Spine History of Illness - New Patient

I certify that the following information is correct to 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 make in the completion of this form.

Patient Name (Print: First, Middle, Last) _____ *Patient Signature* _____ *Date* _____

I have reviewed and discussed this form with this patient.

Physician's Signature _____

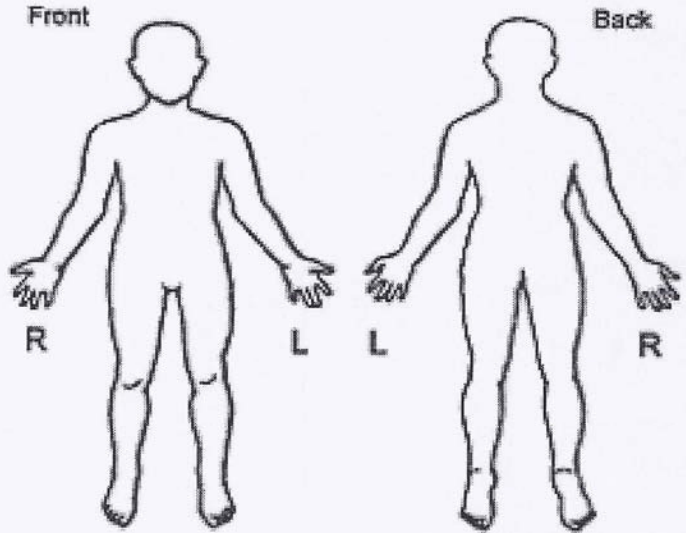
List the reason for today's visit *(what is the problem?)*	

✓	Symptoms: *(all that apply to today's visit)*	Constant	Intermittent	Mark Your Typical Pain Intensity Here ↓ (← Least Pain Worst →) 0	1	2	3	4	5	6	7	8	9	10
	Neck pain													
	Back pain													
	Right arm pain													
	Left arm pain													
	Right leg pain													
	Left leg pain													
	Weakness			Describe any weakness, numbness or neurologic problems here:										
	Numbness													
	Balance problems													
	Trouble using hands													

Onset of Problem	*< 1 month*	*1- 3 months*	*3-6 months*	*6 months - 2 yrs*	*> 2 yrs*
Approximate duration of current problem					
When did you first seek medical attention?					

Pain Diagram

Using the symbols below, mark the location and type of pain on the diagram on the left. Include all affected areas.



SENSATIONS

aching	^ ^ ^ ^ ^ ^
sharp or stabbing	X X X X X
burning	/ / / / / / / / /
pins and needles	- - - - - - - -
numbness	0 0 0 0 0 0

Please answer the following questions	✓ yes	✓ no
Do you smoke cigarettes?		
If so, how many packs per day?		
How many years have you been smoking?		
Do you smoke a pipe or cigars?		
Do you dip snuff or chew tobacco?		
Do you drink alcohol?		
How often and how much alcohol do you drink?		
Do you use any street drugs?		
If so, which drugs do you use?		
Who do you live with?		

REVIEW OF SYSTEMS (ROS)

Please ✓ symptoms you currently have or have had in the past year

	General
	Fevers or Chills
	Dizziness
	Fainting spells
	Fatigue
	Frequent headaches
	Insomnia
	Sweats
	Weight changes
	Other:
	Cardiovascular
	Ankle swelling
	Chest pains
	Enlarged heart
	Heart attack
	Heart murmur
	Heart palpitations
	High blood pressure
	Shortness of breath
	Irregular heart beat
	Prolonged bleeding
	History of blood clots
	Other:
	Endocrine
	Blood sugar problem
	Use of steroids
	Over Active Thyroid
	Under Active Thyroid
	Other:

	Eye, Ear, Nose, Throat
	Difficulty swallowing
	Hearing loss
	Hoarseness
	Nose bleeds
	Ringing in ears
	Sinus problems
	Vision-blurred
	Poor vision
	Other:
	Gastrointestinal
	Poor appetite
	Bowel changes
	Constipation
	Diarrhea
	Excessive thirst
	Heartburn
	Nausea
	Rectal bleeding
	Stomach pain
	Ulcers
	Vomiting
	Other:
	Skin
	Bruise easily
	Foot ulcers
	Rashes
	Sores that won't heal
	Other:

	Musculoskeletal
	Joint pains
	Muscle aches
	Ankylosing spondylitis
	Weak bones
	Rheumatoid arthritis
	Osteoarthritis
	Bone cancer
	Bone infections
	Other:
	Genito-Urinary
	Bladder control
	Blood in urine
	Frequent urination
	Kidney stones
	Painful urination
	Urgent urination
	Weak stream
	Other:
	Neurological
	Loss of fine motor control
	Weakness
	Paralysis
	Poor balance
	Seizures
	Speech difficulties
	Tremors
	Muscle wasting
	Other:

	Psychiatric
	Anxiety
	Depression
	Psychiatric hospitalization
	Panic attacks
	Suicidal thoughts
	Psychiatric drugs
	Memory loss
	Other:
	MEN only
	Breast lumps
	Enlarged prostate
	Erectile dysfunction
	Penis discharge
	Prostate cancer
	Other:
	WOMEN only
	Abnormal Pap Smear
	Breast Lumps
	Vaginal Discharge
	Severe menstrual pain
	Hot flashes
	Other:
Date of last period:	
Age periods began:	
Age of menopause:	
Are you pregnant?	
# of pregnancies:	
# of live births:	

Height	
Weight	

Health History New Patient

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Patient Name ***(Print: First, Middle, Last)***	***Patient Signature***	***Date***

What is your age?		What hand do you write with?	☐ Right ☐ Left

List **ALL** your **Diagnosed Medical Problems** *(not just those related to your current office visit)*		
✓if true		I have no known medical problems.

Medications: list ALL that you are currently taking.			**Allergies:** list ALL medications and foods allergies.		
✓if true		I take no medications currently.	***✓if true***		I have no known allergies.

List **ALL** prior **operations or surgeries** you have had (include dates if known).		
✓if true		I have not had any surgery in the past.

List **ALL** medical problems in your family or blood relatives: *(list the member affected by the medical problem).*		
✓if true		There are no known medical problems in my family.

Please answer the following questions						
	Laying Down		Sitting	Standing	Walking	Bending/Twisting
What makes your symptoms better?						
What makes your symptoms worse?						

Neurologic Functioning	Yes	No	Explain
Are you losing bowel or bladder control?			
Are you losing control of your arms or hands?			
Are you losing control of your legs or feet?			
Are you noticing problems with "fine motors skills" (i.e. buttoning buttons, opening jars, handwriting)			
Are you noticing difficulties in balance?			

Work			
What is your occupation?			
Are you out of work due to your spinal condition?			How long have you been out of work?
Do you have a workman's compensation claim?			List date of the work injury

Previous Treatments	Yes	No		Did treatment help? Yes	No
Have you had physical therapy for your spine?			How long in therapy?		
Have you had epidural injections?			How many?		
Have you had other spinal injections?			What type?		
Have you taken anti-inflammatory medications? (Motrin, Advil, Celebrex, etc...)			List medications		
Have you taken pain medications? (Percoset, Vicodin, Darvocet, Oxycontin, etc...)			List medications		
Have you tried nerve medications? (Neurontin, Lyrica, Cymbalta, etc...)			List medications		
Have you seen a chiropractor?			Chiropractor's name		
Have you tried acupuncture?			Practitioner's name		
Have you tried traction?					
Do you use walking aids? (cane, crutches, walker, wheel chair, etc...)			What type?		

Accidents	Yes	No	
Did your problem begin with an auto accident?			Date of the accident:
Were you the vehicle driver?			
Were you wearing a seat belt?			
Are you involved in a legal accident claim?			Name of your lawyer: