THE SPINE + PAIN INSTITUTE

MEDICAL HISTORY FORM

Date: _____ Patient Name: _____ DOB: _____ Age: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ Dominant Hand: ☐ Right ☐ Left

Family Doctor: _____ Phone Number: _____

Address: _____

Who referred you to this office: _____ Phone Number: _____

Address: _____

Reason for your visit today: _____

Symptoms: _____

Date / Time of injury or symptom onset: _____

Is this injury or condition work related: ☐ Yes ☐ No

How / Where did the injury occur: _____

Were x-rays taken? When: _____ Results: _____

Please indicate which <u>Diagnostic Tests</u> you have had in evaluation of your problem:

X	EXAM	X	EXAM	X	EXAM	OTHER
	Plain x-ray		EMG / NCV		Bone Scan	
	MRI		Discogram		Arthrogram	
	CT Scan		Myelogram		DEXA Scan	

Please indicate which <u>Treatments</u> you have had for your problem and indicate whether or not it was helpful:

X	Treatment	Helpful?	X	Treatment	Helpful?
	Electrical Stim / TENS			Massage Therapy	
	Physical Therapy			Pool Exercise	
	Chiropractic			Home Exercise	
	Heat Packs			Manipulation	
	Cold Packs			Acupuncture	
	Neck / Back Brace			Injections	
	Other			Surgery	

Patient Signature: _____ Date: _____ Time: _____

Staff Signature: _____ Date: _____ Time: _____

Doctor use only:

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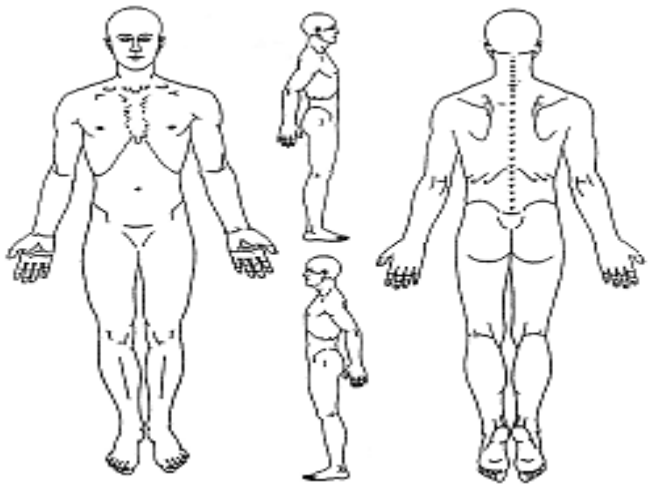
Using the symbols below, please draw in the location of your symptoms on the diagrams:



XXX = Pain

000 = Numbness

//// = Aching

----- = Pins and Needles

Circle the number below, indicating your usual <u>level of pain.</u>

(0 means no pain, 10 means the worst pain in your life).

0 1 2 3 4 5 6 7 8 9 10
Least Worst

Activities of Daily Living:

Please check the activities are currently limited due to this injury:

Self Care: ☐ Bathing ☐ Grooming ☐ Dressing ☐ Eating

Communication: ☐ Hearing ☐ Speaking ☐ Reading ☐ Writing

Physical activities: ☐ Standing ☐ Sitting ☐ Walking ☐ Pushing ☐ Pulling ☐ Climbing

Sensory Function: ☐ Hearing ☐ Seeing ☐ Feeling ☐ Tasting ☐ Smelling

Travel: ☐ Riding ☐ Driving

Sexual Function: ☐ Participating in desired sexual activity

Sleep: ☐ Having a restful sleep pattern

Social / Recreational: ☐ Participating in activities ☐ Sports ☐ Hobbies

What activity makes the symptoms/pain better:

Please check what helps relieve your discomfort.

☐ General Activity ☐ Bending ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Coughing ☐ Bowel movements

☐ Home Remedies: _____

How long can you stand with no pain or minimal pain? _____

How far can you walk with no pain or minimal pain?

☐ ≤ 50 feet ☐ 50 - 200 feet ☐ 200 - 500 feet ☐ ≥ 500 feet ☐ ≥ 1/2 mile

Do you need support to walk? ☐ Yes ☐ No If Yes, what kind of support? _____

Past Medical / Surgical History:

Medication Allergies: _____

Current Medications: _____

Medications you have tried in the past for this condition: _____

Any significant disease or medical condition, currently or in the past? _____

_____

Any significant disease or medical condition(s) in the family? _____

_____

Previous Surgeries: _____

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Substance Use:

Tobacco use: ☐ Yes ☐ No If yes, type: ☐ Cigarettes ☐ Cigars ☐ Chewing tobacco Quantity per day: _____

Alcohol: ☐ Yes ☐ No If yes, type: ☐ Beer ☐ Wine ☐ Liquor Quantity per day: _____

Other: _____

Have you ever been treated for drug or alcohol addiction? ☐ Yes ☐ No When? _____

Do you now or have you ever used illegal drugs? ☐ Yes ☐ No What? _____

Current employment status: ☐ Employed ☐ Retired Date last worked: _____

Employer: _____ Job Title: _____

Job duties: _____

Do you have a living will or POA? ☐ Yes ☐ No

Please check any of the following symptoms that you currently have:

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss

GU
- ☐ Difficulty with urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Loss of control with urination

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Tachycardia
- ☐ Swelling

Hematologic
- ☐ Bruises easily
- ☐ Swollen lymph nodes

GI
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Blood in stool
- ☐ Loss of control with bowel movement

Respiratory
- ☐ Cough
- ☐ Shortness of breath

Psychiatric
- ☐ Depression
- ☐ Insomnia
- ☐ Behavior changes
- ☐ Stress
- ☐ Suicidal thoughts
- ☐ Nervousness

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Restriction of joint motion
- ☐ Muscle weakness

HEENT
- ☐ Difficulty swallowing
- ☐ Headache
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Vision loss
- ☐ Glaucoma
- ☐ Cataracts

Neurological
- ☐ Memory loss
- ☐ Seizures
- ☐ Numbness in extremities
- ☐ Incoordination
- ☐ Gait disturbance

Integumentary
- ☐ Rash
- ☐ Changes in moles
- ☐ Hives

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