



COMPLETE as much as possible

Today's Date _____

NAME (Confirm proper spelling) _____ Birthdate: _____

- GENERAL MEDICAL HISTORY**
- Skin Disorders Immune Disorders Heart High blood pressure
 - Cancer Bleeding Problems Drug abuse Depression/ Anxiety/ Other Neurologic Diabetes
 - Seizures / Loss of consciousness Infection/Fevers Kidney/Urination Liver/Jaundice
 - Stomach/Intestinal Muscle or Bone disorders Female Disorders Difficulty with anesthesia
 - Recurrent or Chronic Infections Lungs/Breathing problems Other conditions or medical problems

Describe **Other** Past Medical Problems and Non Spinal **Surgeries**: _____

Height _____ ft _____ in Weight _____ lbs Who is your Family Doctor? _____

Tobacco or Nicotine Use: NO Tobacco use I use Chewing Tobacco I use Nicotine Gum / Patches
 YES I smoke tobacco, but: less than 1 Pk per day more than 1 Pk per day **or** Pipe/Cigars

Alcohol Use: None Rare 1-2 days per week 2-4 days per week 5 to 7 days per week

I Have: Unexpected weight Loss or Gain Frequent Soaking night sweats Definite Fever
 Recurring Rashes Shaking Chills Joint swelling Shortness of Breath: at rest activity (circle if applies)

Other? _____

List **ALL Medicines** you take: I take non prescription pain medicine I Take Herbal Medicines (NKDA, t)

<u>Names</u>	<u>Dosage</u>	<u># Taken Per Day</u>	<u>per week, other?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Use the back side of this page if additional space is needed, or provide a separate list of your medications / and medical history.

Family Medical problems? : **NONE** That I Know of
Father Mother Brothers _____ Sisters _____

Initial _____

INJURY & TREATMENT HISTORY

Date _____

How did you hurt yourself? Check all that apply

- Don't know Car Accident At Work Other Accident?

Do you need a copy of report sent to an attorney? **No** **Yes** _____

If Injured, The Date(s) of Injury / / / / If more dates.... use backside

When did your symptoms 1st start? / / **(Approximates dates OK)**

Prior to these dates: Have you had similar symptoms in the past? **No** **Yes**
 or
 Ever sought treatment for these symptoms before? **No** **Yes**

When the pain symptoms started, did you have to quit or change jobs?

I am NOT WORKING at present If off work are you receiving payments? **YES** **NOT YET** **NO**

I am WORKING at the same job

I am WORKING at a different job { Sinc , Wha }

Tests I have had For this condition:

- MRI EMG / Nerve Tests Myelogram Xrays CAT Scan Discogram Bone Scan

Other tests

Prior Spinal Surgery(s)? List from Most Recent to Oldest (A. to D & E to H) or NONE

- Laminectomy(s)**
 A. Levels? _____ Year _____
 B. Levels? _____ Year _____
 C. Levels? _____ Year _____
 D. More

Surgeon(s) : { W / B Timing }

Hospital(s) :

- Fusion(s)**
 E. Levels? _____ Year _____
 F. Levels? _____ Year _____
 G. Levels? _____ Year _____
 H. More

	(Circle if applicable)	(Circle if applicable)	
Screws/Rods/Plates	Anterior (front)	Posterior (back)	XLIF (side)
S/R/P	A	P	X
S/R/P	A	P	X
S/R/P	A	P	X

After Surgery I had : (If you had these complications Circle the letter of the surgery as listed above)

- Infection A. B. C. D. E. F. G. H.
 Nerve Damage A. B. C. D. E. F. G. H.
 Spinal Fluid Leak? A. B. C. D. E. F. G. H.

I have had a **Spinal Cord Stimulator**:..... Trial Implanted Recommended (Circle if applicable)

I have had a **Medication Pump**: Trial..... Implanted Recommended (Circle if applicable)

Non Surgical Treatments I have had For this condition Include:

- Manipulation/Chiropractic Brace Physical Therapy Traction Injections TNS Unit

Other

What Treatments Have Worked the BEST:

With Treatment my symptoms are: Temporarily Better Permanently better

With Treatment overall I am getting: Much Better A Little Better Staying the Same Worse

What Pain Medicine(s) work(s) the best?: _____

Symptoms can include pain, but also numbness, tingling (O) or muscle spasms (S). Pain can be described as "Sharp" (X), "Achy" (A), "Burning" (B) or "Other" (T). Mark on the figures all areas where your PRESENT symptoms are located, even if only occasional. The physician may later ask you to indicate where the most severe symptoms & what are constant. **BE COMPLETE!** If your only symptom is weakness, leave this page blank.

Draw upon these Anatomic Pictures to Indicate Areas of Symptoms **USE ONE or MORE OF THESE SYMBOLS (A, B, X, T, O, S)**. If more than one type of symptom in the same location, use arrows.

