Spine Center

PLEASE COMPLETE THIS ENTIRE FORM

Name:_______________________________________ Date of Appointment: ___/____/___

Date of Birth: ___/___/___

Who referred you – ____

☐ Physician: ____________________________________ ☐ Relative ☐ Friend

☐ Advertisement: where – _________________________ ☐ Other: ______________________

Tell us why you are here today: –

☐ Lower back pain (Axial Lumbosacral pain)

☐ Neck pain (Axial neck pain)

☐ Mid back pain (Axial Thoracic pain)

☐ Shoulder/Arm pain (Cervical Radic pain)

☐ Mid back pain radiating to the trunk (Thor Radic pain)

☐ Hip and leg pain (L-S Radic pain)

☐ Other: ________________________________

Do you have any allergies? ☐ Yes ☐ No

____

If 'Yes,' indicate which medications: ____________________________________

____

Pharmacy name: ____________________________________ **Location:** ____________________

What medications are you CURRENTLY taking? (Attach a separate piece of paper if needed.)

Medication Name	Dose (#mg)	Times Taken Per Day

What medications did you PREVIOUSLY take for your pain?

Medication Name	Dose (#mg)	Times Taken Per Day

Does your pain refer to any other location? If so, where?

☐ right side of back ☐ left side of back ☐ to the left leg ☐ to the right leg ☐ to both legs

☐ to the right hip ☐ to the left hip ☐ to both sides of the hip ☐ it does not radiate

Have you had a previous history of these symptoms or is this a new problem?

☐ previous history ☐ new problem

How would you describe your pain?

☐ deep seated ☐ electrical ☐ sharp ☐ stabbing ☐ dull ☐ burning ☐ achy

Is your pain: ☐ constant ☐ intermittent

On a scale of 0 to 10, with 0 being very minimal pain and 10 being the worst pain, what is the pain level that you are experiencing?

(minimal pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

How long have you had this pain? _____Days _____Weeks _____Months _____Years

Indicate what activity, if any, seemed to cause your current pain condition:

☐ unknown ☐ sitting ☐ lifting ☐ athletic activity ☐ a fall

☐ auto accident: date ___/___/___ ☐ other trauma ☐ other (describe) ________________

How quickly did the pain start following the accident/event? (Please enter a number — how many.)

_____ Minutes _____ Hours _____ Days _____Weeks _____Months _____Years

Was the onset of pain: ☐ very quick ☐ spontaneous and gradual

If you had symptoms prior to the accident, are your current symptoms getting:

☐ better ☐ more constant ☐ worse

Indicate what activities increase and decrease the pain:

ACTIVITY	INCREASES PAIN	DECREASES PAIN
Sitting		
Standing		
Walking		
Lying Down		
Changing Position		

Please indicate if you have received any of the following treatments for your pain condition, when the treatment occurred, and whether the outcome was positive (+) or negative (-).

Treatment	Approximate Month & Year	Result (+ or -)
Surgery		
Physical Therapy		
Chiropractic Treatment		
Injections in the Office		
Injections Guided by X-Ray ☐ Epidural Steroid Injection ☐ Facet Joint Injection ☐ Sacroiliac (SI) Joint Injection ☐ Hip Joint Injection ☐ Other		

Have you had any diagnostic imaging (MRI, CT, x-rays, bone scan) within the past 6 months, and if so, at what facility?

____

REVIEW OF SYMPTOMS – Please check (√) any of the following symptoms or problems that you have experienced during the last six (6) months.

