

patient information

Date: _____

LAST NAME	FIRST NAME	DATE OF BIRTH	CURRENT AGE
PRIMARY CARE PHYSICIAN		PHONE NUMBER	
REFERRING PHYSICIAN		PHONE NUMBER	

reasons for visit

Work comp injury Automobile accident Other injury

PRIMARY REASON FOR THIS VISIT (describe location of pain)

factors of complaint

Explain how your pain or problem began and how it happened Recent injury On-the-job

How long have you had this problem? _____

FOR OFFICE USE ONLY

DX:
PLAN:

PRIOR SURGERY(S)

Yes No

Prior surgery for this problem

Number of surgeries _____

TIME OFF FROM WORK

Yes No

Off work due to this recent problem

How long _____

PREVIOUS OCCURRENCES

Yes No

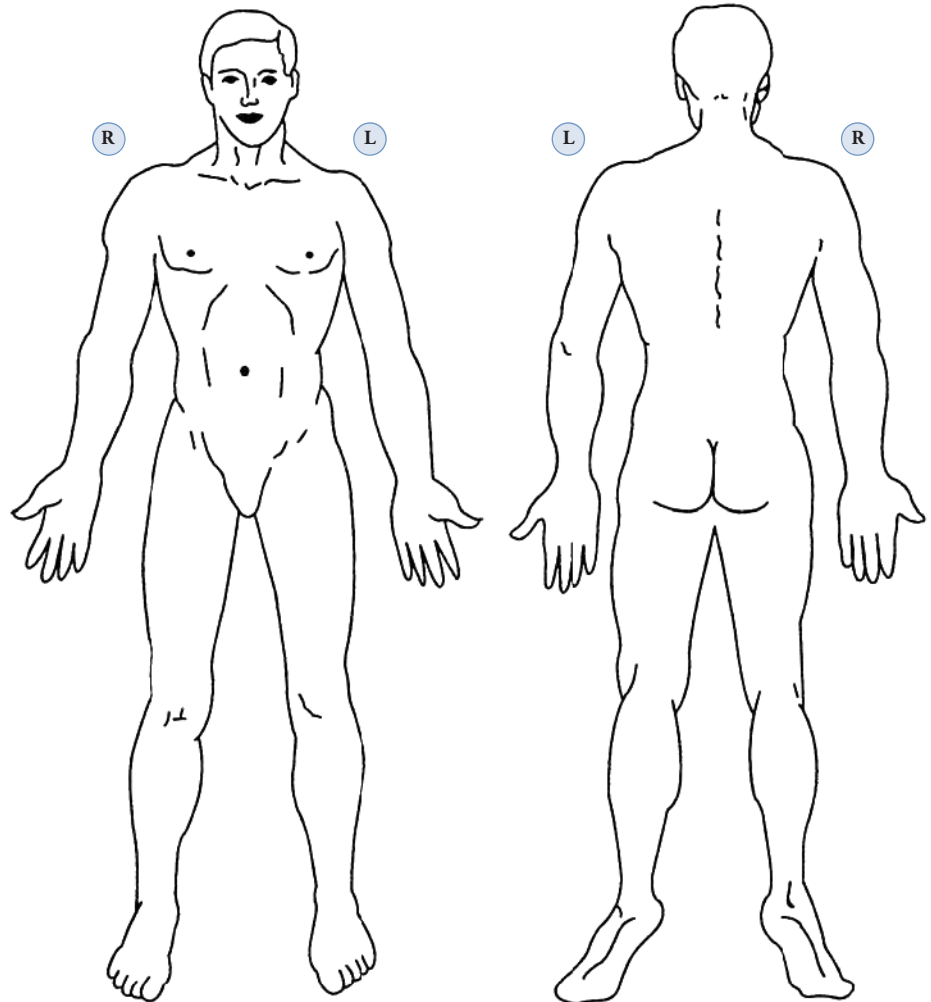
Have you had any previous occurrences?



ortho pain chart

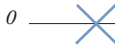
Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

numbness	= = =
pins & needles	o o o
burning/aching	x x x
stabbing	/ / /



current pain levels

Please indicate your current pain level by placing an x on the line
"0" = no pain & "10" = worst pain imaginable

Example 0  10

How bad is your **low back** pain now?

