ANN ARBOR SPINE CENTER

Patient History Form

Name:_____ Date:_____
Contact Phone Number:_____ Age:_____ Date of Birth:_____
Insurance:_____

Family Doctor/Internist:
Name:_____
Address:_____
City, State, Zip_____
Zip_____
Send them a letter? Yes No

Who referred you to us?
Name:_____
Address:_____
City, State,

Send them a letter? Yes No

Check all that apply:
____Injury on the job ____Auto accident injury ____Receiving disability income
____Legal proceedings pending ____Receiving workers comp. ____Working with a rehab nurse

Imaging: _____MRI _____CT _____X-Ray _____Myelogram _____Bone Scan

Are you employed? ____Yes ____No Occupation _____

Does this problem keep you from working? ____Yes ____No (If yes; date last worked:_____)

Reason for Visit (Chief Complaint): _____
Describe the onset and/or cause of your problem: Date of onset:_____
_____
_____
_____
_____

Have you ever had back or neck surgery? Please list procedures and dates: (please list any complications and outcome of surgery)
_____
_____
_____

How long have you had BACK/NECK pain? _____ Years _____ Months _____ Weeks
How long have you had ARM/LEG pain? _____ Years _____ Months _____ Weeks

Circle the number on the line best describing your current BACK or NECK pain:

0 1 2 3 4 5 6 7 8 9 10
No pain — moderate pain — severe pain

Circle the number on the line best describing your current LEG or ARM pain:

0 1 2 3 4 5 6 7 8 9 10
no pain — moderate pain — severe pain

Reviewed with patient: Physician/PA Signature:_____Date:_____

Describe the character (quality) of your pain:

Aching	Sharp	Exhausting	Vicious
Throbbing	Pinching	Tingling	Penetrating
Burning	Punishing	Lancinating	Tearing
Dull	Shooting	Stabbing	Pressure

Other: _____

What makes your pain better?

_____lying down	_____manipulation	_____physical therapy
_____sitting	_____exercise	_____aspirin
_____standing	_____prescription pain pills	_____Tylenol
_____walking	_____muscle relaxers	_____over the counter medications

other:_____

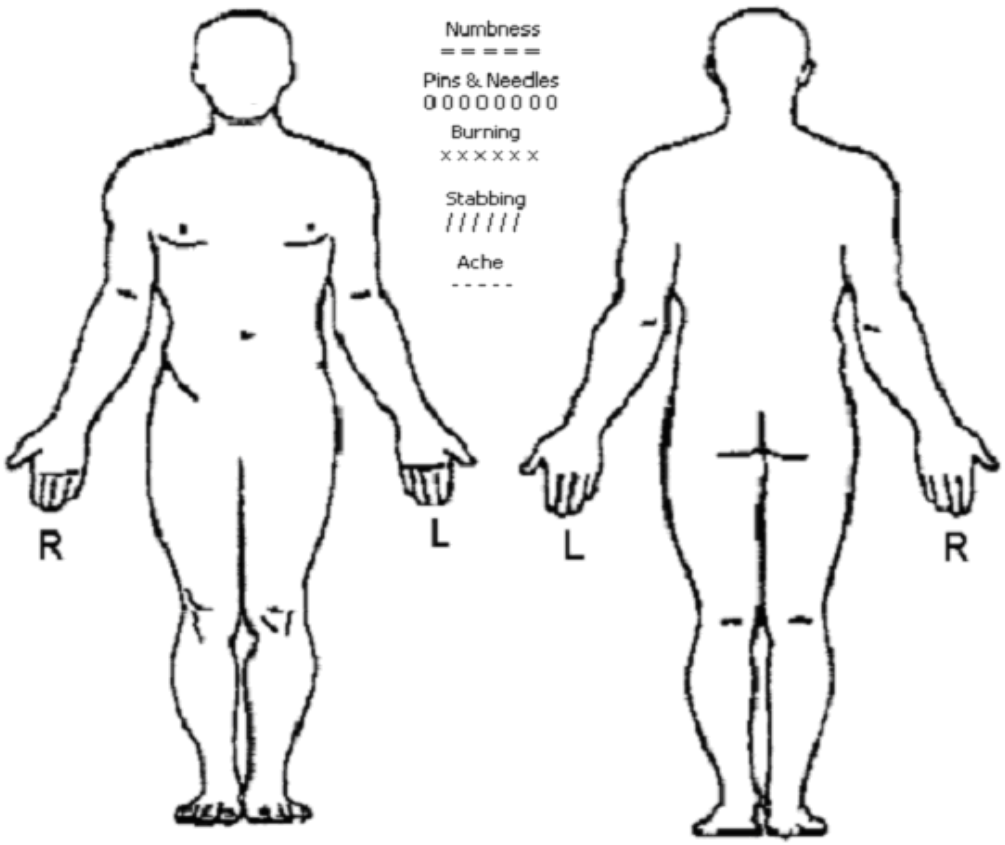
What makes your pain worse?

