



CENTER FOR SPINE CARE

PATIENT MEDICAL HISTORY

(Existing patient - new problem)

NAME _____ AGE _____ GENDER [] Male [] FEMALE

Today's Date: ____/____/____

CHIEF COMPLAINT:

WHERE IS THE PAIN LOCATED ON YOUR BODY? _____

HOW LONG HAVE YOU HAD THE PAIN? _____

HISTORY OF PRESENT ILLNESS:

DID THE PROBLEM RESULT FROM A MOTOR VEHICLE COLLISION? [] YES [] NO

DID THE PROBLEM RESULT FROM A WORK RELATED ACCIDENT? [] YES [] NO

DID THE PROBLEM RESULT FROM A SPECIFIC INJURY? [] YES [] NO

IF YES, HOW DID YOU GET INJURED? _____

IF NO, HOW LONG HAVE YOU HAD THE CONDITION? _____

IS THERE UNRESOLVED LITIGATION REGARDING THIS INJURY? [] YES [] NO

WHERE IS YOUR PAIN NOW? Mark the areas on your body where you feel the described sensations:

ACHE
AAA

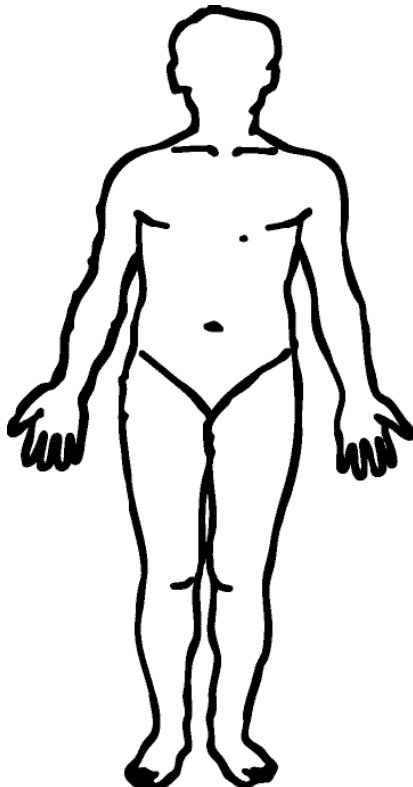
NUMBNESS
OOO

PINS & NEEDLES
===

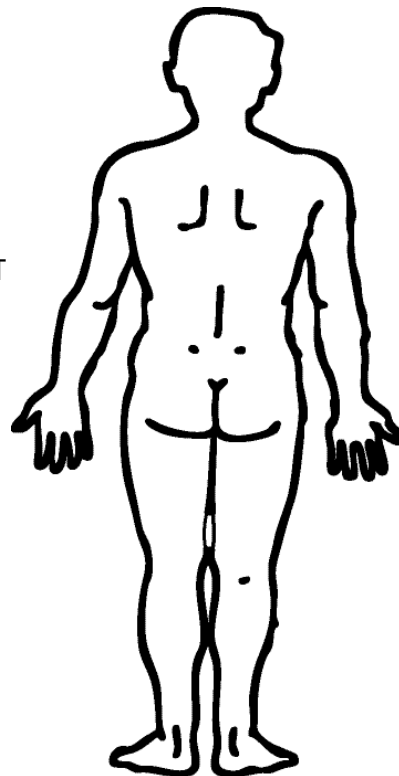
BURNING
xxx

STABBING
///

RIGHT



LEFT LEFT



RIGHT

Pain Scale

On a scale of 0 to 10, Mark **the intensity** of pain on the areas that apply (10 being the most painful)

BACK _____ RIGHT LEG _____ LEFT LEG _____
NECK _____ RIGHT ARM _____ LEFT ARM _____

On a scale of 0 to 10, Mark **how often** you have pain on the areas that apply (10 being all of the time)

BACK _____ RIGHT LEG _____ LEFT LEG _____
NECK _____ RIGHT ARM _____ LEFT ARM _____

Describe your pain: [] CONSTANT [] OCCASIONAL
[] SHARP, [] DULL, [] ACHING, [] STABBING, [] TINGLING, [] SHOOTING, [] EXHAUSTING

What time of day is the pain the worst? [] MORNING, [] AFTERNOON, [] EVENING, [] NIGHTTIME

What if anything makes your symptoms better? _____

What if anything makes your symptoms worse? _____

Have you seen another physician for this injury? [] YES [] NO If yes who? _____

What treatments have you tried? [] NOTHING, [] MEDICATIONS: _____
[] PHYSICAL THERAPY (duration) _____, [] EXERCISE, [] ACCUPUNCTURE, [] CHIROPRACTIC,
[] INJECTIONS (specify: Epidural, Selective Nerve Root Block, Facet, Sacroiliac joint, other _____),
[] OTHER _____.

Diagnostic Testing

Have you had any of the following tests for your spine? Are you claustrophobic [] YES [] NO

TEST	DATE (month/ year)	FACILITY IF KNOWN (clinic/ hospital)
[] Regular X- Ray	_____	_____
[] MRI Scan	_____	_____
[] CT Scan	_____	_____
[] Myelogram	_____	_____
[] Discogram	_____	_____
[] EMG/NCV	_____	_____
[] Bone Scan	_____	_____
[] Bone Density Test	_____	_____
[] Other	_____	_____

Please note any other significant factor regarding your condition. _____

PAST MEDICAL/ SURGICAL HISTORY:

Please list any changes in your Medical or Surgical History since your last visit:

[] NO CHANGES SINCE LAST VISIT ON (date) _____

ALLERGIES:

Are you allergic to any medication? [] YES [] NO.

If yes, what medication was it and what type of reaction did you have?

Name of Medication(s)	Reaction (rash, swelling, difficulty breathing, cough, difficulty swallowing, etc...)
_____	_____
_____	_____

MEDICATIONS:

Please list all Medications you are currently taking:

	NAME OF MEDICATION	DOSE	HOW OFTEN TAKEN	REASON
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

PHYSICAL EXAM: Height _____ Weight _____ BMI _____

Center for Spine Care use

PHYSICAL EXAM:

CERVICAL

ROM: [] Normal full active/passive
 [] Abnormal
 F ___ E ___ RLB ___ LLB ___
 Rotation: R ___ L ___

DTR's: [] Normal 2+ = B
 [] Abnormal
 C5 bicep R ___ L ___
 C6 Brachioradialis R ___ L ___
 C7 Tricep R ___ L ___

Sensation: [] Normal = B
 [] Abnormal
 R _____
 L _____

Motors: [] Normal 5/5 = B
 [] Abnormal
 C5 Deltoid R ___ L ___
 C6 Bicep, WE R ___ L ___
 C7 Tricep, WF R ___ L ___
 C8 Finger Flex R ___ L ___

Phalen's pos / neg R L B
Tinels pos / neg R L B
Hoffman's pos / neg R L B
Spurling pos / neg R L B

LUMBAR

ROM: [] Normal full active/passive
 [] Abnormal
 F ___ E ___ RLB ___ LLB ___
 Ext. Rotation: R ___ L ___

DTR's: [] Normal 2+ = B
 [] Abnormal
 L5 Patella R ___ L ___
 S1 R ___ L ___ R ___ L

Sensation: [] Normal = B
 [] Abnormal
 R _____
 L _____

Motors: [] Normal 5/5 = B
 [] Abnormal
 L2 Hip Flexors R ___ L ___
 L3 Knee Ext R ___ L ___
 L4 Ankle Dorsi R ___ L ___ R ___ L
 L5 EHL R ___ L ___
 S1 Plantar flex R ___ L ___

Straight Leg Raise
 [] Normal
 [] Abnormal
 Seated R ___ L ___
 Supine R ___ L ___

Gait : normal, non-ambulatory, antalgic, hemiplegic
Foot Drop: no / yes R ___ L ___ B ___
Clonus: Absent / present R ___ L ___ B ___