

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

Any numbness or tingling? No Yes, where? _____

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

Acupuncture

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:

<i>Physician</i>	<i>Specialty</i>	<i>City, State</i>	<i>Treatment</i>

Medications taken for **this** problem:

<i>Name of Medication</i>	<i>Dose</i>	<i>Reason</i>

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

	<i>Results</i>	<i>Date</i>	<i>Location/Facility</i>
<input type="checkbox"/> X-rays			
<input type="checkbox"/> MRI			
<input type="checkbox"/> CT scan			
<input type="checkbox"/> Bone scan			
<input type="checkbox"/> 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?

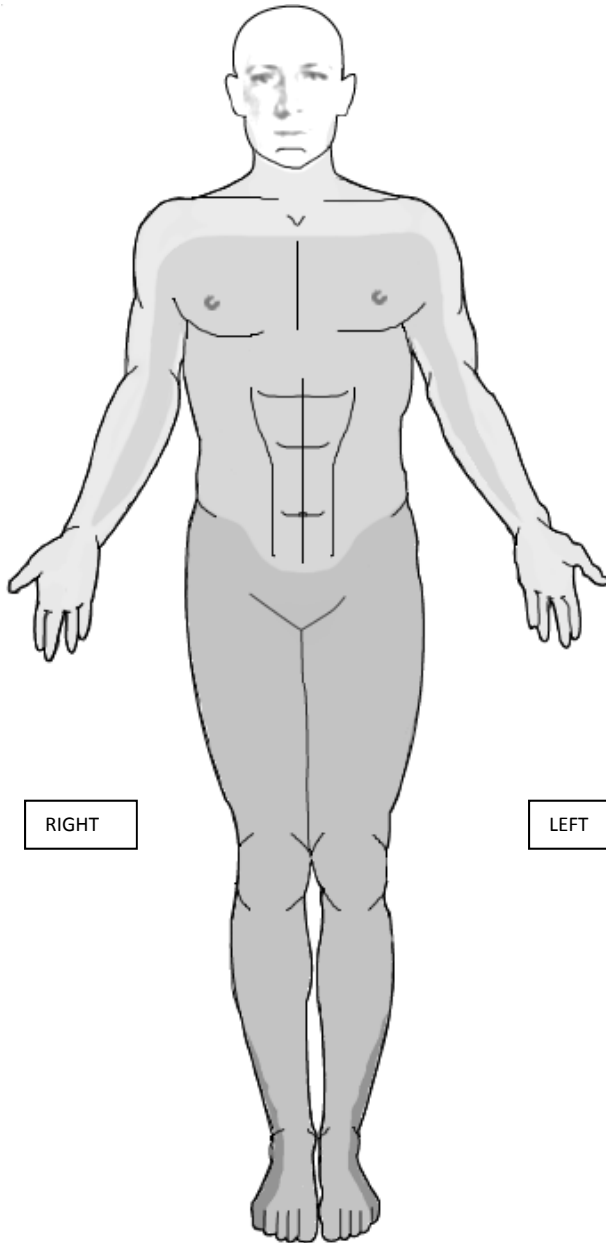
Using the appropriate symbols, mark all of the areas on your body where you feel the sensations described below

PAIN x x x x

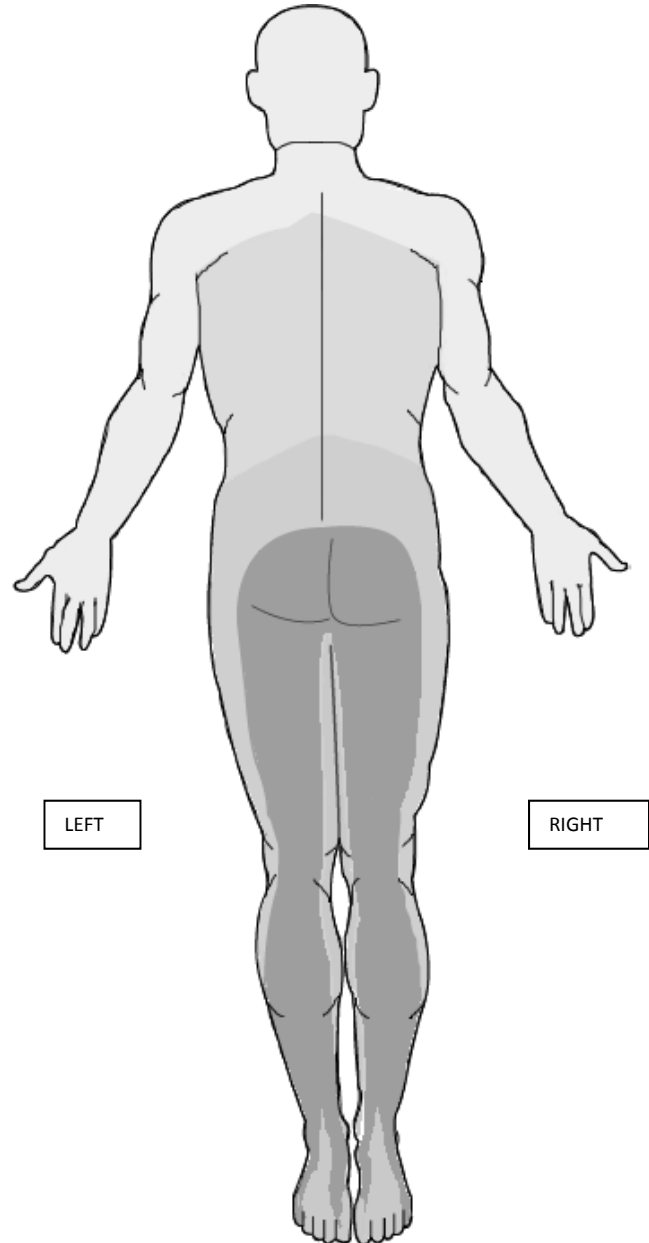
BURNING + + + +

TINGLING - - -

NUMBNESS o o o o



FRONT



BACK

My number one problem is:

___ back/neck pain

___ arm/leg pain

___ numbness/tingling

___ weakness

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
- 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 breath
- 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: _____