_____lying down	_____sneezing	_____exercise
_____sitting	_____coughing	
_____standing	_____bending forward	
_____walking	_____bending backward	

other:_____

How far can you walk? _____ Blocks (number____) _____ Around the house
_____ Unlimited _____ other: _____

Mark these drawings according to where you hurt (if the back of your neck hurts, mark the back of your neck, etc.).
If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.
If the markings are not applicable, indicate the areas of pain in your own words.



Name:_____

Who have you seen for treatment of pain/symptoms in the past? (please list names also)

- Primary care doctor _____
- Orthopaedic Spine Surgeon _____
- Neurosurgeon_____
- Rehab doctor_____
- Neurologist _____
- Emergency room_____How many times?_____
- Pain clinic _____
- Chiropractor_____
- Psychologist_____
- Psychiatrist_____
- Other _____

Have you had: (check all that apply, include dates if known)

____ X-rays _____ ____ MRI _____ ____ CAT scan _____
____ Bone Scan _____ ____ EMG _____ ____ Bone Density _____
____ Myelogram _____ ____ Discogram _____

What treatments have you tried for pain relief: (check all that apply)

	Did It Help?			Did it help?	
_____ Physical therapy	YES	NO			
Attended PT for how long?_____			_____ Taken time off of work	YES	NO
_____ Aqua therapy	YES	NO	_____ Altered daily activities	YES	NO
_____ Traction	YES	NO	_____ Rested	YES	NO
_____ Massage	YES	NO	_____ Used ice	YES	NO
_____TENS	YES	NO	_____ Used heat	YES	NO
_____ Acupuncture	YES	NO	_____ Nerve Block	YES	NO
_____ Anti-inflammatory meds	YES	NO	_____ Facet Block	YES	NO
How long did you take medications?_____			_____ Oral Steroids	YES	NO
_____ Pain medications	YES	NO	_____ Epidural Steroid Injections	YES	NO
_____ Worn a brace	YES	NO			

Past Medical History/Family History (check all that apply):

HEIGHT _____ WEIGHT _____

You	Family		You	Family
____	____	Heart attack	____	_____ Bleeding problem
____	____	Heart failure	____	_____ Stress test
____	____	High Blood Pressure	____	_____ Cancer
____	____	Stroke	____	_____ Hepatitis
____	____	Kidney disease	____	_____ Pulmonary embolus
____	____	Heart catheterization	____	_____ Blood clotting
____	____	Diabetes	____	_____ High Cholesterol

List all past surgeries: (include dates if known)

_____
_____
_____
_____

Social History:

Are you married?	YES	NO	
Females—are you pregnant?	YES	NO	UNSURE
Do you smoke?	YES	NO	(# packs_____ for _____ years)
Do you use other forms of tobacco?	YES	NO	(What? _____)
Do you drink alcohol?	YES	NO	(# drinks weekly_____)

Allergies to medications and reactions (include tape and latex allergies):

_____
_____
_____
_____
_____

Please list all current medications, supplements, vitamins, and herbs you take:

Drug	Dose	How many times taken daily

Review of Systems:

YES	NO	General
____	____	fever
____	____	weight gain
____	____	weight loss
____	____	sexual dysfunction
____	____	cancer
____	____	HIV

YES	NO	Ears, Nose, Throat
____	____	cold symptoms
____	____	headache
____	____	nasal drainage
____	____	sore throat
____	____	hearing loss

YES	NO	Eyes
____	____	sharp vision
____	____	glaucoma
____	____	cataracts
____	____	blindness

YES	NO	Heart
____	____	chest pain (angina)
____	____	palpitations
____	____	irregular heart beat
____	____	poor circulation
____	____	valve disease

YES	NO	Lungs
____	____	shortness of breath
____	____	cough
____	____	sleep apnea

YES	NO	Lymph Nodes
____	____	enlarged lymph nodes

YES	NO	Stomach (GI)
____	____	abdominal pain
____	____	diarrhea
____	____	constipation
____	____	nausea/vomiting
____	____	reflux
____	____	liver cirrhosis
____	____	loss of bowel control

YES	NO	Renal (Urinary)
____	____	renal failure
____	____	difficulty urinating
____	____	urgency
____	____	frequency
____	____	UTI
____	____	kidney stones
____	____	loss of bladder control
____	____	blood in urine

YES	NO	Muscle/ Bone
____	____	arthritis
____	____	osteoporosis
____	____	lupus
____	____	rheumatoid arthritis
____	____	sciatica
____	____	radiculopathy

YES	NO	Skin
____	____	rash
____	____	cancer
____	____	infection
____	____	psoriasis
____	____	eczema
____	____	ulcers

YES	NO	Brain/ Nerves
____	____	seizure
____	____	memory loss
____	____	paralysis
____	____	mini stroke
____	____	facial drooping
____	____	slurred speech

YES	NO	Blood Disorders
____	____	Sickle cell anemia
____	____	VonWillebrands
____	____	Hemophilia
____	____	Excessive bleeding
____	____	Easy bruising

YES	NO	Sleep/Psychological
____	____	Insomnia
____	____	excessive tiredness
____	____	anxiety
____	____	depression
____	____	manic depression