ABOUT YOU

What is your name? ____

What do you prefer to be called? ______________________________________

Are you: Right: _____ or Left: _____ Handed? Sex: Male: _____ or Female:_____

Date of birth: ___________________ Age: _________

REASON FOR VISIT

<u>The reason for this visit is the result of (please circle):</u>

WORK SPORTS AUTO TRAUMA CHRONIC OTHER

Please explain what happened: ____

____

____

____

____

____

____

____

____

When did this condition begin? ____

Is this condition changing? ____

Explain: ____

Who referred you to us? ____

Who is your primary M.D.? ____

Have you seen a neurologist or another neurosurgeon and if so, who? ______________________

What types of treatments have you already had regarding this condition (please circle):

PHYSICAL THERAPY SPINAL INJECTIONS PAIN MANAGEMENT EMG/NCV

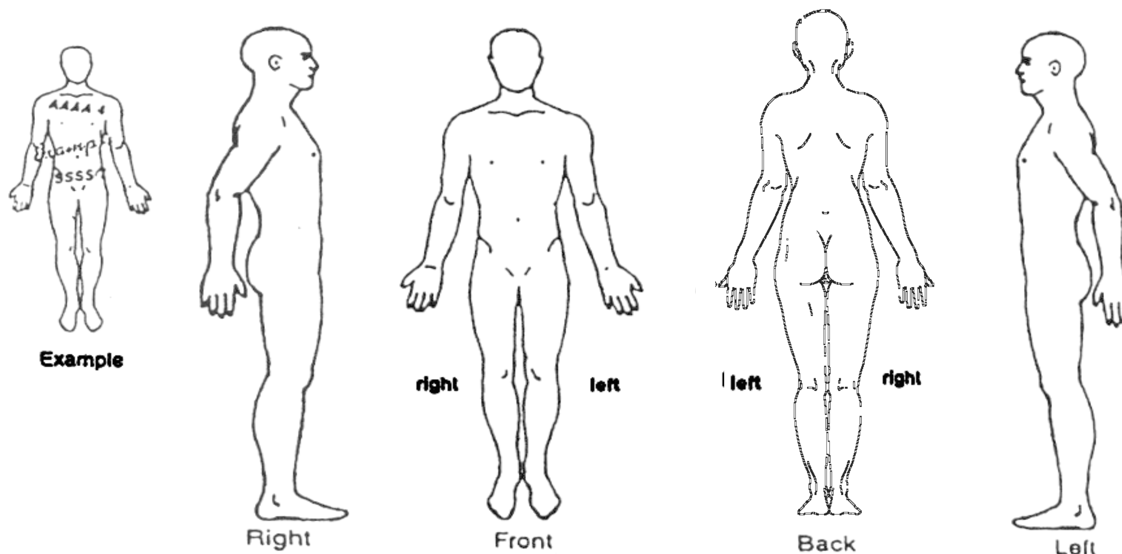
Did any of the above help and if so for how long? ___________________________________

M.D. USE ONLY

NOTES:

SHOW US WHERE YOUR DISCOMFORT IS

Please mark area(s) of injury or discomfort using the appropriate symbols, as shown in the example below.
Please include all affected areas. Please circle any areas of pain not represented by a symbol.
ACHING : **AAA** *BURNING*: **BBB** *STABBING*: **SSS** *NUMBNESS*: **NNN** *PINS & NEEDLES*: **PPP**



REVIEW OF SYSTEMS

Do you currently have any of the following diseases/medical conditions?:

__Appetite decrease
__Artificial bones/joints _______
__Bleeding tendency
__Blood in stools
__Bowel habit changes
__Bowel incontinence
__Breathing difficulty lying flat
__Breathing difficulty
__Bruise easily
__Chest pain or tightness
__Cough, persistent or unusual
__Dizziness
__Dry eyes, mouth or throat

__Fatigue (excessive)
__Fevers (unexplained)
__Headaches, severe/frequent
__Hearing Loss
__Joint pain and/or swelling
__Kidney problems
__Lower back pain/problems
__Muscle tenderness
__Neck pain (frequent)
__Night sweats
__Paralysis
__Sinus problems
__Skin rashes

__Sleeping difficulty
__Stiffness in the AM
__Stomach problems/pain
__Stress at home/work
__Swollen ankles
__Urinary difficulty
__Urinary incontinence
__Urinating frequently at night
__Visual disturbance or change
__Weakness of arms or legs (circle)
__Weight loss of >10 lbs. (intentional)
__Other ______________________

For Male Patients Only: Are you currently experiencing erectile dysfunction? ___________________

For Female Patients Only: Do any of the following apply to you?

__Currently pregnant
__Disorders of the breast
__Perform monthly self-breast exam
__Mammogram within the last 2 years
__Vaginal bleeding other than at the time of your period

__Taking birth control pills
__Currently in menopause
__Pap smear within the last 2 years
__Take over 1000mg of calcium daily

RATE YOUR PAIN

Circle the face that best describes your pain on an *average* day. Then answer the questions in the table below.

0
No Hurt

1 - 2
Hurts
Little Bit

3 - 4
Hurts
Little More

5 - 6
Hurts
Even More

7 - 8
Hurts
Whole Lot

9 -10
Hurts
Worst

Pain Level	Description	How Often
9 - 10	**What one word describes what "9-10" means to you? ____________________** What is your functional ability at this level of pain? Give examples of what causes a "9-10". What do you do to relieve this level of pain?	**How often or what % of your day are you at this level?**
7 - 8	**What one word describes what "7-8" means to you? ____________________** What is your functional ability at this level of pain? Give examples of what causes a "7-8". What do you do to relieve this level of pain?	**How often or what % of your day are you at this level?**
5 - 6	**What one word describes what "5-6" means to you? ____________________** What is your functional ability at this level of pain? Give examples of what causes a "5-6". What do you do to relieve this level of pain?	**How often or what % of your day are you at this level?**
3 - 4	**What one word describes what "3-4" means to you? ____________________** What is your functional ability at this level of pain? Give examples of what causes a "3-4". What do you do to relieve this level of pain?	**How often or what % of your day are you at this level?**
1 - 2	**What one word describes what "1-2" means to you? ____________________** What is your functional ability at this level of pain? Give examples of what causes a "1-2". What do you do to relieve this level of pain?	**How often or what % of your day are you at this level?**
0	**What one word describes what a “0” means to you? ____________________** What is your functional ability at this level of pain? Give examples of what causes a "0". What do you do to relieve this level of pain?	**How often or what % of your day are you at this level?**

YOUR PAST HEALTH HISTORY

Have you had any of the following diseases/medical conditions?:

__Alcoholism
__Anemia
__Artificial valves
__Asthma
__Blood pressure high or low
__Cancer/tumors ________
__Congenital heart defect
__Coughing up blood

__Depression problems
__Diabetes _______
__Drug Abuse_______
__Emphysema
__Heart attack
__Heart murmur
__Heart surgery/pacemaker
__Hepatitis

__HIV+/AIDS
__Mental health condition _______
__Neuritis
__Peripheral vascular disease
__Seizure disorders _______
__Stroke ______
__Tuberculosis
__Ulcers/Colitis/GI problems (circle one)
__Other:________________

YOUR FAMILY MEDICAL HISTORY

Please identify any family medical problems or conditions (high blood pressure, stroke, cancer, etc.)

FAMILY MEMBER	HEALTH PROBLEMS	AGE	LIVING/DECEASED

PAST SURGICAL HISTORY

Please list previous hospitalizations/surgeries:

DATE	TYPE OF SURGERY	PHYSICIAN/SURGEON	PLACE

SOCIAL HISTORY

Are you currently employed or retired? __________________ Employer is:__________________
Are you on disability? ____ Yes or ____ No If yes, since what date? _________________________
What is your marital status? *Married* *Single* *Divorced* *Separated* *Widowed*
Do you have children?___________ If so, how many? ________________ Ages: ________________
Hobbies and Recreational Activities? ____
Do you smoke? *Now/Past* What substance? ___________ How many per day? ______How long? _____
Do you drink alcohol? *Now/Past* What kind? __________ How much? __________ How long? ______
Do you use recreational drugs? *Now/Past* What kind? _____________________ How long? _________

MEDICATIONS

Please list all of the medications (prescriptions and non-prescriptions) that you now take:

NAME OF MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED BY

ALLERGIES

Please list anything that you may be allergic to (medications, tape, food, etc.):

ALLERGIC TO:	REACTION:

DIAGNOSTIC TESTING

Which of the following diagnostic tests have you had during the last two years?

TEST	DATE	PLACE	M.D. USE ONLY
X-RAY'S			
CT SCAN			
MRI			
MYELOGRAM			
EMG/NCV			
OTHER			

Please sign and date this form as being true and correct:

Patient ______________________ Date ______________

Patient's Representative ______________________ Date ______________