Spine Health History 2018 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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What number best describes how, during the past week, the pain has interfered with your **enjoyment of life**?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

What number best describes how, during the past week, the pain has interfered with your **general activity**?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1.Little interest or pleasure in doing things	0	1	2	3
2.Feeling down, depressed or hopeless	0	1	2	3
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3

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

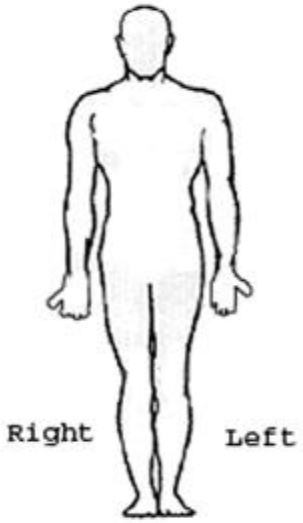
Do you ever experience a catch or shift in your neck / back? Yes / No
Have you lost control over your bowel or bladder function?
☐ no ☐ yes, describe _____

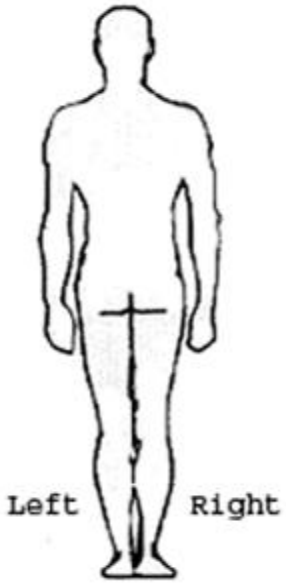
I also have: ☐ Balance problems ☐ Leg / foot weakness/numbness/tingling
☐ Hand clumsiness ☐ Hand weakness/tingling/numbness
Do you have pain or tingling at night? Yes / No

Work Status (Please circle those that apply)
1. Working; this problem has not affected my work
2. Before my pain, I normally worked **full or part time**? _____hrs/week
3. Working less because of this problem; approx ___% less or ___hrs/wk less
4. Retired, permanently disabled, home duties, seeking work, unable to work
Describe any job tasks that affect your pain:_____
_____

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel. (Top image = Front)

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





Back

Please rate your pain by indicating 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

What number best describes your pain, on average, over the past week?

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

Please complete BOTH sides of this form

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

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

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

Surgery for this problem or area:

Date	Surgery Type	Surgeon
____/_____/_____	_____	

Other Treatments: Please circle those that apply	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

Medications currently taking for **spinal or presenting pain** injury/problem

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

Medications **previously** tried:

List all other medications you are taking:

_____ _____
_____ _____
_____ _____
_____ _____

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

Please List any previous surgeries or hospitalizations you have had:

_____

Tell Us About your **Family History.** Do any of your family members have a history of

- ☐ Diabetes [Mother___ Father____ Sibling ___ Child ___ Other___]
- ☐ Cancer [Mother___ Father____ Sibling ___ Child ___Other___]
- ☐ Multiple Sclerosis [Mother___ Father____ Sibling ___ Child ___Other___]
- ☐ Heart Disease [Mother___ Father____ Sibling ___ Child ___Other___]
- ☐ Neurological Disease (MS?) [Mother___ Father____ Sibling ___ Child ___Other___]
- ☐ Scoliosis [Mother___ Father____ Sibling ___ Child ___Other___]
- ☐ Other _____ [Mother___ Father____ Sibling ___ Child ___Other___]

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

- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Stroke or TIA
- ☐ Stomach ulcer or Reflux
- ☐ High blood pressure
- ☐ 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 those that apply **or check none at the bottom**.

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

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

Height_____Weight_____BP_____GUGT_____ Reviewed by: _____, MD/DO/PA Date _____