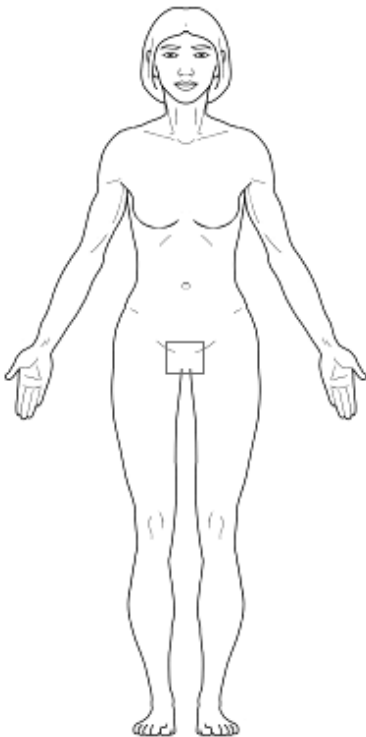
• **For Areas of Constant or Occasional PAIN**

Draw: A's for "Achiness" B's for "Burning" X's for "Sharp, Stabbing, Catching" T's for "Other"

• **Other Constant or Occasional Other Symptoms**

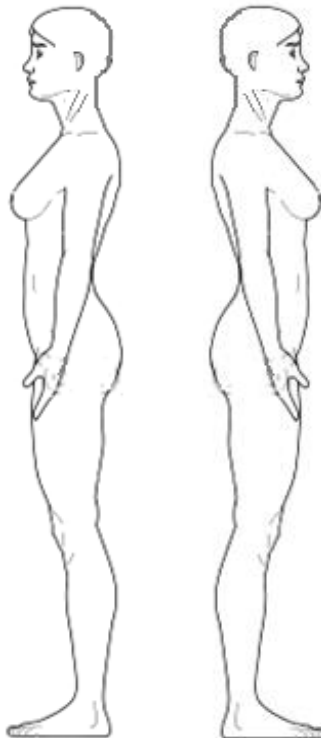
Draw: O's to mark areas of Numbness and / or Tingling

S's for areas of Spasm



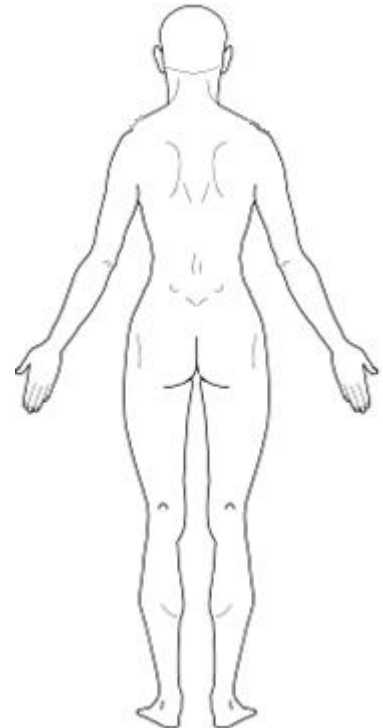
Right

Left



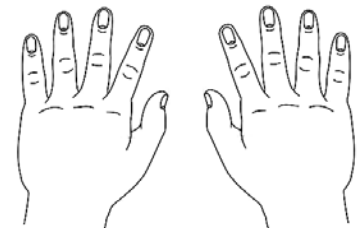
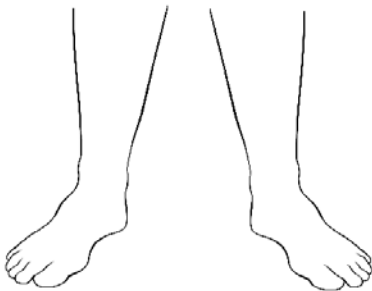
Left

Right



Left

Right



Any Additional Information Regarding Your Symptoms ? :

Initial _____

SYMPTOM QUALITIES

Date _____

Regarding Pain Please Answer the Following

Most comfortable position Sitting Standing Laying None, **always exactly equally** uncomfortable

Worst pain is in: my Spinal area my Leg/Arm area Both

Pain is worse in: the morning afternoon evening all of the time

Pain **regularly** keeps me from: Any Activity Chores Exercise Shopping Get out of bed Drive car

Back Symptoms increase: <input type="checkbox"/> Walking <input type="checkbox"/> Laying <input type="checkbox"/> Sitting	Neck Symptoms increase : <input type="checkbox"/> Driving <input type="checkbox"/> Laying <input type="checkbox"/> Sitting
Leg Symptoms increase: <input type="checkbox"/> Walking <input type="checkbox"/> Laying <input type="checkbox"/> Sitting	Arm Symptoms increase: <input type="checkbox"/> Use <input type="checkbox"/> At night <input type="checkbox"/> Sitting

Other symptoms include:

- Weakness Increased pain with weather changes Difficulty Sleeping Frequent Headaches
 Bowel/Bladder problems Morning stiffness Painful hair Abdominal Pain Tremor
 Other:

Check the number for Pain level when taking it easy. Use **X** over the number for pain when active

Example

0	1	2		4	5	6	7	X	9	10
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USE 0 to 10 Pain Scale: 0 = No Pain 5 = Pain limits Daily Activity 10 = Had to call an ambulance

Average Daily **Neck** pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Average Daily **Arm** pain.....

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

I have ARM Weakness Numbness Tingling I do not have Arm Pain

Average Daily **Back** pain (*below neck*)

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Average Daily **Leg** pain.....

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

I have LEG Weakness Numbness Tingling I do not have Leg Pain

Overall most severe Pain level in last 3 Months..

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Overall least Pain level over the last 3 Months.....

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Pain level if not taking pain medicine.....

0	1	2	3	4	5	6	7	8	9	10
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List Other Physicians seen for this: