Patient Name: _____ Today's Date: _____

Birthdate: _____

Back Symptoms

On a scale of 1-10 (10 being the worst), what is your current level of pain? _____

Reason for visit: (Please provide a brief history of what is bothering you, what part of your spine bothers you and how it happened)

_____

_____

_____

What is the location of your symptoms: □ None

□ Upper back □ Mid Back □ Lower back □ Gluteal/buttock area

Check any areas of your body that your back symptoms radiate to: □ None

□ Left Thigh □ Right Thigh □ Left Hip □ Right Hip □ Left Groin □ Right Groin

□ Left Calf □ Right Calf □ Left Foot □ Right Foot

Are your symptoms: □ Recurring □ Improving □ Worsening

What is the severity of your symptoms: □ Mild □ Moderate □ Severe □ Incapacitating

□ Other _____

How often do your symptoms occur: □ Constantly □ Daily □ Weekly □ Randomly

□ Other _____

Select the quality/description of your back symptoms: □ None

□ Ache □ Numbness □ Sharp

□ Shooting □ Weakness □ Other _____

Check all activities that aggravate your back symptoms: □ None

□ Sitting □ Bending

□ Standing □ Lifting □ Other _____

Check all items that make your back symptoms better: □ None

□ Exercise □ Movement □ Lying Down □ Pain Meds/Drugs □ Rest □ Changing Positions

□ Heat □ Stretching □ Ice □ Over the counter medications

□ Other _____

Patient Name: _____ Today's Date: _____

Birthdate: _____

Neck Symptoms

On a scale of 1-10 (10 being the worst), what is your current level of pain? _____

Reason for visit: (Please provide a brief history of what is bothering you, what part of your spine bothers you and how it happened)

_____

_____

_____

What is the location of your symptoms: □ None

□ Right Front of Neck □ Right Side of Neck □ Right Back of Neck □ Right Arm □ Right Shoulder

□ Left Front of Neck □ Left Side of Neck □ Left Back of Neck □ Left Arm □ Left Shoulder

□ Bilateral Front of Neck □ Bilateral Side of Neck □ Bilateral Back of Neck □ Both Arms □ Both Shoulders

Check any areas of your body that your neck symptoms radiate to: □ None

□ Right Upper Arm □ Right Shoulder □ Right Hand □ Right Forearm

□ Left Upper Arm □ Left Shoulder □ Left Hand □ Left Forearm

□ Both Upper Arms □ Both Shoulders □ Both Hands □ Both Forearms

Are your symptoms: □ Recurring □ Improving □ Worsening

What is the severity of your symptoms: □ Mild □ Moderate □ Severe □ Incapacitating

□ Other _____

How often do your symptoms occur: □ Constantly □ Daily □ Weekly □ Randomly

□ Other _____

Select the quality/description of your neck symptoms: □ None

□ Ache □ Numbness

□ Sharp □ Shooting □ Weakness □ Other _____

Check all activities that aggravate your neck symptoms: □ None

□ Lifting □ Rotation/turning head

□ Driving □ Flexion (looking down) □ Extension (looking up) □ Other _____

Check all items that make your neck symptoms better: □ None

□ Exercise □ Movement □ Lying Down □ Pain Meds/Drugs □ Rest □ Changing Position

□ Heat □ Stretching □ Ice □ Over the counter medications

□ Other _____

Medications:

List any medications that you are currently taking including all pain medications.

□ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Primary Pharmacy

Pharmacy Name/Address/City: _____

Allergies:

Select any allergies from the list:

□ No known allergies

□ Accupril (Quinapril)
□ Acetaminophen
□ Acyclovir
□ Advil (Ibuprofen)
□ Altace (Ramipril)
□ Ampicillin
□ Amaryl (Glimepiride)
□ Augmentin (Amoxicillin)
□ Aspirin
□ Bactrim
□ Ceclor (Cefaclor)
□ Celebrex
□ Cephalosporins
□ Cipro (Ciprofloxacin)
□ Compazine (Promazine)
□ Contrast Media (Ioversol)
□ Codeine
□ Coumadin
□ Darvon
□ Demerol
□ Depakote
□ Doxycycline
□ Egg
□ Erythromycin
□ Famotidine
□ Flagyl
□ Floxin
□ Gabapentin
□ Glucotrol(Glipizide)
□ Heparin
□ Hydrocodone
□ Ibuprofen
□ Inderal (Propranolol)
□ Indocin (Indomethacin)
□ Insulin
□ Iodine or Shellfish
□ IVP Dye
□ Keflex (Cephalexin)
□ Klonopin
□ Lasix (Furosemide)
□ Latex
□ Levofloxacin
□ Levaquin
□ Lidocaine
□ Lipitor
□ Lisinopril
□ Lodine
□ Lopressor (Metoprolol)
□ Morphine
□ Motrin (Ibuprofen)
□ Naprosyn (Naproxen)
□ Niacin
□ Oxycodone
□ Peanut
□ Penicillin
□ Percocet (Oxycodone)
□ Plavix
□ Prednisone
□ Prevacid
□ Prilosec
□ Ranitidine
□ Sulfa
□ Tagamet (Cimetidine)
□ Tetanus Toxoid
□ Tetracycline
□ Tramadol
□ Valium (Diazepam)
□ Vancomycin
□ Zithromax
□ Zocor (Simvastatin)
□ Zyloprim (Allopurinol)

_____
_____
_____
_____

Medical History: Select all current and past medical conditions and include the year of diagnosis

□ None

□ Abnormal Heart Rhythm _____
□ Anemia _____
□ Asthma _____
□ Cancer _____
□ Liver Disease _____
□ Hypertension _____
□ Inflammatory Bowel _____
□ Depression _____
□ Diabetes _____
□ Endometriosis _____
□ Ovarian Cyst _____
□ Heart Attack _____
□ Osteoarthritis _____
□ Tuberculosis _____
□ Bronchitis _____
□ Emphysema _____
□ Hepatitis _____
□ Irritable Bowel _____
□ Stomach Ulcer _____
□ Kidney Failure _____
□ Anesthetic Complications _____
□ Anorexia _____
□ Bulimia _____
□ Kidney Stones _____
□ Rheumatoid Arthritis _____
□ Bleeding Disorder _____
□ Blood Clots _____
□ HIV _____
□ Alcoholism _____
□ Scoliosis _____
□ Seizure Disorder _____
□ Sleep Apnea _____
□ Stroke _____
□ Thyroid Disease _____
□ Anxiety _____
□ Schizophrenia _____
□ Low Potassium _____
□ Osteoporosis _____

Surgical History: **Year** **Year**

□ No Previous Surgery

□ Abdominal Surgery _____
□ Angioplasty _____
□ Back Surgery _____

If you have had back surgery, what part of your back?

- □ Lumbar (Lower Back)
- □ Thoracic (Middle Back)
- □ Unknown

If you have had back surgery, was this a Fusion Surgery?

□ Yes □ No □ Unknown

□ CABG _____
□ Cardiac Pacemaker _____
□ Gastric Bypass _____
□ Hip Replacement _____
□ Knee Replacement _____
□ Mastectomy _____
□ Neck Surgery _____
□ Rotator Cuff Repair _____
□ Thyroidectomy _____
□ _____ _____
□ _____ _____

List any prior diagnostic tests and treatments

Test/Treatment	Date(s)	Body Area Tested/Treated	Facility
CT Scan			
MRI			
EMG			
X-ray			
Physical Therapy			
Spinal Injection			
Chiropractic			
Massage			
Acupuncture			

Family Medical History (circle family member if known)

□ Alcoholism	Brother	Father	Mother	Sister
□ Alzheimer's disease	Brother	Father	Mother	Sister
□ Asthma	Brother	Father	Mother	Sister
□ Bleeding/Blood Disorder	Brother	Father	Mother	Sister
□ Cancer	Brother	Father	Mother	Sister
□ Cardiovascular Disease	Brother	Father	Mother	Sister
□ Colitis	Brother	Father	Mother	Sister
□ Congenital Heart Disease	Brother	Father	Mother	Sister
□ COPD	Brother	Father	Mother	Sister
□ Coronary Artery Disease	Brother	Father	Mother	Sister
□ Depression	Brother	Father	Mother	Sister
□ Diabetes	Brother	Father	Mother	Sister
□ Elevated Lipids	Brother	Father	Mother	Sister
□ Genetic Disease	Brother	Father	Mother	Sister
□ High Blood Pressure (Hypertension)	Brother	Father	Mother	Sister
□ Liver Disease	Brother	Father	Mother	Sister
□ Mental Illness	Brother	Father	Mother	Sister
□ Obesity	Brother	Father	Mother	Sister
□ Osteoporosis	Brother	Father	Mother	Sister
□ Parkinson's disease	Brother	Father	Mother	Sister
□ Kidney/Renal Disease	Brother	Father	Mother	Sister
□ Seizure Disorder	Brother	Father	Mother	Sister
□ Stroke	Brother	Father	Mother	Sister
□ Thyroid Disorder	Brother	Father	Mother	Sister

Previous Spine Injury History:

Have you had a previous injury to your spine? □ Yes □ No If yes, what is the injury date _____

Is this injury from a Motor Vehicle Accident? □ Yes □ No If yes, what is the MVA date _____

Is this injury work related? □ Yes □ No If yes, what is the injury date _____

Were you referred to us by a provider?

If so, please list provider name and clinic: _____

Social History:

Marital status: □ Married □ Single □ Divorced □ Widowed

Children: □ Yes □ No Number of Sons _____ Number of Daughters _____

Hand Dominance: □ Right-Handed □ Left-Handed □ Ambidextrous

Occupation: _____

Employment Status: _____

Restrictions: _____

Have you ever used tobacco? □ No/Never □ Yes □ Former **–** Age when you quit _____

Type of tobacco used: _____

If cigarettes, how many packs per day? _____

Have you ever had a problem with drug dependency? □ Yes □ No

Do you drink alcohol? □ Yes – how much? _____ □ No

Review of Systems

Select **POSITIVE** if you are experiencing any of these symptoms, select **NEGATIVE** if you are not experiencing any of these symptoms.

Description	Positive (Yes)	Negative (No)	Office Use Only
Fever	☐	☐	Constitutional
Chills	☐	☐	Constitutional
Blurred Vision	☐	☐	Eyes
Double Vision	☐	☐	Eyes
Difficulty swallowing (Dysphagia)	☐	☐	ENT
Chest Pain	☐	☐	Cardiovascular
Shortness of Breath (Dyspnea)	☐	☐	Respiratory
Heartburn	☐	☐	Gastrointestinal
Nausea	☐	☐	Gastrointestinal
Vomiting	☐	☐	Gastrointestinal
Urinary Incontinence (leaky urine)	☐	☐	Genitourinary
Joint Pain	☐	☐	Musculoskeletal
Muscle Spasm	☐	☐	Musculoskeletal
Rashes	☐	☐	Integumentary (skin)
Numbness	☐	☐	Neurologic
Tingling	☐	☐	Neurologic
Bruising	☐	☐	Hematologic
Hair Loss	☐	☐	Endocrine
Seasonal Allergy	☐	☐	Allergic
Depression	☐	☐	Psychiatric

Office Use:

Entered Date _____

Initials _____