SPINE PROGRAM NEW PATIENT FORM

Name:_____ **Today's Date:**_____

Date of Birth:_____ **Are you right or left handed?**_____

What are your goals for the visit?_____

Who referred you to us?

☐ Primary Doctor

☐ Another Doctor – Dr. _____ Of what specialty?_____

☐ Someone else:_____

PAIN

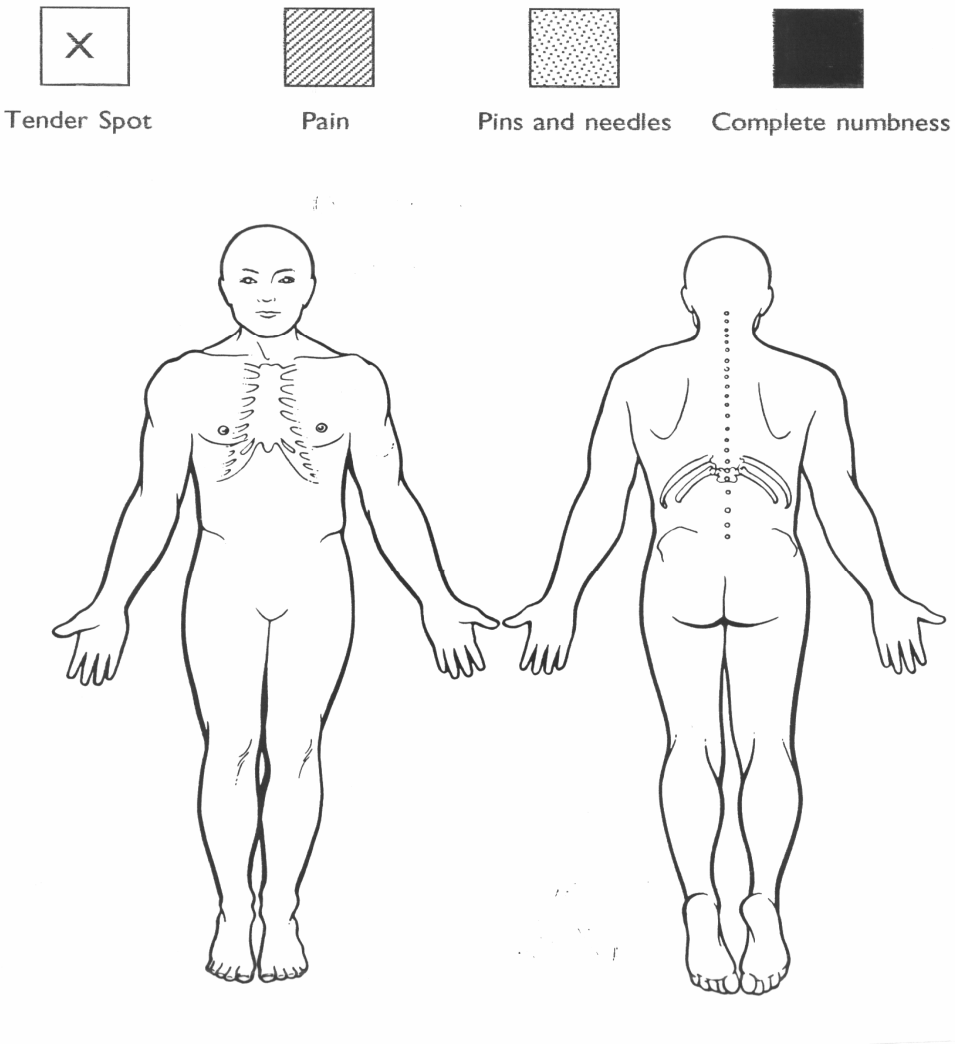
1. **Tell me about your pain or the main complaint for seeing the doctor:**
   - When did it start? _____
   - Describe what it felt like: _____
   - What is it like now? _____
   - Where is it located? _____
   - What brought pain on? _____
2. **Are your current symptoms:**
   - Constant:
     ☐No ☐Yes
   - Not constant, but present about _____ times a **day**
   - Not present every day, but present about _____ times a **week**
   - Present less than once a week
   - With time are your symptoms
     Improving: ☐No ☐Yes
     About the same: ☐No ☐Yes
     Worsening: ☐No ☐Yes
   - What activities/positions significantly **worsen** your symptoms? _____
   - What activities/positions significantly **improve** your symptoms? _____
3. **Have you ever had any similar problems in a similar body area before this?**
   ☐No ☐Yes:_____

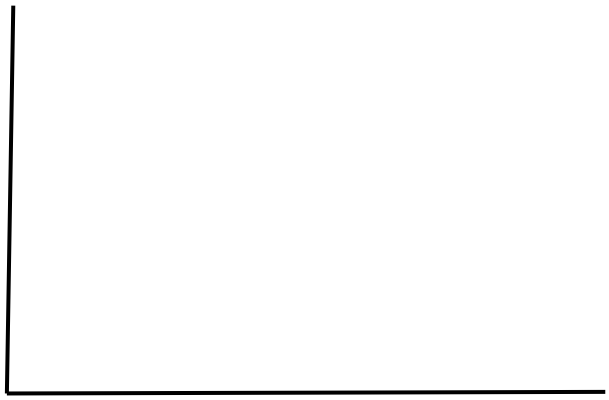
PAIN DRAWING On the figure below, please mark the areas of your body where you feel your symptoms. Use the appropriate symbols.

On a scale of 0 to 10, how severe are your symptoms: (circle one)

PAIN DRAWING

On the figure below, please mark the areas of your body where you feel your symptoms. Use the appropriate symbols.





	Least Severe										Most Severe
On the average?	0	1	2	3	4	5	6	7	8	9	10
At their best?	0	1	2	3	4	5	6	7	8	9	10
At their worst?	0	1	2	3	4	5	6	7	8	9	10
Now?	0	1	2	3	4	5	6	7	8	9	10

REVIEW OF SYMPTOMS

Please check all symptoms that you have had **IN THE LAST MONTH** that are **NOT RELATED TO** the reason you are being seen (your pain issues).

☐Recent and unexplained fevers, chills, night sweats, unexplained cough
☐Recent and unexplained weight loss of greater than 10 pounds
☐Recent difficulty sleeping
If yes, how many minutes does it usually take you to fall asleep:_____
Once you're asleep, how many times a night do you awaken?_____
☐Depression/Anxiety
☐Frequent headaches
☐Unconsciousness
☐Problems with vision
☐Problems with hearing
☐Difficulty swallowing
☐Pain in your legs or calves when walking
☐Neck pain
☐Back pain
☐Joint pain
☐Skin problems
☐Stomach problems/nausea, vomiting

☐Problems with your bowel movements
- ☐Constipation
- ☐Diarrhea
- ☐Accidental bowel movements

☐Problems with urination
- ☐Burning while urinating
- ☐Foul smelling urine
- ☐The urge to urinate more frequently than usual
- ☐Inability to urinate
- ☐Accidental urination

☐Problems with your sexual function
☐Muscle weakness, aching or cramps
☐Numbness or tingling in your arms, forearms, or hands
☐Numbness or tingling in your thighs, legs or feet

If you are a female:

Is there any chance you could be pregnant now? ☐No ☐Yes
Are your symptoms worsened near your period? ☐No ☐Yes

MEDICATIONS

4. What medications have you tried in the past for this problem?

Medication	Dose	Start Date	Stop Date	Why Stopped	Helped
					☐A lot ☐A little ☐No Effect ☐Made Worse
					☐A lot ☐A little ☐No Effect ☐Made Worse
					☐A lot ☐A little ☐No Effect ☐Made Worse
					☐A lot ☐A little ☐No Effect ☐Made Worse
					☐A lot ☐A little ☐No Effect ☐Made Worse

5. What <u>prescription</u> medications do you <u>TAKE NOW</u>?
(You may attach a current list of all your medications in place of filling in this section) ☐See attached

	Medication	What is it for?	Dose/How often?	Date you started taking the Med.
1.				
2.				
3.				
4.				
5.				

6. What <u>Non</u>-prescription medications do you <u>TAKE NOW</u>? (Including herbals)
(You may attach a current list of all your medications in place of filling in this section) ☐See attached

	Medication	What is it for?	Dose/How often?	Date you started taking the Med.
1.				
2.				
3.				
4.				
5.				

