

# Spine Associates

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PATIENT NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE \_\_\_\_\_ HEIGHT: \_\_\_\_\_ FT: \_\_\_\_\_ IN: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

## EXPLAIN HOW YOUR PAIN BEGAN:

Injury Yes or No  Sports  On the Job  Motor vehicle accident

I don't know how it began

Date of Injury \_\_\_\_\_

Explain How it happened \_\_\_\_\_

## RATE YOUR PAIN: (Mark X on the Line)

1. How bad is your Low Back Pain Now:

0 \_\_\_\_\_ 2 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 8 \_\_\_\_\_ 10  
Worse Possible

2. How bad is your Leg Pain Now?

0 \_\_\_\_\_ 2 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 8 \_\_\_\_\_ 10  
Worse Possible

3. How Bad is your Neck or Upper Back Pain Now?

0 \_\_\_\_\_ 2 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 8 \_\_\_\_\_ 10  
Worse Possible

4. How Bad is your Arm Pain now?

0 \_\_\_\_\_ 2 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 8 \_\_\_\_\_ 10  
Worse Possible

Have you had Back/Neck Pain before this episode?  Yes or  No

If yes when \_\_\_\_\_ For how long \_\_\_\_\_

## WHAT MAKES YOUR DISCOMFORT WORSE: (PLEASE CHECK ALL THAT APPLY)

### NECK

Activity  Bending Neck Forward  Bending Neck Backward

Bending neck to the left  Bending Neck to the Right

Other \_\_\_\_\_

### BACK

Activity  Bending Forward  Bending Backward  Sitting  Standing

Walking  Sneeze/Cough/Straining going to bathroom/bearing down

Other \_\_\_\_\_

**WHAT MAKES YOUR DISCOMFORT BETTER: (PLEASE CHECK ALL THAT APPLY)**

**NECK**

- Bed Rest  Massage  Stretching "Popping" Neck  Heat  Ice  
 Other \_\_\_\_\_  Nothing Helps

**BACK**

- Bed Rest  Decrease Activities  Bending Forward  Bending Backward  
 Other \_\_\_\_\_  Nothing Helps

**I ALSO HAVE THE FOLLOWING PROBLEMS:**

- Specific Weakness in my arms or hands  
 Generalized weakness of arms or hands due to pain or discomfort  
 Numbness TINGLING OF:  Arms  Hands  Legs  Feet  Torso  
 Specific Weakness of legs  
 Generalized weakness of legs due to pain and discomfort  
 My legs fatigue or hurt when I walk too far  This is relieved by resting my legs  
I can walk:  Less than a block  1-2 Blocks  More than 3 blocks  
 Trouble with my bladder (Urine) control  
 Can't empty bladder  
 Loss of urine (accidents)  
 Trouble with bowels  
 Constipation  
 Loss of bowel (accidents)  
 My pain is worse at night  
 My pain awakens me from sleep

**OCCUPATION:**

Employed Yes or No      Date last worked \_\_\_\_\_      Retired \_\_\_\_\_  
Employer \_\_\_\_\_

**MY JOB REQUIREMENTS ARE:**

- Heavy: Lifting over 60 Lbs. and Frequent bending and stooping  
 Medium: Lifting 30 – 50 Lbs.  
 Light: Lifting 10 – 20 Lbs.  
 Sedentary: Sit most of the time and very little lifting

**GENERAL MEDICAL HISTORY**

**YEAR    ILLNESS**

- \_\_\_\_\_  Heart Trouble  Angina  Heart Attack  Heart Failure  Heart Murmur  
\_\_\_\_\_  Valve Disease  Other \_\_\_\_\_  
\_\_\_\_\_  High Blood Pressure  
\_\_\_\_\_  Stroke  
\_\_\_\_\_  Ulcer:  Stomach  Duodenal  Colon  
\_\_\_\_\_  Diabetes (High Blood Sugar)  
\_\_\_\_\_  Liver Disease:  Hepatitis  Type A  Type B  Other  
\_\_\_\_\_  Cirrhosis  Other \_\_\_\_\_  
\_\_\_\_\_  Kidney Disease:  Stones  Infections  Other \_\_\_\_\_  
\_\_\_\_\_  Lung Disease:  Emphysema  TB  Chronic Brochitis  Cancer  Asthma  
\_\_\_\_\_  Frequent Pneumonia  Other \_\_\_\_\_  
\_\_\_\_\_  Blood Disorders:  Anemia  Leukemia  Bleeding Tendency  Other  
\_\_\_\_\_  Eye Disease  Glaucoma  Other \_\_\_\_\_  
\_\_\_\_\_  Arthritis  Degenerative  Rheumatoid  Gout  Other  
\_\_\_\_\_  Cancer Type and Sites: \_\_\_\_\_  
\_\_\_\_\_  HIV Positive  Aides \_\_\_\_\_  
\_\_\_\_\_  Psychological Difficulties:  Depression  Psychosis  Other \_\_\_\_\_  
\_\_\_\_\_  No Major Illnesses

