Spine Health History

Name_____ **Birth Date** _____

Today's Date _____/_____/_____
Who referred you to us? _____
Age: _____ Handedness: Right / Left Sex: M / F
What are your symptoms? _____
_____
_____
When did your symptoms begin? _____

Did a specific injury cause your symptoms? Yes / No
☐Auto accident ☐Lifting Injury ☐Fall
☐Job Injury ☐Other _____

Is there an attorney involved with this injury / problem? Yes / No

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If Neck Pain / Arm Pain, please mark below which is worse:

|_____|_____|
100% Neck Pain 50% neck pain / 50% arm pain 100 % Arm Pain Right or Left

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If Low Back Pain / Leg Pain, please mark below which is worse:

|_____|_____|
100% Back Pain 50% back pain / 50% leg pain 100 % Leg Pain Right or Left

What activities increase your pain?
☐Standing ☐Walking ☐Changing Positions
☐Sitting / Driving ☐Lying Down

Do you ever experience a catch or shift in your neck / back? Yes / No
Have you lost control over your bowel or bladder function?
☐no ☐ yes, describe _____
I also have:
☐ Balance problems ☐ Leg / foot weakness/numbness/tingling
☐ Hand clumsiness ☐ Hand weakness/tingling/numbness
☐ None of these
Do you have pain or tingling at night? Yes / No

What are **three** things in your life that you can't do, or have difficulty doing, because of your pain, and which most dearly would you want restored? *These should be simple, realistic, daily life improvements that other people can see most of the time.*

Activity	Restored
1. _____	No A Bit A Lot Completely
2. _____	No A Bit A Lot Completely
3. _____	No A Bit A Lot Completely

What level of pain would allow you to do the above desired activities?

Goal Pain: 0 1 2 3 4 5 6 7 8 9 10

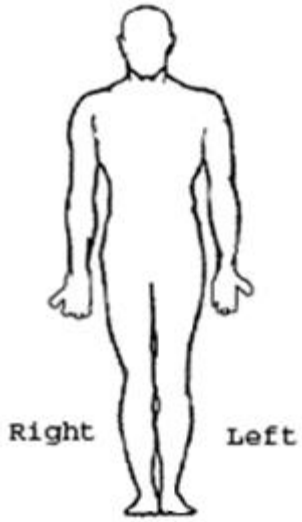
Have you had 2 or more falls in the last year? Yes No

Were you injured in a fall in the last year? Yes No

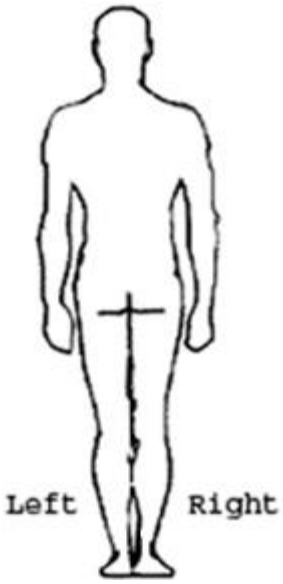
Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

Aching * * *
Numbness = = =
Pins and needles O O O
Burning X X X
Stabbing / / /

Front



Back



Please rate your pain by circling the number that best describes your average pain in the last 24 hours on a 0 (no pain) to 10 (pain as bad as you can imagine) scale.

24 Hr. Avg. 0 1 2 3 4 5 6 7 8 9 10

Please complete BOTH sides of this form

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Allergies (medications, contrast dyes, latex, foods):

Current Medications including over-the-counter medications and supplements:

Medication type	Strength	Actual # taking / day	Results (does it help?)

Medications previously tried for pain:

Imaging for problem area:

	Date	Where were they done?	Did you bring the disc(s)?
X-ray	____/_____/_____	_____	Yes / No
MRI	____/_____/_____	_____	Yes / No
CT Scan	____/_____/_____	_____	Yes / No
EMG	____/_____/_____	_____	Yes / No

Other Treatments: Please check those that apply	Date (month/year):	Was this treatment helpful?
☐ Physical Therapy, Exercise Therapy	_____/_____	Yes / No
☐ Chiropractor / Osteopathy	_____/_____	Yes / No
☐ Massage Therapy	_____/_____	Yes / No
☐ TENS Unit / Brace	_____/_____	Yes / No
☐ Acupuncture	_____/_____	Yes / No
☐ Natural Therapies (TCM, Homeopathy)	_____/_____	Yes / No
☐ Other_____	_____/_____	Yes / No

Injections: Type	Date	Provider	Immediate relief	Long term relief
_____	____/_____/_____	_____	Yes / No	Yes / No
_____	____/_____/_____	_____	Yes / No	Yes / No

Surgery for this problem or area:

Date	Surgery Type	Surgeon
____/_____/_____	_____	

Please list any other **surgeries** or **hospitalizations** you have had:

_____

Occupation: _____ Employer:_____

Do you smoke? Y / N Packs per day?_____ How many years?_____

Do you drink alcohol? Y / N How many drinks a week? _____

Marital Status: S / M / D / W Children? Y / N How many? _____

How many times in the past year have you used an illegal drug or used a prescription medication for non- medical reasons? Never / 1 or more times

Family History: Do any of your family members have a history of

☐ Diabetes [Mother___ Father____ Sibling ___ Child ___ Other___]
☐ Hypertension [Mother___ Father____ Sibling ___ Child ___Other___]
☐ Heart Disease [Mother___ Father____ Sibling ___ Child ___Other___]
☐ Stroke [Mother___ Father____ Sibling ___ Child ___Other___]
☐ Mental Illness [Mother___ Father____ Sibling ___ Child ___Other___]
☐ Cancer [Mother___ Father____ Sibling ___ Child ___Other___]
☐ Other: _____ [Mother___ Father____ Sibling ___ Child ___Other___]

Have you ever been **diagnosed** with one of the following medical conditions? Check all that apply:

☐ Bleeding disorder/blood clots
☐ Stroke or TIA
☐ Stomach ulcer or Reflux
☐ High blood pressure
☐ Thyroid Disease
☐ Heart disease
☐ Diabetes
☐ HIV
☐ Hepatitis
☐ Rheumatoid arthritis
☐ Enlarged prostate
☐ Osteoporosis or Osteopenia
☐ Cancer:
Type:_____
Year Diagnosed:_____
☐ Other

_____
_____
_____

Have you recently had any of the following symptoms? Check all that apply **or check none at the bottom**:

☐ Fevers
☐ Night sweats
☐ Weight loss
☐ Vision changes
☐ Ringing of the ears
☐ Swelling
☐ Wheezing or breathing problems
☐ Chest pain
☐ Stomach pain
☐ Loss of bowel control
☐ Problems with urination
☐ Pain or cramping in the legs with exertion
☐ Skin rash
☐ Poor balance
☐ Problems thinking or remembering
☐ Depression or anxiety
☐ **None**

Work Status: Please check those that apply

☐ Working; Full-time ☐ Working; Part-time ☐ Unable to work ☐ Seeking work ☐ Home Duties ☐ Permanently Disabled
☐ Retired Does this represent your pre-injury work status? Y /N

Height (in): _____Weight (lbs): _____ Reviewed by: _____, MD / DO / PA Date_____