have any bowel or bladder problems? \_\_\_\_\_  
\_\_\_\_\_incontinence \_\_\_\_\_constipation \_\_\_\_\_hesitancy

Are there any associated signs or symptoms (i.e. nausea, loss of balance, etc.) \_\_\_\_\_

What treatments in the past have made your pain better? \_\_\_\_\_

What treatments in the past have made your pain worse? \_\_\_\_\_

Have you been in a physical therapy program? \_\_\_\_yes \_\_\_\_no  
When/Where/How often? \_\_\_\_\_ Did it help you? \_\_\_\_\_

Are you currently working? \_\_\_\_no \_\_\_\_yes → what type \_\_\_\_\_  
\_\_\_\_Full Duty \_\_\_\_Modified Duty → \_\_\_\_\_

Date last worked \_\_\_\_\_ Are you able to perform your usual duties? \_\_\_\_\_

### WORK COMP INFORMATION

Employer at time of injury \_\_\_\_\_ Length of time on job \_\_\_\_\_

Job description \_\_\_\_\_ Job title \_\_\_\_\_

Movements required for your job:

____twisting	____pushing	____pulling	____sitting
____standing	____stooping	____crawling	____lift____pounds
____bending	____crouching	____climbing stairs	____grasping
____balancing	____squatting	____kneeling	____climbing ladders
____reaching above shoulders		____repeated wrist/hand movements	

Sitting time \_\_\_\_\_ Standing time \_\_\_\_\_ Machines used \_\_\_\_\_

Describe how you were injured \_\_\_\_\_

\_\_\_\_\_  
If work comp, who is your attorney? \_\_\_\_\_

If work comp, who is your case manager? \_\_\_\_\_

## MEDICAL/SURGICAL HISTORY

Have you had spine surgery in the past? \_\_\_\_\_ How many? \_\_\_\_\_

Please list types of spine surgeries and dates/doctor/hospital of surgeries:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list all medical problems: \_\_\_\_\_

\_\_\_ high blood pressure                      \_\_\_ rheumatoid arthritis  
\_\_\_ thyroid                      \_\_\_ stroke                      \_\_\_ diabetes                      \_\_\_ heart attack  
\_\_\_ asthma                      \_\_\_ stomach ulcer                      \_\_\_ cancer → what type \_\_\_\_\_  
\_\_\_ seizure                      \_\_\_ kidney stones                      \_\_\_ blood clots in leg or lungs

Please list other previous surgeries/year: \_\_\_\_\_

\_\_\_ Tonsils                      \_\_\_ head/neck cancer                      \_\_\_ brain surgery  
\_\_\_ appendectomy                      \_\_\_ cardiac/heart                      \_\_\_ lung cancer  
\_\_\_ ulcer                      \_\_\_ gall bladder                      \_\_\_ kidney  
\_\_\_ bladder                      \_\_\_ abdominal cancer                      \_\_\_ prostate  
\_\_\_ hernia                      \_\_\_ hysterectomy                      \_\_\_ hip/knee replacement  
\_\_\_ shoulder                      \_\_\_ peripheral vascular                      \_\_\_ knee  
\_\_\_ ankle                      \_\_\_ elbow                      \_\_\_ wrist  
\_\_\_ c-section                      \_\_\_ melanoma                      \_\_\_ hand  
\_\_\_ foot                      \_\_\_ hip fracture                      \_\_\_ infection

Current medications: \_\_\_\_\_

Have you tried Anti-inflammation medications (ibuprofen, etc.) \_\_\_\_\_

Does it help? \_\_\_\_\_ Does it upset your stomach? \_\_\_\_\_

Allergies: \_\_\_\_\_

Are you married? \_\_\_\_\_ Children? \_\_\_\_\_

Who do you live with at home? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? (pack/day) \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_