7. Are you allergic to any medicines? ☐No ☐Yes ***If yes, please list medicines(s) and the reaction you have:***

Medication	Reaction

<u>TREATMENTS</u>

8. What treatments have you had for this problem?
Did these help?

☐No ☐Yes Physical Therapy
☐No ☐Yes Occupational Therapy
☐No ☐Yes Manipulation or other chiropractic treatments
☐No ☐Yes Injections or nerve blocks
☐No ☐Yes Medications
☐No ☐Yes Psychological / psychiatric counseling
☐No ☐Yes Acupuncture
☐No ☐Yes Homeopathic or alternative medicine
☐No ☐Yes Surgery
☐No ☐Yes Other

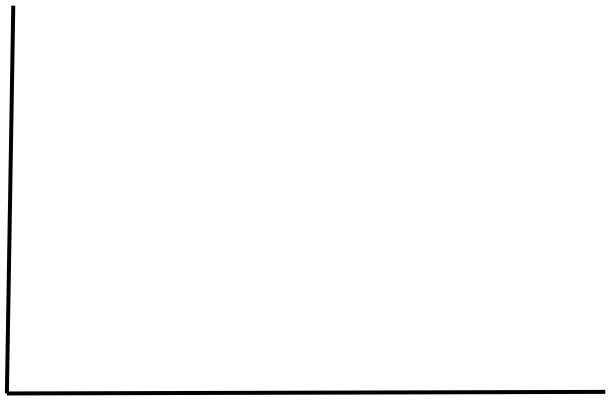
9. Physical Therapy:

Therapy was done at:_____

☐ Still Attending

☐ Discharged

	Helped a lot.	Helped a little.	No Effect.	Made worse
☐ Ice packs	☐	☐	☐	☐
☐ Ice directly on the skin	☐	☐	☐	☐
☐ Heat packs	☐	☐	☐	☐
☐ Ultrasound	☐	☐	☐	☐
☐ Whirlpool	☐	☐	☐	☐
☐ Massage	☐	☐	☐	☐
☐ Electrical Stimulation	☐	☐	☐	☐
☐ TENS Unit	☐	☐	☐	☐
☐ Braces or Splints	☐	☐	☐	☐
☐ Traction	☐	☐	☐	☐
☐ Biofeedback	☐	☐	☐	☐
☐ Stretching Exercises	☐	☐	☐	☐
☐ Strengthening Exercises	☐	☐	☐	☐
☐ Aerobic Exercises	☐	☐	☐	☐
☐ Other:	☐	☐	☐	☐



10. Injections:

- Location:_____
  ☐Helped a lot. ☐Helped a little. ☐No Effect ☐Made Worse.
  Physician:_____ Date(s) Injected:_____

- Location:_____
  ☐Helped a lot. ☐Helped a little. ☐No Effect ☐Made Worse.
  Physician:_____ Date(s) Injected:_____

11. What other doctors or therapists have you seen for this problem?

Name	Specialty	Approximate date seen

12. Have you had any:

- X-Rays: ☐No ☐Yes, Where:_____When:_____
  What body part(s): _____
- CT Scans: ☐No ☐Yes, Where:_____When:_____
  What body part(s): _____
- MRIs: ☐No ☐Yes, Where:_____When:_____
  What body part(s): _____
- EMG: ☐No ☐Yes, Where:_____When:_____
- Bone scans: ☐No ☐Yes, Where:_____When:_____
- Myelogram ☐No ☐Yes, Where:_____When:_____

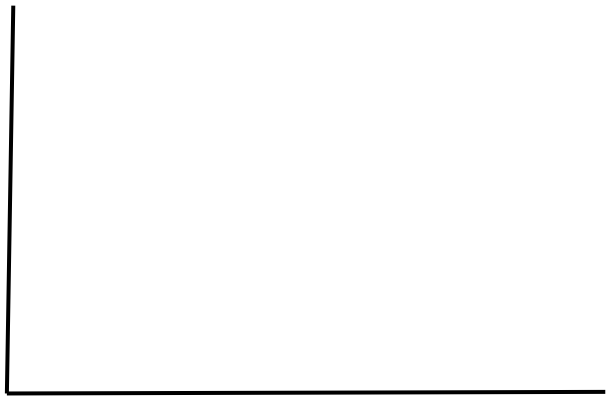
FUNCTIONAL HISTORY

13. Do you exercise regularly?

- If yes, how often and what kinds of exercises do you do?

