HISTORY OF PRESENT COMPLAINT

1. Age: _____ o Male o Female Pain is on which side? o Right o Left

2. Where is your problem located? o Neck o Upper Back o Arm o Lower Back o Hip o Leg

3. How long have you had this problem? _____ Since? _____/_____/_____ month day year

4. Briefly, please give the details of how this problem originally started:

_____

_____

_____

_____

5. Was this from a work-related injury? o No o Yes - Is it under workers compensation o No o Yes

Have you missed any work because of this problem? o No o Yes, how much? _____

6. Please describe your present pain/problem now (what you feel, where, when, etc.):

_____

_____

_____

7. Have you had spinal surgery in the past: (Check one) o Yes o No How many times? _____

What type of surgery(s) was/were performed? o Discectomy o Laminectomy o Fusion o IDET o Unknown o Other _____ What spinal level? _____

What was the date of your most recent spine surgery? _____

Did you improve from your spine surgery procedure(s)? o Yes o No

8. Which of the following best describes your ratio for neck & arm or back & leg discomfort (if appropriate)

A. 100% back pain and 0% leg pain	A. 100% neck pain and 0% arm pain
B. 90% back pain and 10% leg pain	B. 90% neck pain and 10% arm pain
C. 75% back pain and 25% leg pain	B. 75% neck pain and 25% arm pain
D. 50% back pain and 50% leg pain	C. 50% neck pain and 50% arm pain
E. 25% back pain and 75% leg pain	D. 25% neck pain and 75% arm pain
F. 10% back pain and 90% leg pain	F. 10% neck pain and 90% arm pain
G. 0% back pain and 100% leg pain	E. 0% neck pain and 100% arm pain

9. For any pain/numbness in your arm(s) or leg(s), which side is worse? (Choose one if appropriate)

Leg Symptoms	**Arm Symptoms**
A. 100% left leg and 0% right leg	A. 100% left arm and 0% right arm
B. 75% left leg and 25% right leg	C. 75% left arm and 25% right arm
C. 50% left leg and 50% right leg	D. 50% left arm and 50% right arm
D. 25% left leg and 75% right leg	E. 25% left arm and 75% right arm
E. 0% left leg and 100% right leg	G. 0% left arm and 100% right arm

(Continued on next page)

CURRENT PAIN PROFILE

10. Please choose letters A – F (in first column) to answer the questions in column two.

A. Unable to tolerate	How long can you sit? _____
B. About 15 minutes only	
C. About 30 minutes only	How long can you stand? _____
D. About 45 minutes	
E. About 1 hour	How long can you walk? _____
F. Indefinitely	

11. Which of the following activities change the nature of your pain?

	Aggravates Pain	**Relieves Pain**	**Neither**
Sitting	o	o	o
Standing	o	o	o
Walking	o	o	o
Leaning forward (brushing teeth)	o	o	o
Bending forward	o	o	o
Lying in your side	o	o	o
Lying on your back	o	o	o
Lying on your stomach	o	o	o
Rising from sitting	o	o	o
Changing positions	o	o	o
Coughing / Sneezing	o	o	o
Driving	o	o	o

Now go back and CIRCLE the box to indicate **the most aggravating activity** and the **most relieving activity.**

12. If the symptoms of your present pain have changed, please indicate the most appropriate statement: (Circle one)
    A. My symptoms have remained the same since the time of onset.
    B. My symptoms are more severe since the time of onset
    C. My symptoms are less severe since the time of onset.

13. How have the symptoms of your present pain changed: (Circle one)
    A. no change in symptoms
    B. increased aggravation in one arm or leg
    C. increased aggravation in both arms or legs
    D. increased aggravation in the back or neck
    E. increased aggravation in both arms/legs and back/neck

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BB:	Myl:
NP:	

(Continued on next page)

PAST BACK HISTORY

14. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury: (Check one of each)

	Which type	Helpful	No Help	Not Used
Antiinflammatory	_____	o	o	o
Muscle Relaxants	_____	o	o	o
Narcotic Pain Medications	_____	o	o	o
Hot Packs	_____	o	o	o
Ice	_____	o	o	o
Ultrasound	_____	o	o	o
TENS Unit / Muscle Stim (Circle)	_____	o	o	o
Physical Therapy Treatment	_____	o	o	o
Back/Neck Exercises	_____	o	o	o
Chiropractor	_____	o	o	o
Epidural Block/Injection	_____	o	o	o
Facet Block/Injection	_____	o	o	o
SI Joint Block/Injection	_____	o	o	o
Trigger Point Injection	_____	o	o	o
Acupuncture / Massage	_____	o	o	o
Traction / VAX-D (Circle)	_____	o	o	o
Other: _____	_____	o	o	o

15. Please indicate whether you have had any of the following studies and write when/where the most recent was:

	YES	NO	WHEN/WHERE		YES	NO	WHEN/WHERE
Regular X-ray of Spine	o	o	_____	Myelogram	o	o	_____
CT Scan of spine	o	o	_____	Discogram	o	o	_____
EMG	o	o	_____	MRI of spine	o	o	_____
Nuclear Bone Scan	o	o	_____	Bone Density	o	o	_____

16. Have you had any past episodes of similar pain or injury? o Yes o No (please describe)

_____

_____

_____

17. List all other physicians with whom you have consulted in the past year for this problem.

_____

_____

_____

HEALTH HISTORY *(Confidential)*

Patient Name: _____ Today's Date: _____

Symptom or problem for which you are seeing the doctor today: _____

Birth date: _____Pharmacy name and phone number: _____

Referring Doctor: _____Cardiologist: _____

SYMPTOMS: CHECK (√) SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

GENERAL
- □ Anxiety
- □ Balance problems
- □ Chills
- □ Depression
- □ Difficulty walking
- □ Dizziness
- □ Fainting
- □ Fever
- □ Headache
- □ Hot flashes
- □ Loss of sleep
- □ Loss of weight
- □ Numbness

WOMEN ONLY

Menopause:
□ Yes □ No

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- □ Arms □ Hips
- □ Back □ Legs
- □ Feet □ Neck
- □ Hands □ Shoulders
- □ Groin

GENITO-URINARY
- □ Lack of bladder control
- □ Difficulty/pain urinating

GASTROINTESTINAL
- □ Bowel changes
- □ Lack of bowel control
- □ Heartburn/Indigestion
- □ Hemorrhoids
- □ Nausea
- □ Stomach pain

CARDIOVASCULAR
- □ Chest pain
- □ Irregular heart beat
- □ Rapid heart beat
- □ Swelling of ankles

EYE, EAR, NOSE, THROAT
- □ Difficulty swallowing
- □ Loss of hearing
- □ Sinus problems

SKIN
- □ Bruise Easily
- □ Itching
- □ Rash

CURRENT HEIGHT _____

CURRENT WEIGHT _____

PHYSICIAN NOTES:

CONDITIONS: CHECK (√) CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

- □ AIDS/HIV
- □ Alcoholism
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Bi-polar Disorder
- □ Bleeding Disorders
- □ Blood Pressure, High
- □ Bronchitis
- □ Cancer_____
- □ Cerebral Palsy
- □ Chemical Dependency
- □ Cirrhosis of Liver
- □ COPD
- □ Diabetes
- □ Emphysema
- □ Epilepsy or Seizures
- □ Fractures _____
- □ GERD
- □ Glaucoma
- □ Gout
- □ Heart Disease
- □ Hepatitis Type A, B, C
- □ High Cholesterol
- □ Kidney Disease
- □ Legally Blind
- □ Liver Disease
- □ Lupus
- □ Meningitis
- □ Migraine Headaches
- □ Multiple Sclerosis
- □ Neuropathy
- □ Osteoporosis
- □ Pacemaker
- □ Pneumonia
- □ Polio
- □ Prostate Problem
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis
- □ Ulcers in Stomach
- □ Ulcers of Skin
- □ Other _____

_____

_____

FAMILY HISTORY: CHECK (√) ALL THAT APPLIES AND INDICATE THEIR RELATIONSHIP TO YOU:

- □ Heart Disease _____
- □ Arthritis _____
- □ Cancer_____
- □ Diabetes _____
- □ Osteoporosis _____
- □ Scoliosis _____

SOCIAL HISTORY:

Do you exercise? □ Yes □ No Type of exercise: _____ Times per week: _____

Tobacco Use: Current every day smoker Current some day smoker Never smoker Former Smoker

Alcohol Use: None Social Moderate Heavy

Employer/Occupation: _____ Are you able to work now? _____

Is your current problem related to work or an accident? _____ Is there an attorney working with you? _____

List all medications (PRESCRIPTIONS and NON-PRESCRIPTION) you are presently taking, include frequency and dose.

MEDICATION NAME	DOSE	HOW OFTEN PER DAY
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
• **Are you taking any blood thinners** (Coumadin, Heparin, Plavix, Aspirin)		
•		
•		
•		

Do you have any allergies to medicines and foods? □ Yes □ No

If yes, please list:_____

_____

Do you have skin sensitivity or allergy to metals: □ Yes □ No

_____

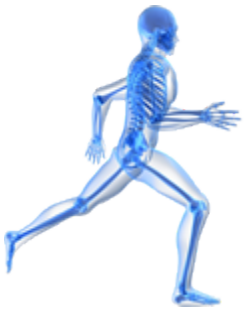
List all surgical procedures you have had and the approximate date.

SURGICAL PROCEDURE	DATE

I certify that the above information is correct to be the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Legal Guardian Signature: _____

Reviewed by: _____Date:_____



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Transcription Form

Patient Name:_____

DOB: _____Date:_____

Referring Physician_____

Where are they located? _____

Would you like reports sent to this doctor? Yes or No

Primary Care Physician_____

Where are they located? _____

Would you like reports sent to this doctor? Yes or No