### Review of symptoms:

\_\_\_ fever                      \_\_\_ chills                      \_\_\_ sore throat  
\_\_\_ weight loss                      \_\_\_ night sweats                      \_\_\_ headaches  
\_\_\_ blurred vision                      \_\_\_ double vision                      \_\_\_ coordination loss  
\_\_\_ fainting                      \_\_\_ shortness of breath                      \_\_\_ chest pain  
\_\_\_ palpitations                      \_\_\_ dizziness                      \_\_\_ loss of consciousness  
\_\_\_ bloody stools                      \_\_\_ stomach pain                      \_\_\_ diarrhea  
\_\_\_ tarry stools                      \_\_\_ light color stools                      \_\_\_ pain in joints  
\_\_\_ joint swelling                      \_\_\_ bloody urine                      \_\_\_ severe stiffness

other: \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

What other doctors have seen you and/or treated you for this problem? \_\_\_\_\_

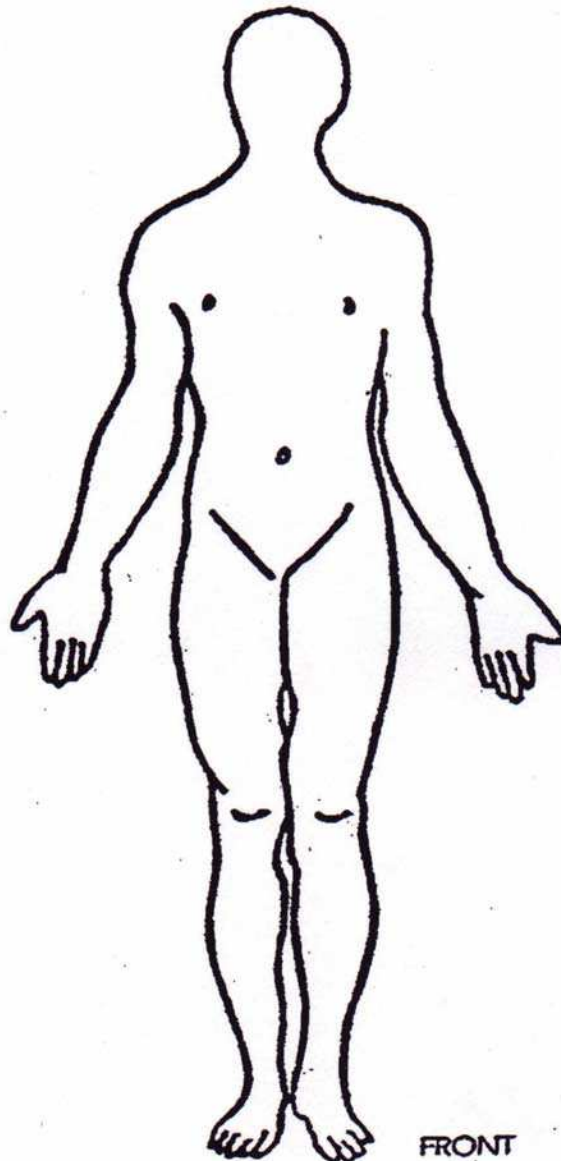
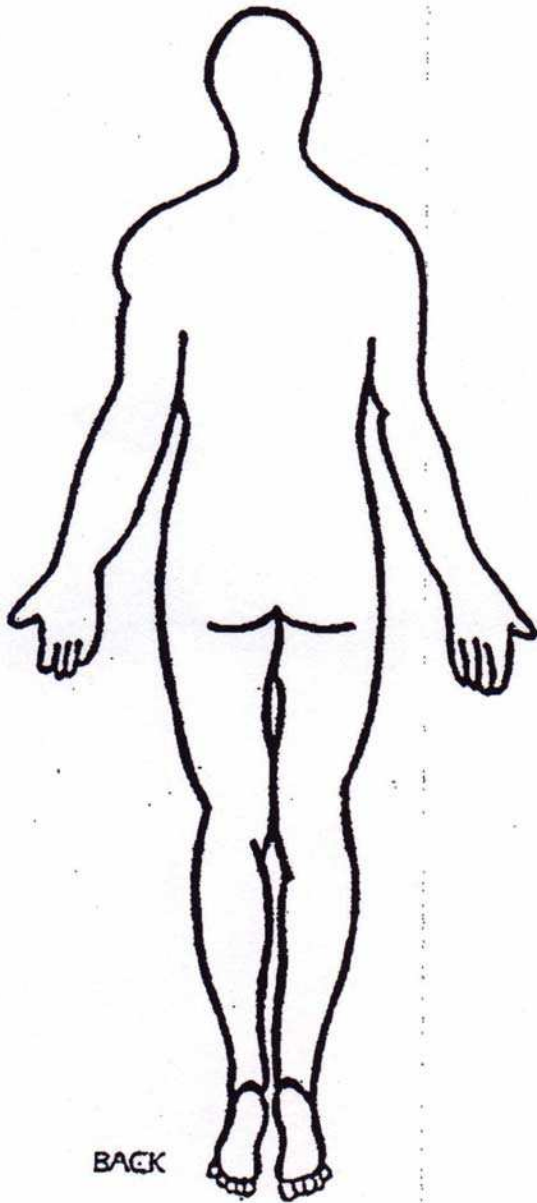
What has happened since your last exam? \_\_\_\_\_