CONSTITUTIONAL

- ☐ Weight gain
- ☐ Weight loss
- ☐ Marked fatigue
- ☐ Fever
- ☐ Sweats
- ☐ Excessive thirst
- ☐ Heat/Cold intolerance
- ☐ Depression or other emotional changes

CARDIOVASCULAR

- ☐ Chest pain/pressure/tightness
- ☐ Palpitations
- ☐ Rapid heart rate
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Shortness of breath
- ☐ Poor circulation

GASTROINTESTINAL

- ☐ Persistent/recurring stomach pain
- ☐ Loss of bowel control
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Heartburn or indigestion
- ☐ Nausea/vomiting
- ☐ Yellow jaundice

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint redness or swelling
- ☐ Weakness
- ☐ Cramps

NEUROLOGICAL

- ☐ Headaches
- ☐ Blackouts/fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Memory loss

RESPIRATORY

- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Wheezing

EARS, NOSE, THROAT

- ☐ Loss of hearing
- ☐ Vertigo/dizziness
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN

- ☐ Frequent bruising
- ☐ Rash
- ☐ Nail or hair changes
- ☐ Hives
- ☐ Sores that don't heal

EYES

- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye pain

GENITOURINARY

- ☐ Blood in urine
- ☐ Painful urination
- ☐ Urgency to urinate
- ☐ Loss of bladder control
- ☐ frequent urination
- ☐ difficulty urinating

MEN ONLY

- ☐ Breast lump
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Lump on testicle
- ☐ Other :____________________

WOMEN ONLY

- ☐ Extreme menstrual pain
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Breast lump – if yes, date of last mammogram _______________

MEDICAL HISTORY – Check (√) any of the following symptoms or problems that you have faced at any time in your life.

- ☐ AIDS
- ☐ Alzheimers / Dementia
- ☐ Anorexia / Bulemia
- ☐ Arthritis
- ☐ Asthma / COPD
- ☐ Bleeding Disorder
- ☐ Cataracts
- ☐ Cancer

  Type:____________
- ☐ Chicken pox
- ☐ Diabetes

  Type:____________
- ☐ Drug Dependency

Emphysema

Glaucoma

Headaches

Heart Disease

Hepatities

Type: _____________

Hernia

HIV Positive

High Cholesterol

Hypertension

Kidney Diease

Liver Disease

Lung Disease

Measles

Migraine Headaches

Mononucleosis

Multiple Sclerosis

Mumps

Obesity

Pacemaker Implant

Pneumonia

Polio

Prostate Problems

Psychiatric Conditions

Rheumatic Fever

Stomach Ulcer

Stroke

Thyroid Condition

Tuberculosis

Typhoid Fever

Vascular Disease

Other (list)

____

____

____

____

____

____

____

____

____

SURGICAL HISTORY – Please list any previous surgeries ansd their respective dates.

Date	Surgery

FAMILY HISTORY – Please (√) any conditions experienced by your parents, grandparents, or siblings:

		Relationship to patient
	High Blood Pressure	
	Diabetes	
	Cancer	
	Heart Disease	
	Stroke	
	Back/Neck Pain	
	Rheumatoid Arthritis	

SOCIAL / VOCATIONAL / WORK HISTORY

Are you: ☐ right handed ☐ left handed

Do you smoke cigarettes? ☐ yes ☐ no

☐ current everyday ☐ current someday ☐ never ☐ former

Do you drink alcoholic beverages? ☐ yes ☐ no

Do you have a history of alcohol or drug abuse? ☐ yes ☐ no

Marital Status ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Employment Status ☐ unemployed ☐ employed ☐ full time ☐ part time

If unemployed right now, indicate the last date worked: ____/____/____

If out of work, what was your reason for leaving? ☐ Due to pain problem ☐ Not due to pain

Do you drink coffee, tea, or soft drinks with caffeine? ☐ yes ☐ no

PAIN DIAGRAM

Name: ____ **Date:** _______________

Draw the location of your pai on the body outlines & mark how severe it is on the pain line at the bottom of the page. Use a red pen if available.

Aching	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	=> => =>	000000	*****	/////	xxxx
^^^^	=> => =>	000000	*****	/////	xxxx

PAIN LINE: Draw a perpendicular line or arrow to indicate your usual level of pain.