**MAJOR INJURIES:**

Auto or Cycle accidents, etc. (Describe) \_\_\_\_\_  
 Other Major Injuries: \_\_\_\_\_

**HOSPITALIZATION:** (Explain) \_\_\_\_\_

**LADIES MENSTRUAL HISTORY:** Pregnant Yes or No

Menopausal  hormone treatment

**MEN:**  Problems with Sexual Function

**FAMILY MEDICAL HISTORY:**

Members of my family (brothers, sisters, grandparents, aunts and uncles) suffer with the following:

Stroke  High Blood Pressure  Cancer-type \_\_\_\_\_

Diabetes  Heart Attack  Lung Disease

Arthritis  Other: \_\_\_\_\_  I Don't Know

**SOCIAL HISTORY:**

I live with my children or other relatives.

Explain: \_\_\_\_\_

I drink Yes or No If yes  beer  Wine  "Hard" Drinks  None  Daily  Socially

I honestly consider myself to drink too much  I don't think I drink too much

I smoke Yes or No If yes  Cigarettes  Pipe  Cigars \_\_\_\_\_ Parts/Day for \_\_\_\_\_ Years

My Recreational activities includes:  Jogging  Bicycling  Sports – List \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Do you have problems other than Neck or Back: \_\_\_\_\_

Eyes  Ears  Nose  Throat  Explain: \_\_\_\_\_

Skin, Moles, Spots, or Sores that are unusual Explain: \_\_\_\_\_

Unusual Humps or Bump under skin, such as enlarged lymph nodes Explain: \_\_\_\_\_

Trouble breathing  Short of Breath  Cough  Pain w/Breathing  Other

Chest Pain Discomfort  Sharp  Aching  Arm Discomfort along with Chest Discomfort

With Activity  After Meals  When under stress  Other \_\_\_\_\_

Trouble with Stomach or Bowels  Nausea / Vomiting  Stomach Pain  Diarrhea

Constipation

Bleeding in Bowel  Black / Tarry Stools  Other \_\_\_\_\_

Trouble with Legs  Fatigue with walking/Relieved by rest

Other \_\_\_\_\_

Trouble with Nerves  Anxious / Fearful  Down/Depressed

**ALLERGIES:** REACTION: Itching Nausea Hospitalized

Penicillin \_\_\_\_\_

Sulfer \_\_\_\_\_

Keflex \_\_\_\_\_

Codeine \_\_\_\_\_

Other \_\_\_\_\_

None

**CURRENT/PREVIOUS TREATMENT: (For Back or Neck)**

None

Physician's Name: \_\_\_\_\_

He Prescribed Medications (Give Names): \_\_\_\_\_

Anti-Inflammatories: \_\_\_\_\_

Muscle Relaxers: \_\_\_\_\_

Pain Meds: \_\_\_\_\_

List other medications: \_\_\_\_\_

Physical Therapy Yes or No If Yes When \_\_\_\_\_

Traction

Exercises

Manipulations (Osteopath) \_\_\_\_\_

Heat  Ice

Chiropractor's Name: \_\_\_\_\_

Physical therapy facility: \_\_\_\_\_

Injections Yes or No If yes when \_\_\_\_\_

Physician's name: \_\_\_\_\_

Type of injections: \_\_\_\_\_

Surgery Yes or No

Please list surgeries:

Type of Surgery \_\_\_\_\_

Date: \_\_\_\_\_ Where: \_\_\_\_\_ Doctor: \_\_\_\_\_

Described: \_\_\_\_\_

Infections: \_\_\_\_\_ Treatment: \_\_\_\_\_

Type of Surgery \_\_\_\_\_

Date: \_\_\_\_\_ Where: \_\_\_\_\_ Doctor: \_\_\_\_\_

Described: \_\_\_\_\_

Infections: \_\_\_\_\_ Treatment: \_\_\_\_\_

Type of Surgery \_\_\_\_\_

Date: \_\_\_\_\_ Where: \_\_\_\_\_ Doctor: \_\_\_\_\_

Described: \_\_\_\_\_

Infections: \_\_\_\_\_ Treatment: \_\_\_\_\_

**I HAVE HAD THE FOLLOWING TESTS: (PLEASE CHECK ALL THAT APPLY)**

Regular X Rays  CT scan  MRI  Myelogram  Discogram  Bone scan

EMG/Nerve Conduction Studies

I have seen other doctors for my condition. List types of doctors and who they are:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_