Pain on average 0 _____ 10

Pain at its worst 0 _____ 10

Pain at its best 0 _____ 10
(Lying down, resting)

How bad is your **leg** pain/numbness now?

Pain on average 0 _____ 10

Pain at its worst 0 _____ 10

Pain at its best 0 _____ 10
(Lying down, resting)

How bad is your **middle back** pain now?

Pain on average 0 _____ 10

Pain at its worst 0 _____ 10

Pain at its best 0 _____ 10
(Lying down, resting)

How bad is your **neck or upper back** pain now?

Pain on average 0 _____ 10

Pain at its worst 0 _____ 10

Pain at its best 0 _____ 10
(Lying down, resting)

How bad is your **arm** pain/numbness now?

Pain on average 0 _____ 10

Pain at its worst 0 _____ 10

Pain at its best 0 _____ 10
(Lying down, resting)

current pain profile

WHICH OF THE FOLLOWING ACTIVITIES CHANGE THE NATURE OF YOUR PAIN

- | | | | |
|-----------------|--|--|----------------------------------|
| Sitting | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Standing | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Walking | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Long car rides | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Bending forward | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |

LIST ANYTHING ELSE THAT DECREASES OR INCREASES YOUR PAIN (ex. temperature changes, laughing, using the restroom, etc.):

functional history

PLEASE INDICATE THE ACTIVITIES THAT YOU REQUIRE ASSISTANCE PERFORMING:

- | | | |
|---|---|---|
| <input type="checkbox"/> Driving | <input type="checkbox"/> Bathing | <input type="checkbox"/> Household chores (laundry, dishes, vacuuming, etc.) |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Using the washroom | <input type="checkbox"/> Outdoor yard work (mowing lawns, trimming hedges, raking, gardening, etc.) |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Dressing | <input type="checkbox"/> Buttoning shirt |
| <input type="checkbox"/> Ambulating up or down stairs | <input type="checkbox"/> Shopping | Do you frequently drop things? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Writing | |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Ambulating | |

PATIENT INITIALS DATE

sleep history

What time do you go to bed? _____ # hours to fall asleep: _____

of times you wake up at night: _____ # hours you sleep per night: _____ How many hours do you require? _____

Have you taken any sleep medications or natural supplements to help you fall asleep? Yes No

Please list: _____

family history

WHAT ILLNESSES RUN IN YOUR CLOSE FAMILY

- | | | |
|--|--|---|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Spine disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Other _____ |

tests & treatment

Yes No

Any previous tests (examinations) or treatments for your current condition

(If yes, please complete the following, if no, please skip to "past back history" section)

PREVIOUS TREATMENTS FOR THIS CONDITION

medications

- | | | | |
|---------------------------|---|---|------------------------------------|
| Anti-inflammatories _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Muscle relaxants _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Pain medications _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Other(s) _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |

therapies

- | | | | |
|-------------------------|---|---|------------------------------------|
| Chiropractic care _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Physical therapy _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Other(s) _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |

injections

(i.e. epidural steroid injections, nerve-root blocks)

- | | | | |
|---------------------------------|---|---|------------------------------------|
| Date _____ Injection type _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |
| Date _____ Injection type _____ | <input type="checkbox"/> Temporary relief | <input type="checkbox"/> Lasting relief | <input type="checkbox"/> No relief |

Previous treating doctors _____

Specialty(s) (i.e. surgeon) _____

spine imaging history

PLEASE INDICATE WHETHER YOU HAVE HAD ANY OF THE FOLLOWING STUDIES AND WRITE WHEN & WHERE THE MOST RECENT WAS

- | | | | |
|--|------------------------|------------|-------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Regular x-ray of spine | When _____ | Where _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | CT scan of spine | When _____ | Where _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | EMG | When _____ | Where _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone scan | When _____ | Where _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Myelogram | When _____ | Where _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Discogram | When _____ | Where _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | MRI of spine | When _____ | Where _____ |

medical history

PLEASE CHOOSE ALL CURRENT & PAST MEDICAL CONDITIONS

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> No medical problem | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Anorexia/bulimia |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Cancer <i>where?</i> _____ | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Seen a psychiatrist |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood clots in leg/lung | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Use CPAP |

Are you under a doctor's care for any other medical condition Yes No

If yes, please explain _____

surgical history

PLEASE CHOOSE ALL SPINAL SURGERIES YOU HAVE HAD

- | | | |
|---|-----------------------|---------------|
| <input type="checkbox"/> Spine-neck | Type of surgery _____ | Date(s) _____ |
| <input type="checkbox"/> Spine-lower back | Type of surgery _____ | Date(s) _____ |
| <input type="checkbox"/> Other _____ | Type of surgery _____ | Date(s) _____ |
- _____

current medications *(may attach a list)*

NAME	DOSE	# PER DAY

allergies *(may attach a list)*

No known medical allergies

SUBSTANCE	REACTION

review of systems

PLEASE CHECK OFF ANY CURRENT OR RECENT PROBLEMS YOU HAVE

general

- Unexplained weight loss
- Appetite change
- Fevers or chills
- Night sweats
- Marked fatigue
- Difficulty sleeping

cardiovascular

- Heart or chest pain
- Abnormal heartbeat
- Poor heart function

musculoskeletal

- Joint pain/swelling
- Back pain
- Neck pain
- Muscle aches

digestive

- Nausea or vomiting
- Stomach pain or ulcers
- Heartburn/acid stomach
- Frequent diarrhea
- Frequent constipation
- Uncontrolled loss of stool
- Blood in stool

skin

- Easy bruising
- Swollen ankles

lung

- Morning cough
- Shortness of breath
- Productive cough or sputum

neurological

- Seizures
- Blackouts/fainting
- Tremor
- Headaches/migraines
- Chronic pain syndrome
- Fibromyalgia
- Chronic fatigue syndrome
- Reflex sympathetic dystrophy
- Loss of balance
- Increased clumsiness
- Difficulty buttoning shirt
- Dropping things

genitourinary

- Burning on urination
- Difficulty starting urination
- Incontinence
- Pelvic pain
- Urinate at night more than once
- Unable to completely empty bladder

psychiatric

- Depression
- Nervous exhaustion
- Anxiety
- Paranoia
- Obsessive/compulsive behavior
- History of sexual abuse
- History of physical abuse

Other: _____

social history

- Married Divorced Separated Single Widow/Widower

Number of children _____ At home Away Other dependents _____

Yes No I live with my children or other relatives (*Explain*) _____

Highest educational level attained Grammar High school College Post graduate

Do you drink? Yes No

I drink Beer Wine "Hard" drinks
Frequency Rarely Socially Daily

Do you smoke? Yes No

I smoke Cigarettes Cigar/pipe Smokeless/leaf
Frequency Per day _____ Years _____
I quit When _____ _____

work history

Employment status: Full time Part time Self employed Disabled Retired Unemployed

Last date of employment: _____

I work as a _____ Previous occupation(s) _____

Describe job duties: _____

How many hours/day do you work: _____ How many days/week do you work: _____

How many hours do you spend: Standing _____ hours Sitting _____ hours Walking _____ hours

Bending _____ hours Computer work _____ hours Lifting _____ hours

How much weight do you lift? _____ hours How many repetitions per day? _____ reps/day

- Yes No Do you have any lawsuits pending
 Yes No Are you considering filing a lawsuit regarding this problem?
 Yes No Do you have any workman's compensation claims pending
 Yes No Have you ever had any past workman's compensation claims

effect of your injury or complaint on lifestyle

- Yes No I describe my home setting as supportive of me during this time
 Yes No I describe my work setting as supportive of me during this time
 Yes No My pain has affected my interaction with my family and friends
 Yes No My pain has affected my ability to do my job or get a job
 Yes No The changes in my lifestyle due to my problem have been difficult for me
 Yes No Do you like your job situation

Ability to enjoy life

- Excellent Very good Good Fair Poor

what do you want to happen as a result of this visit

- Discuss surgical options
 Discuss non-surgical options
 Other: _____
 Yes No Is there anything we have failed to ask you that you believe is important
Explain _____

patient information

FOR OFFICE USE ONLY:

Height: _____ Weight: _____

Vitals: _____ Blood pressure: _____ Pulse: _____

physical exam

imaging studies

assessment/plan