Spine Specialty CENTER[sm]

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Name:____ Date:_____________
Birthdate:_____________ Height:_______ft _______in Weight:___________
Social Security #: ______________________
Referring doctor name and address: ____
____
____

Internist or family doctor name and address: _____________________________________
____
____
(*Letters will be sent to the above physicians about your progress unless you specify otherwise)*

Reason for visit (check all that apply): Neck Pain Back Pain
Arm/Hand Pain Arm/Hand Numbness Arm/Hand Weakness
Buttock/Leg Pain Leg/Foot Numbness Leg / Foot Weakness
Other Reason not listed:____

Your age: _____ years _____ months Sex: Female Male

When did your pain (or your problem) start?____________________________________

Since your pain (or your problem) started is it: Better Worse Same

What started the pain (or problem)? ____
____
____

A. FOR PATIENTS ONLY WITH PROBLEMS OF THE NECK, ARMS OR HANDS, ANSWER SECTION A.
IF YOU ARE SEEING THE DOCTOR FOR BACK, OR LEG PROBLEMS, SKIP TO SECTION B.

How much of your pain is neck and how much is in your arms or hands?
All arm or hand pain / No Neck pain
Mostly arm or hand / Some Neck pain but not a major problem
Arm or hand pain **and Neck** pain bother me equally
Mostly Neck pain / Some arm pain but not a major problem
All Neck pain / No arm or hand pain

There is: No arm or hand pain Arm or hand pain as follows
RIGHT arm or hand pain ONLY
Mostly RIGHT arm or hand pain / some LEFT arm or hand pain not major
BOTH bother me equally
Mostly LEFT arm or hand pain / some RIGHT arm or hand pain not major
LEFT arm or hand pain ONLY

When arm pain is present it is present in the:

RIGHT	Shoulder blade	Shoulder	Forearm	Hand/fingers
LEFT	Shoulder blade	Shoulder	Forearm	Hand/fingers

Raising the arm makes the pain: Better Worse Same

Moving the neck makes the pain: Better Worse Same

There is: No weakness of the arms or hands (skip to next question).

Weakness is present (check below)

RIGHT	Shoulder	Upper Arm	Forearm	Hand/fingers
LEFT	Shoulder	Upper Arm	Forearm	Hand/fingers

I have difficulty with picking up small objects like coins or buttoning clothes.

Yes No

I have trouble keeping my balance or my walking has changed. Yes No

I have (Frequent Occasional No) headaches in the back of the head.

B. Complete section B only if you have back, buttock or leg pain, numbness or weakness. If you are seeing the doctor for neck problems skip to section C.

How much of your pain is back and how much is in your buttocks or legs?

All **leg** or buttock pain / No Back pain

Mostly **leg or buttock** / Some Back pain but not a major problem

Leg or buttock pain **and Back pain** bother me equally

Mostly Back pain / Some leg or buttock pain but not a major problem

All BACK pain / No leg or buttock pain

There is: No leg or buttock pain Leg or buttock pain as follows

RIGHT leg or buttock pain ONLY

Mostly RIGHT leg or buttock pain / some LEFT leg or buttock pain not major

BOTH bother me equally

Mostly LEFT leg or buttock pain / some RIGHT leg or buttock pain not major

LEFT leg or buttock pain ONLY

When leg or buttock pain is present it is present in the:

RIGHT	Buttock	Thigh (front)	Thigh (back)	Calf	Foot
LEFT	Buttock	Thigh (front)	Thigh (back)	Calf	Foot

I have No weakness in my legs (skip to next question)

Weakness in my legs (check below all that apply).

RIGHT	Thigh	Calf	Ankle	Foot	Big toe
LEFT	Thigh	Calf	Ankle	Foot	Big toe

I have No numbness in my legs (skip to next question)

Numbness in my legs (check below all that apply).

RIGHT	Thigh	Calf	Foot
LEFT	Thigh	Calf	Foot

My pain is made worse by: Sitting Standing Walking
What distance can you walk without pain? ___________________________
How many minutes can you walk without pain?
0-15 15-30 30-60 more than 60
How many minutes can you stand in one place without pain?
0-15 15-30 30-60 more than 60
Lying down makes the pain: Better Worse Same
Bending forward makes the pain: Better Worse Same

C. ALL PATIENTS SHOULD COMPLETE THIS SECTION.

Coughing or sneezing makes the pain: Better Worse Same
There is: No loss of bowel or bladder control
Loss of bowel or bladder control since: ____________
I have not missed work because of this problem missed (how much?) work ___.
Treatments for THIS problem have included: NONE

Exercises with a physical therapist
Massage & Ultrasound
Traction
Manipulation
Tens Unit
Shoulder Injections
Brace

Prescription medications
Over the counter medications
Epidural steroid injections_____ times
which worked for how long _______
Other injections (describe): __________
____
Did these help? _________________

List pain medications and dose taken for this problem: NONE
____
____
____

Previous doctors seen for this problem. Please be as complete as you can. NONE

Date	Doctor	Specialty	City	Treatments

Tests done to evaluate THIS problem with the date and place they were done. NONE
The physician may perform his own reading/interpretation of any or all of the studies listed in order to manage your care and proceed with a treatment plan.

	Neck	Back	Date	Location
X-Rays				
Myelogram				
CT Scan				
MRI				
EMG				
Bone Scan				
Other:				

CHECK ALL THAT APPLY. None apply

Reading glasses	Toothache	Frequent Headaches
Change of vision	Gum Trouble	Blackouts
Loss of Hearing	Nausea/Vomiting	Seizures/Epilepsy
Ear Pain	Stomach Pain	Frequent Rash
Hoarseness	Ulcers	Hot or Cold Spells
Nosebleeds	Frequent Belching	Recent Weight Loss
Difficulty Swallowing	Frequent Diarrhea	Poor Appetite
Morning Cough	Frequent Constipation	Nervous Exhaustion
Shortness of Breath	Hemorrhoids	
Fever or Chills	Frequent Urination	*Women Only:*
Heart of Chest Pain	Burning on Urination	Irregular Periods
Abnormal Heartbeat	Difficulty Urinating	Possibly Pregnant
Swollen Ankles	Get up more than once at night to urinate	
Calf Cramps with Walking		

Is your primary doctor aware of the above checked problems? Yes No

HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING
(check all that apply) None Apply

Heart Attack	Mental Illness	Stomach Ulcers
Heart Failure	Kidney Stones	Liver Trouble
High Blood Pressure	Kidney Failure	Hepatitis
Osteoarthritis	Alcoholism	Thyroid Trouble
Rheumatoid Arthritis	Lung Disease	Bleeding Disorders
Ankylosing Spondylitis	Asthma	AIDS or HIV
Gout	Emphysema	Anemia
Osteoporosis	Tuberculosis	Blood Clot in Leg
Diabetes	Stroke	Blood Clot in Lung
Epilepsy	Cancer (if yes, what type) ________________________	

Please explain any other problems, serious injuries or accidents: ______________________

PLEASE LIST ALL SURGERIES YOU HAVE HAD, THE SURGEON AND THE DATE. None

Date	Operation	Surgeon

MEDICATIONS YOU TAKE (CONTINUE ON BACK IF NEEDED, PLEASE DON'T FILL OUT AGAIN IF YOU HAVE LISTED THESE ELSEWHERE) None

Medication	Dosage	Frequency

ALLERGIES TO MEDICATIONS: No known drug allergies

Please list any medication allergies and the reaction you had

____

____

WHAT DISEASES OR PROBLEMS RUN IN YOUR FAMILY? None

Stroke	Gout	Cancer
Heart Disease	Seizures	Bleeding Disorders
High Blood Pressure	Spine Problems	Alcoholism
Diabetes	Kidney Problems	Mental Illness

Other: ____

ANSWER THE FOLLOWING QUESTIONS AS THEY PERTAIN TO YOUR DAILY LIFESTYLE:

Work Status: Homemaker Working Unemployed Retired

Disabled On Leave or sick time Occupation:____________________

Marital Status: Married Single Widowed Divorced Cohabitating

I live: alone with: ____________________________________

Tobacco Use: Never Cigar Chew Pipe

Cigarettes _____ packs per day for _____ years.

Quit smoking (year) _____ after smoking _____ packs per day for ____ years.

Alcohol: Never or Rare Socially Frequently Drunk

Alcoholic Recovering Alcoholic

Drug Abuse: Never Currently In the past

Because of this spine problem, I have filed or plan to file:

A lawsuit A workman's compensation claim Neither

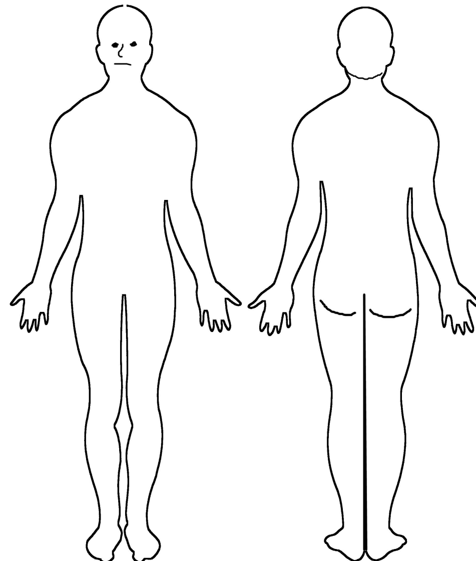
MY PAIN OR DISCOMFORT TODAY IS:

(please circle the appropriate description of your pain rated on a scale from 1 to 10):

0	1	2	3	4	5	6	7	8	9	10

NONE SLIGHT MILD MODERATE SEVERE EXCRUCIATING

PLEASE SHOW WHERE YOU ARE FEELING YOUR PAIN ON THE PICTURE.



MEDICATION RECORD

Name ____
Home # ________________ Cell # ________________
Pharmacy _________________ Phone # ___________

DATE	MEDICATION	DOSAGE AND FREQUENCY	# OF REFILLS