  _____

- If no, why not? _____
- Does the pain affect your sleep? ☐No ☐Yes
- Do you have difficulty with prolonged sitting? ☐No ☐Yes
- Do you have difficulty with prolonged standing? ☐No ☐Yes
- Do you have difficulty with prolonged walking? ☐No ☐Yes



GENERAL MEDICAL HISTORY

14. Have you been diagnosed with any other medical problems?

☐Angina
☐Aortic aneurysm
☐Arthritis
☐Bowel problems
☐Breathing problems
☐Broken Bones
☐Cancer
☐Circulatory disorders / vascular disease
☐Diabetes
☐Easy bleeding or blood clots
☐Gout
☐Heart Attack
☐Hepatitis
☐High blood pressure
☐HIV / AIDS
☐Kidney problems
☐Kidney Stones
☐Ligament sprains
☐Liver problems
☐Major trauma (accidents, falls, etc)
☐Migraine headaches
☐Muscle strains
☐Nerve or muscle disease
☐Psychiatric disorder
☐Rheumatologic condition
☐Seizures
☐Severe head injury
☐Stroke
☐Thyroid disease
☐Tuberculosis
☐Ulcers
☐Other:_____

SURGERIES

15. Have you ever had any surgery for something other than the problem for which you are coming to see us? ☐No ☐Yes

Type of Surgery. When surgery was done. Why was the surgery done?

_____

_____

_____

FAMILY MEDICAL HISTORY

16. What diseases run in your family? _____

_____

SOCIAL

17. Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

18. Who do you live with? ☐Alone ☐Spouse ☐Significant other ☐Children ☐Parent(s) ☐Friends or relatives

19. Number of children & their ages _____

20. *WE ARE REQUIRED TO ASK THE FOLLOWING:*

Are you now or have you been in a relationship in which you've been hurt, injured, threatened or emotionally abused? ☐No ☐Yes ☐Declined to answer

_____

_____

Have you been hit, kicked or punched by someone close to you? ☐No ☐Yes ☐Declined to answer
If yes, what is the date it last happened?_____

21. Do you have any history of:

- Tobacco use: ☐No ☐Yes, Pkgs/day:_____ Quit/When:_____
- Alcohol use: ☐No ☐Yes, How often/how much?_____
- Illegal substance use/abuse ☐No ☐Yes, What used:_____
  How often:_____ Last use:_____

22. Have you been diagnosed with or are you taking medication for:

- Anxiety? ☐No ☐Yes, Treated by:_____ Meds:_____
- Depression? ☐No ☐Yes, Treated by:_____ Meds:_____
- Other mental health needs:_____

23. What are your leisure interests?_____

EDUCATION

24. What is the highest level of education completed? (Years of school / degree)

WORK INFORMATION ☐Retired

25. Who were you working for at the time your symptoms started?
Employer: _____
26. Did your symptoms first come on at work? ☐No ☐Yes ☐Unsure
27. Is your problem covered by Workers' Compensations? ☐No ☐Yes ☐Unsure
28. Briefly describe your job at the time your symptoms started:_____

29. Are you still employed by the same employer?

☐**Yes:**
Do you still hold the same position? ☐No ☐Yes
If you do not still hold the same position, briefly describe your current job:_____

☐**No:**
If you are not still working for the same employer, who are you working for now?
Employer: _____
Do you enjoy your work? ☐No ☐Yes

30. How many hours per week were you working PRIOR to your problem?_____
Has your problem caused you to reduce your work hours? ☐No ☐Yes
If you reduced your hours, when was your last full day of work?_____
How many hours per week are you working now?_____
If you're not working at all now, when was your last day of any work?_____

31. Does your current job involve:

Repetitive motions? ☐No ☐Yes
Prolonged desk work? ☐No ☐Yes
Exposure to extremes of hot or cold? ☐No ☐Yes
Lifting heavy loads? ☐No ☐Yes

If yes, what is the heaviest load you would **ever** need to lift?_____
What is the heaviest load you would need to lift **frequently**?_____

32. Has a doctor ever restricted you from work for this or a previous problem? ☐No ☐Yes

If yes, which physician gave you restrictions?_____
What injury or disease was the doctor treating?_____
Exactly what restrictions were officially placed upon your activities?_____
_____
Are these restrictions still in effect? ☐No ☐Yes

FINANCIAL AND LEGAL

33. Is this related to a Motor Vehicle Accident? ☐No ☐Yes
34. Worker's Compensation? ☐No ☐Yes
35. Any lawsuits pending or possible? ☐No ☐Yes
36. Do you have a prior permanent disability rating? ☐No ☐Yes
37. Do you have permanent activity restrictions for this problem or any other? ☐No ☐Yes
38. Are you currently receiving compensation for your pain problem? If yes, what kind?

_____

39. Case manager name and contact information if pertinent:

_____

_____ _____

Patient Signature Date/Time