The Advanced Spine Center

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For Office Use Only:
HR: _____
BP: _____/_____

ADULT SPINE HISTORY

Name of Patient: _____ **Date**: _____

Date of Birth: _____ Age: _____ Height: ____ft ____ in Weight: _____ lbs

Form Completed By: _____ Relationship to Patient: _____

Referring Doctor Name and Address: _____

What problem is the doctor seeing the patient for today? (Check all that apply)

❑ Spinal Deformity (Scoliosis, Kyphosis, Flatback Syndrome, Spondylolithesis, etc)

❑ Neck Pain Arm: ❑ Pain ❑ Numbness ❑ Weakness

❑ Back Pain Leg: ❑ Pain ❑ Numbness ❑ Weakness

Other: _____

Please describe your problem: _____

_____

How long has the pain/problem been present? _____

How severe is the pain at the location described above (circle below):

0 1 2 3 4 5 6 7 8 9 10

No pain Slight Mild Moderate Severe Excruciating

Has the pain/problem worsened recently? ❑ No ❑ Yes, how recently? _____

Quality of the pain: ❑ Sharp ❑ Burning ❑ Aching ❑ Dull

What makes the problem better? _____ Worse? _____

Is the pain (check all that apply): ❑ Continuous ❑ Night pain ❑ Activity related ❑ Unpredictable

Does the patient have numbness or weakness in his/her arms or legs? ❑ No ❑ Yes

If yes, where? _____

Are there any problems with loss of bowel or bladder control? ❑ No ❑ Yes

Are there any problems with balance, fine motor control, or dexterity? ❑ No ❑ Yes

How far can you walk? (number of blocks) _____ Are you right or left handed? _____

What treatments have you tried? (check all that apply) ❑ *No previous treatment*

Neck	Back		Neck	Back	
❑	❑	Physical therapy/Exercise	❑	❑	Anti-Inflammatory medications
❑	❑	Massage/Ultrasound	❑	❑	Narcotic medication
❑	❑	Chiropractic treatment	❑	❑	TENS unit
❑	❑	Traction	❑	❑	Braces

❑ ❑ Epidural steroid injections, _____ times, which relieved the pain for how long? _____

❑ ❑ Trigger point injections, _____ times, which relieved the pain for how long? _____

❑ ❑ Surgery, describe: _____

If recommended, please rate how interested you are in having surgery to treat your problem:

0 1 2 3 4 5 6 7 8 9 10

Not at all Maybe Definitely

Because of this problem, have you filed or do you plan to file a lawsuit? ❑ Yes ❑ No

Previous physicians seen for ***this*** problem:

Physician	*Specialty*	*City, State*	*Treatment*

Medications taken for ***this*** problem:

Name of Medication	*Dose*	*Reason*

X-rays and Tests for ***this*** problem:

	Results	*Date*	*Location/Facility*
❑ X-rays			
❑ MRI			
❑ CT scan			
❑ Bone scan			
❑ Other			

Is there any other information that the doctor should be aware of? _____

_____

FOR PATIENTS WITH SPINAL DEFORMITY/BACK CURVATURE:

How was your spinal deformity discovered? _____

Do you know your present curve measurement(s)? _____

Reasons for seeking treatment at this time: ❑ progressive deformity ❑ pain ❑can't stand straight

❑ don't like the appearance of back/waistline ❑ other: _____

FOR WORKMAN'S COMPENSATION PATIENTS:

Date of injury/incident: _____ Have you been put on light duty? ❑ No ❑ Yes

Describe the injury/incident: _____

_____

Have you been out of work due to this injury? ❑ No ❑ Yes, last date worked: _____

Name of the company that you work(ed) for when the injury occurred? _____

What was your job title? _____ How many years did you work there? _____

Have you had any prior workman's compensation injuries in the past? ❑ No ❑ Yes, describe below:

_____

Prior to this injury, have you ever seen a physician/chiropractor for neck or back pain? ❑ No ❑ Yes

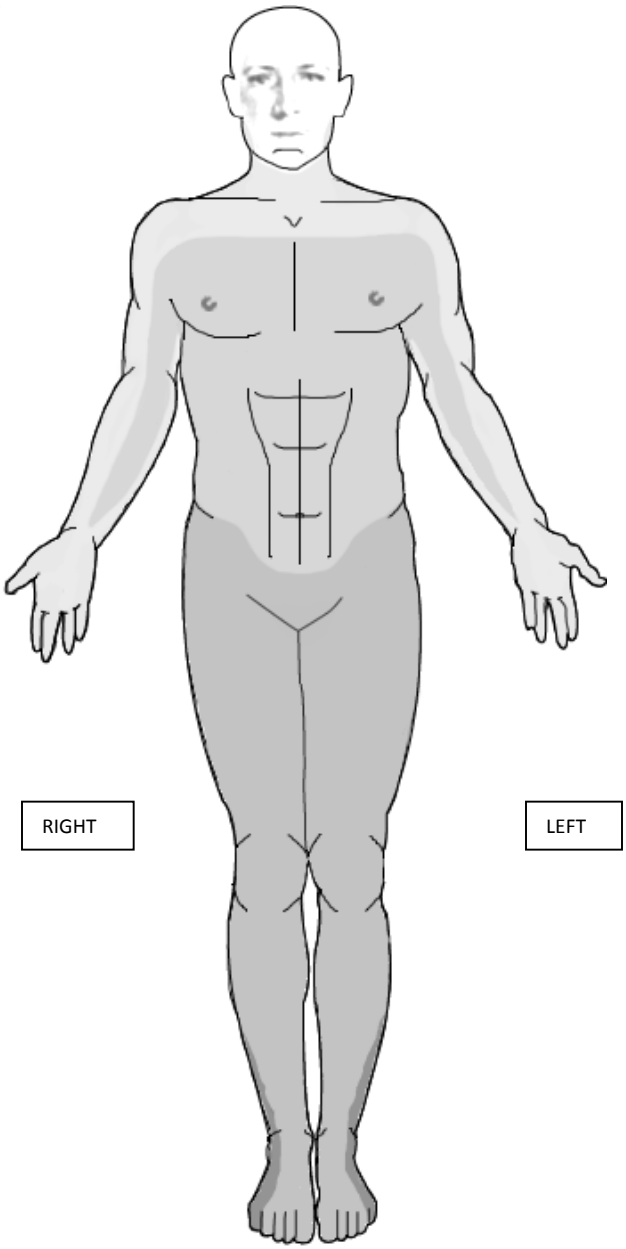
Describe: _____

Any history of a previous motor vehicle accident? ❑ No ❑ Yes

WHERE IS YOUR PAIN NOW?

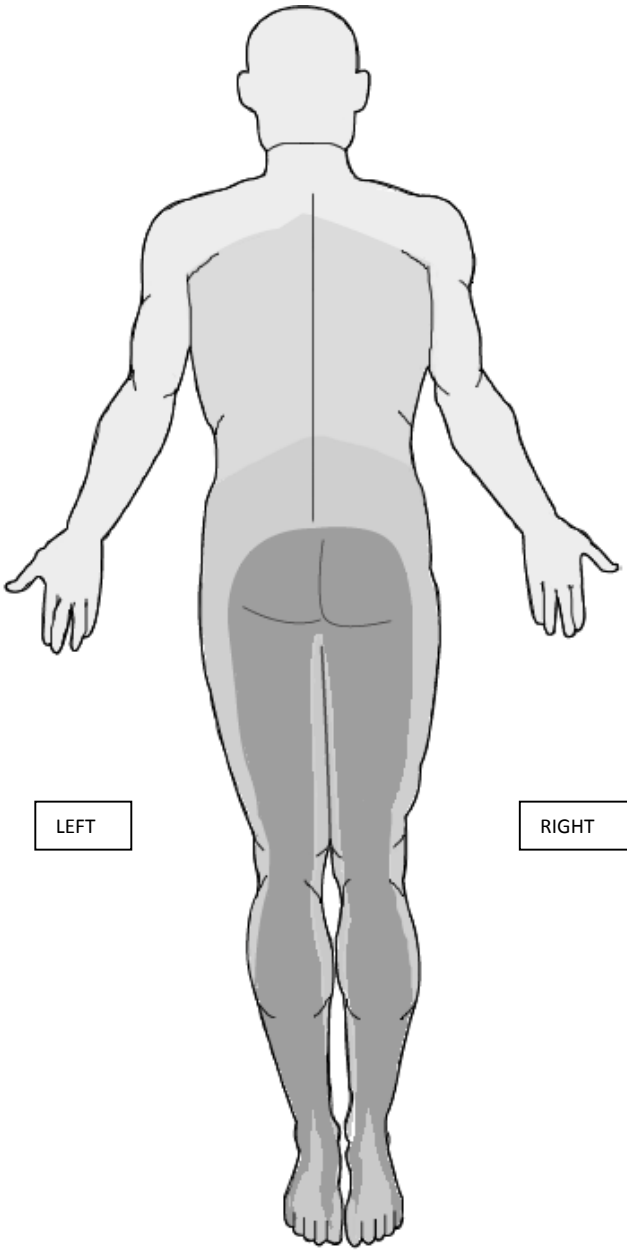
Using the appropriate symbols, mark all of the areas on your body where you feel the sensations described below

