DATE______________

PATIENT HISTORY – SPINAL PROBLEMS

Name: ____ Age: _______Date of Birth_______

Occupation: ____Years at current job ____________

Who referred you to this office? ____

What is the date that you first had the symptoms start for which you are being seen? _______________

(accident / injury date or slow or delayed onset) please circle if applicable

1. Where do you hurt?: Back __ Leg(s) R __ L__ Both___ Back and Leg Pain___ Buttock Pain____ Sacroiliac Joint Pain___ Neck Pain___ Arm Pain___ **(list worst area to least pain 1, 2 , 3,etc)**

   Do you have any numbness or tingling? If so, where?______________________________________

   Have you ever had these symptoms before? ❑ Yes ❑ No if so, When?___________________

   Have you ever had treatment for these symptoms before? ❑ Yes ❑ No

2. Is the current problem Work Related? ❑ Yes ❑ No

   Is this a worker's compensation claim? ❑ Yes ❑ No

   Have you had a prior WC claim? ❑ Yes ❑ No If so, When?_______________

   Were you in a Motor Vehicle Accident? ❑ Yes ❑ No

   Have you had a prior MVA? ❑ Yes ❑ No If so, When? _______________

3. Mechanism of pain onset (check all that apply):

   - ❑ Unknown
   - ❑ Lifting
   - ❑ Twisting
   - ❑ Fall
   - ❑ Other _______________
   - ❑ Bending forward
   - ❑ Bending backward
   - ❑ Pulling
   - ❑ Hit in back
   - ❑ Auto Accident ___Rear ended ____Side swiped ___ Head on ____ Roll over

4. Did you go to the Hospital or an Acute Care Center? ❑ Yes ❑ No, if so, what did they do? _____________________
____

5. What treatment(s) have you had? __Medication __Rest __Physical Therapy __ Bracing __ Chiropractic __ Massage Therapy __ Exercise Program __ Surgery __ Other __ None

6. Has any treatment helped, if so, which ones? ____

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7. What diagnostic studies have you had done?

Study	Performed where	Date
❑ Plain x-rays	Performed where________________________________	Date____________
❑ MRI	Performed where________________________________	Date____________
❑ CT Scan	Performed where________________________________	Date____________
❑ Myelogram	Performed where________________________________	Date____________
❑ Discogram	Performed where________________________________	Date____________
❑ EMG	Performed where________________________________	Date____________
❑ Epidural Steroid	Performed where________________________________	Date____________

CURRENT STATUS

1. Do you have bowel or bladder problems? ❑ Yes ❑ No

   If yes, please explain the symptoms? ____

2. Do you go to sleep easily? ❑ Yes ❑ No Do you wake up during the night? ❑ Yes ❑ No

3. How many hours do you sleep at night? ____ Do you take naps during the day? ❑ Yes ❑ No

4. Do any of the following cause or increase pain? **Sitting** ❑ Yes ❑ No **Standing** ❑ Yes ❑ No **Walking** ❑ Yes ❑ No **Sleeping** ❑ Yes ❑ No

5. Can you walk through the grocery store or supermarket to shop? ❑ Yes ❑ No

6. Can you sit through dinner with your family or friends? ❑ Yes ❑ No

7. What activities make the pain worse? (check all that apply)
   - ❑ Exercise
   - ❑ Sitting
   - ❑ Standing
   - ❑ Walking
   - ❑ Rolling over in bed
   - ❑ Bending forward
   - ❑ Bending backward
   - ❑ Coughing
   - ❑ Sneezing

8. What reduces your pain? (check all that apply)
   - ❑ Lying down
   - ❑ Sitting
   - ❑ Walking
   - ❑ Manipulation/Chiropractic
   - ❑ Massage Therapy
   - ❑ Trigger Point Injections
   - ❑ Physical therapy
   - ❑ Medicine:
     - ❑ Pain pills ❑ Muscle relaxants
     - ❑ Aspirin ❑ Other ______________
   - ❑ Moist Heat ❑ Ice Packs
   - ❑ Other ___________________________

9. Is your pain getting (**please only check one**): ❑ Worse ❑ Better ❑ Constant

10. Rate your typical pain on a scale of 1-10: ______________ (One being mild – Ten being extreme and unbearable)

11. Is your pain the same all day? ❑ Yes ❑ No
    If no, how does it change? ____
    ____

12. Is your pain better during the day, and WORSE at night? ❑ Yes ❑ No

13. Has your ability to work been affected? ❑ Yes ❑ No

14. Have you had to take time off work? ❑ Yes ❑ No If yes, when? __________________

15. Does your pain affect your home life? ❑ Yes ❑ No
    If yes, how? ____

16. Do you have to lie down during the day because of your pain? ❑ Yes ❑ No

17. Please list the current medication(s) you take for your spinal problem:
    ① ________________________ ② _________________________ ③ __________________________

FAMILY HISTORY

Please list family illnesses or serious health problems.

Mother ____ Living ____ Age___ Deceased___
Father ____ Living ____ Age___ Deceased___
Brother(s)____ Living ____ Age___ Deceased___
Sister(s)____ Living ____ Age___ Deceased___
Children____ Living ____ Age___ Deceased ___

Has anyone in your family had back trouble, ongoing pain or surgery? ❑ Yes ❑ No
If yes, please explain____

MEDICAL HISTORY

Do you or have you had any of these medical conditions? (Check all that Apply)

- ❑ Diabetes
- ❑ Heart Disease
- ❑ Circulatory Problems
- ❑ Hepatitis
- ❑ Auto Immune Disease
- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Liver Disease
- ❑ Rheumatic Fever
- ❑ Asthma or Lung Problems
- ❑ Shortness of Breath
- ❑ Kidney Disease
- ❑ Epilepsy (seizures)
- ❑ Anxiety or Panic Disorder
- ❑ Frequent Bladder Infections
- ❑ Irritable Bowel
- ❑ Stomach Ulcers
- ❑ Anemia
- ❑ Any type of Cancer
- ❑ Clinical Depression
- ❑_________________other

Have you ever had any kind of spinal surgery? ❑ Yes ❑ No If yes, please explain ________________
____

List all other surgeries that you have had
① ____________________________________ ② ____________________________________
③ ____________________________________ ④ ____________________________________
⑤ ____________________________________ ⑥ ____________________________________

Do you take any medications regularly? ❑ Yes ❑ No If so, please list
① ____________________________________ ② ____________________________________
③ ____________________________________ ④ ____________________________________
⑤ ____________________________________ ⑥ ____________________________________

Do you have medical allergies? ❑ Yes ❑ No If so, please list the allergy and the reaction you have experienced
① ____________________________________ ② ____________________________________
③ ____________________________________ ④ ____________________________________
⑤ ____________________________________ ⑥ ____________________________________

Has your weight changed in the last year? ❑ Yes ❑ No
If yes, how much have you Gained _____LBS Lost _____LBS

Do you smoke now? ❑ Yes ❑ No If so, How much?____________
Have you ever smoked? ❑ Yes ❑ No, If so when and for how long?________________
Do you use any Tobacco products? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No if yes, How frequently _____
❑ Beer ❑ Wine ❑ Liquor ❑ Mixed Drinks

Have you used any recreational drugs now or in the past 5 years? ❑ Yes ❑ No

EDUCATION

Did you graduate from High School? ❑ Yes ❑ No if no, last year completed______
Did you go to College? ❑ Yes ❑ No if yes, how many years _______
Do you have a College Degree? ❑ Yes ❑ No
Are you in school now? ❑ Yes ❑ No if yes, pursuing ______________
Do you want to go back to school? ❑ Yes ❑ No

MEDICAL-LEGAL STATUS

Do you have a lawyer representing you for your current injury? ❑ Yes ❑ No
If yes, please provide the following:
Firm________________________ Attorney_____________________ Phone Number: _________________________
Address ____
____

Have you ever been involved in any other lawsuits? ❑ Yes ❑ No
If so, please explain the situation ____
____
Is there anything else that you would like us to know about your current problem or the prior care that you have received?
____
____

PHYSICIAN NOTES:____
____
____