Spine Specialty sm
CENTER
6005 Park Avenue, Suite 400, Memphis, TN 38119
901-767-9500 FAX 901-767-0911

Patient Name:_____ Date:_____

What is the reason for your visit to the doctor today?_____
_____
_

Is this a visit for the same problem you last saw the doctor for? YES NO

If NO, briefly describe the problem
today:_____
_____
_____
_____
___

Pain Level TODAY: Absolutely None 1 2 3 4 5 6 7 8 9 10 Excruciating

Since last seen, is your pain: BETTER SAME WORSE?

Circle how much pain you have for each location. ***Please circle Neck or Back.***

Neck / Back	None	1	2	3	4	5	6	7	8	9	10	Excruciating
Right Arm / Leg	None	1	2	3	4	5	6	7	8	9	10	Excruciating
Left Arm / Leg	None	1	2	3	4	5	6	7	8	9	10	Excruciating
Bone Graft	None	1	2	3	4	5	6	7	8	9	10	Excruciating

How well are you functioning?

- ❑ Totally incapacitated
- ❑ Able to do some activities at home with marked limitation of all activities
- ❑ Some limitation of moderate demand activities
- ❑ Limitation of strenuous activities or sports
- ❑ Able to do all activities

What is your work status TODAY?

- ❑ Not working
- ❑ Working part-time
- ❑ Working Full-time
- ❑ N/A (student, retiree, disabled)

Are you currently on disability due to back pain? YES NO

Are you currently on disability for any other reason? YES NO

If YES, reason for your disability_____

Are you currently smoking? YES NO

Have any ***new*** problems been diagnosed in your family? YES NO
If YES, please list:_____

Have you been diagnosed with ***new*** medical problems? YES NO
If YES, please list:_____

Have you had surgery by another doctor ***since last seen***? YES NO
If YES, please describe:_____

Please list any ***new*** medications you are taking:_____
_____
_____
_____
___

Please list any Back/Leg pain medications: ❑ None;_____
_____
_
Please describe any change in work status, job, or living situation:_____
_____
_

Are there any other problems presently affecting you? Please check those 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			
Calf Cramps		at night to urinate	❑		
with Walking	❑				

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

Thank you for keeping us up to date so that we can better help you!

Patient Signature:_____ Date:_____