PAIN xxxx BURNING ++++ TINGLING - - - NUMBNESS oooo



RIGHT LEFT

FRONT



LEFT RIGHT

BACK

My number one problem is:

____ back/neck pain ____ arm/leg pain ____ numbness/tingling ____ weakness

PAST MEDICAL HISTORY: (check all that apply) ❑ *None Apply*

❑ Heart attack (MI)	❑ Asthma	❑ Rheumatoid arthritis	❑ Depression
❑ Heart failure (CHF)	❑ Tuberculosis	❑ Osteoarthritis	❑ ADHD
❑ Abnormal heart beat	❑ Emphysema	❑ Downs syndrome	❑ Seizures
❑ High blood pressure (HTN)	❑ Thyroid problems	❑ Osteoporosis	❑ Migraine
❑ Stroke (CVA)	❑ Stomach ulcers	❑ Cerebral palsy	❑ Cirrhosis
❑ Blood clots in leg (DVT)	❑ Gastric reflux	❑ Hepatitis (A, B, or C)	❑ Gout
❑ Blood clot in lung (PE)	❑ Hiatal hernia	❑ Neurofibromatosis	❑ Spina bifida
❑ Poor circulation (PVD)	❑ Kidney failure (CKD)	❑ Bleeding/platelet disorder	❑ HIV/AIDS
❑ High cholesterol	❑ Kidney stones	❑ Anemia	

❑ Cancer, type/treatment: _____

❑ Diabetes mellitus, year diagnosed: _____ ❑ Neuropathy: ❑ Hands or ❑ Feet

Diabetes is currently controlled with: ❑ insulin ❑ oral medications ❑diet

❑ Other: _____

Menstrual History: ❑ N/A, patient is male

Date of last menstrual period: _____ ❑ Menopause

Is there any chance that you could be pregnant? ❑ No ❑ Yes (*****Please let x-ray tech know***)**

PAST SURGICAL HISTORY: ❑ *No prior surgery*

Operation	*Date*	*Surgeon/Hospital*

Have you ever had general anesthesia? ❑ No ❑ Yes

If yes, any problems related to this? ❑ No ❑ Yes

Please explain any problems related to general anesthesia: _____

Any hospitalizations besides above surgeries? _____

MEDICATIONS: (prescribed and over the counter)

Name of Medication	*Dose*	*Reason*

ALLERGIES: ❑ *None*

Name of Medication	*Reaction (rash, swelling, upset stomach, etc)*

Are you allergic to: ❑ Latex ❑ Nickel

SOCIAL HISTORY:

Do you currently smoke? ❑ No ❑ Yes, how many packs per day? _____ For how many years? _____

Have you quit smoking? _____ If yes, when? _____ How many years did you smoke? _____

How many packs per day did you previously smoke? _____ Other forms of tobacco? _____

Alcohol Use: ❑ None ❑ Rare ❑ Social ❑ Frequently (more than twice a week)
❑ Alcoholic ❑ Recovering alcoholic

Illegal Drug Use: ❑ None ❑ In the past ❑ Currently Types of drugs: _____

Work Status: ❑ Working ❑ Homemaker ❑ Disabled ❑ On leave ❑ Unemployed
❑ Retired ❑ Student

Occupation: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Children: ❑ No ❑ Yes, how many? _____

Do you live alone? _____ If no, who lives with you? _____

Who is your primary care physician? _____

Address: _____

FAMILY HISTORY: (check all that apply) ❑ *No significant family history*

❑ Scoliosis	❑ Diabetes	❑ Arthritis	❑ Bleeding problems
❑ Heart problems	❑ Cancer	❑ High blood pressure	❑ Stroke
❑ Seizure	❑ Alcoholism	❑ Lung problems	❑ Gout
❑ Alcoholism	❑ Mental illness	❑ Blood clots (legs or lungs)	

❑ Other (please list): _____

REVIEW OF SYSTEMS (check all that apply within the last 30 days): ❑ *None within past 30 days*

❑ Fever	❑ Sleep apnea (snoring)	❑ Nausea	❑ **Chest pain**
❑ Chills	❑ Cough	❑ Vomiting	❑ **Palpitations**
❑ Dizziness	❑ Trouble swallowing	❑ Diarrhea	❑ **Shortness of breast**
❑ Headache	❑ Seizures	❑ Constipation	❑ Memory loss
❑ Glasses/contacts	❑ Anxiety	❑ Skin rashes	❑ Weight gain
❑ Incontinence	❑ Seasonal allergies	❑ Gastric reflux	❑ Weight loss
❑ Erectile difficulties	❑ Food allergies	❑ Urinary difficulty	❑ Vision changes

❑ Other: _____

I certify that the above is correct and complete to the best of my knowledge.

Patient's Signature: _____ Physician's Signature: _____