Have you had any recent tests or X-rays? \_\_\_\_\_yes \_\_\_\_\_no

What tests? \_\_\_\_\_MRI \_\_\_\_\_CT scan \_\_\_\_\_Bone Scan Other \_\_\_\_\_

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw your face.

NUMBNESS	—	PINS & NEEDLES	oooo	BURNING	xxxx	STABBING	////
	—		oooo		xxxx		////
	—		oooo		xxxx		////



-----Patients, please do not write below this line-----

# SPINE EXAMINATION

## Constitutional:

Appearance \_\_\_\_\_

Weight \_\_\_\_\_

Psychiatric: \_\_\_\_\_

HEENT: \_\_\_\_\_

Lymphatic: \_\_\_\_\_

Skin: \_\_\_\_\_

Incisions: \_\_\_ normal/intact \_\_\_ healed \_\_\_ healing other \_\_\_\_\_

## Musculoskeletal:

Alignment/Scoliosis/Rib Hump \_\_\_\_\_

Gait \_\_\_\_\_ Heel/Toe Walk \_\_\_\_\_

Tandem \_\_\_\_\_ Heel/Toe Raise \_\_\_\_\_

Myelopathy \_\_\_\_\_

Cranial nerves: \_\_\_\_\_

Palpation: \_\_\_ nontender \_\_\_ tender → \_\_\_\_\_

Carotid bruit \_\_\_\_\_

ROM: Neck- Flexion \_\_\_\_\_ Ext \_\_\_\_\_ Rot \_\_\_\_\_ Lat Flexion \_\_\_\_\_

Back- Flexion \_\_\_/90 Extension \_\_\_/30 Sidebending/Rotation \_\_\_\_\_

Shoulder/Elbow/Wrist ROM \_\_\_ Normal \_\_\_ Abnormal → \_\_\_\_\_

Hip/Knee/Ankle ROM \_\_\_ Normal \_\_\_ Abnormal → \_\_\_\_\_

## Neurologic:

Strength:

	C5	C5, C6	C7	C6	C7	C8	T1
	D	B	T, ECU	WE/ECRL/L	WF/FCR	FF/FDSP/FCU	IO
R							
L							
	L1,L2	L2,L3,L4	L3	L4	L5	L5	S1
	HF/IP	HADD	Q	TA	EHL, EDL	HABD	GS,FHL,HE
R							
L							

Sensory: \_\_\_ intact \_\_\_ not intact → location \_\_\_\_\_

Vibratory: \_\_\_ intact \_\_\_ not intact → location \_\_\_\_\_

Pulses: RUE \_\_\_\_\_ LUE \_\_\_\_\_ RLE \_\_\_\_\_ LLE \_\_\_\_\_

DTR: Biceps Triceps Brachiorad Knee Ankle

R \_\_\_\_\_

L \_\_\_\_\_

Cross Adductor \_\_\_\_\_ Tibialis \_\_\_\_\_ Abdominal \_\_\_\_\_

Special Tests: Babinski \_\_\_\_\_ Clonus \_\_\_\_\_

Hoffmans \_\_\_\_\_ Sh Abd Test \_\_\_\_\_ Adsons \_\_\_\_\_ Spurling \_\_\_\_\_

SLR \_\_\_\_\_ Leseague \_\_\_\_\_ CRAM \_\_\_\_\_ FABER \_\_\_\_\_

Rectal Exam \_\_\_\_\_ BCR \_\_\_\_\_

**XRAY/MRI Findings:** \_\_\_\_\_

**DIAGNOSIS:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**RECOMMENDATIONS:** PT \_\_\_\_\_ Meds \_\_\_\_\_ RTC \_\_\_\_\_

**DISABILITY STATUS:** \_\_\_\_\_