

New Spine Patient Questionnaire

Name: _____ Primary Dr. Address: _____
 DOB: _____ Age: _____ Hand Dominance: R L _____
 Today's Date: _____ Phone Number: _____
 Male Female Pregnant? Yes No Referring Physician: _____
 Height: _____ Weight: _____ Referring Dr. Address: _____
 Primary Physician: _____ Phone Number: _____

Chief Complaint: _____

Date of Injury: _____ Injured at: _____ County of: _____

Did your pain start: gradually suddenly
 Are your symptoms now: worse better no change
 Degree of current pain: none mild moderate severe
 How often do you experience the pain? constant intermittent
 What is your pain scale (scale of 1-10; 10 being the worst pain)? _____
 Describe your pain: aching burning sharp stabbing numbness
tingling _____

What is your back pain to leg pain ration (i.e. 100% back/0%leg)?
N/A 100/0 90/10 80/20 70/30 60/40 50/50 40/60 30/70 20/80 10/90 0/100

What is your neck pain to arm pain ratio (i.e. 100% neck/0% arm)?
N/A 100/0 90/10 80/20 70/30 60/40 50/50 40/60 30/70 20/80 10/90 0/100

Where is your pain located? (check all that apply and circle side)
neck neck and arm(s) R or L arm(s) R or L
back back and arm(s) R or L leg(s) R or L

What aggravates your pain? (standing, sitting, etc.) _____

What relieves your pain? (lying down, sitting, etc.) _____

Do you have numbness? If so, where? _____

Do you have weakness? If so, where? _____

Do you have night pain? _____ Does it wake you up from sleep? _____

Do you have bowel or bladder problems? incontinence constipation hesitancy

Are there any associated symptoms (i.e. nausea, loss of balance, etc.)? _____

What treatments have made your pain better? _____

What treatments have made your pain worse? _____

Have you been in a physical therapy program? yes no Did it help you? yes no

When did you participate in physical therapy? Less than 3 months ago More than 3 months ago

Where did you go to physical therapy for this condition? _____

Are you currently working? no yes what type of work? _____

full duty modified duty: _____

Are you able to perform your usual duties? yes no Date last worked? _____

New Spine Patient Medical and Surgical History

Past Medical History

Check all items that apply and describe below if necessary. Otherwise check "none."				NONE
<input type="checkbox"/> Anesthesia problems:	Describe:			<input type="checkbox"/>
<input type="checkbox"/> Heart problems:	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Stroke	<input type="checkbox"/>
<input type="checkbox"/> Circulation problems:	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Poor circulation		<input type="checkbox"/>
<input type="checkbox"/> Lung problems:	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung Disease <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Diabetes:	<input type="checkbox"/> Date diagnosed:	Controlled with:	<input type="checkbox"/> Insulin <input type="checkbox"/> Oral meds	<input type="checkbox"/>
<input type="checkbox"/> Neuropathy:	<input type="checkbox"/> Loss of Feeling:	<input type="checkbox"/> Hands	<input type="checkbox"/> Feet	<input type="checkbox"/>
<input type="checkbox"/> Endocrine problems:	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Adrenal	<input type="checkbox"/> Pituitary	<input type="checkbox"/>
<input type="checkbox"/> Blood problems:	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding disorder		<input type="checkbox"/>
<input type="checkbox"/> Blood clots:	<input type="checkbox"/> Blood clot in leg	<input type="checkbox"/> Blood clot in lung		<input type="checkbox"/>
<input type="checkbox"/> Cancer:	Type(s):			<input type="checkbox"/>
<input type="checkbox"/> Stomach problems:	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hiatal hernia	<input type="checkbox"/> Gastric reflux	<input type="checkbox"/>
<input type="checkbox"/> Kidney problems:	<input type="checkbox"/> Kidney failure	<input type="checkbox"/> Kidney stones		<input type="checkbox"/>
<input type="checkbox"/> Liver problems:	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Cirrhosis		<input type="checkbox"/>
<input type="checkbox"/> Mental illness:	<input type="checkbox"/> Depression	<input type="checkbox"/> Seizures	<input type="checkbox"/> Alcoholism	<input type="checkbox"/>
<input type="checkbox"/> Bone/Joint problems:	<input type="checkbox"/> Fractures	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>
	<input type="checkbox"/> Gout	<input type="checkbox"/> Rheumatoid arthritis		
<input type="checkbox"/> Immune problems:	<input type="checkbox"/> AIDS	<input type="checkbox"/> HIV	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Descriptions/Other:				

Past Surgical History

no other surgery

use back of page if more space needed

Type of Surgery	Date	Surgeon/Hospital

Medications (include vitamins and herbs)

no medications

use back of page if more space needed

Medication/Strength	Dosage	Reason	Medication/Strength	Dosage	Reason

New Spine Patient Medical and Surgical History

Allergies

no allergies

use back of page if more space needed

Allergy	Reaction(s)	Allergy	Reaction(s)

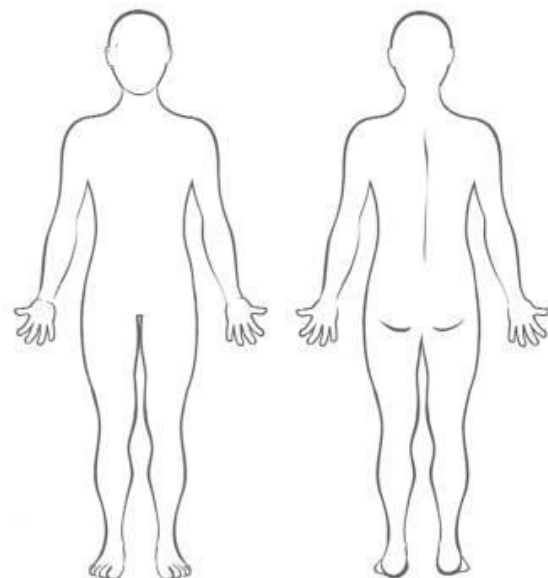
Family History (check all that apply) none apply

- | | | | | |
|--|--|--|---|------------------------------------|
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> kidney problems | <input type="checkbox"/> stroke | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> bleeding problems | <input type="checkbox"/> alcoholism | <input type="checkbox"/> seizures | <input type="checkbox"/> spine problems | <input type="checkbox"/> cancer |
| <input type="checkbox"/> mental illness | <input type="checkbox"/> hypertension | <input type="checkbox"/> diabetes | <input type="checkbox"/> gout | |
| <input type="checkbox"/> other: _____ | | | | |

Social History (check all that apply)

Occupation:				
Work Status:	<input type="checkbox"/> Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Disability leave
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
	<input type="checkbox"/> Co-habiting			
Who do you live with:	<input type="checkbox"/> Alone	<input type="checkbox"/> Spouse/Sig. Other	<input type="checkbox"/> Children	<input type="checkbox"/> Roommate
	<input type="checkbox"/> Other			
Tobacco Use:	<input type="checkbox"/> Never	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigar	<input type="checkbox"/> Pipe chew
	<input type="checkbox"/> Packs per day _____	For _____ years (total)		<input type="checkbox"/> Quit _____ years ago
Alcohol Use:	<input type="checkbox"/> Never	<input type="checkbox"/> Rare	<input type="checkbox"/> Social	<input type="checkbox"/> Frequent (more than 2x per week)
	<input type="checkbox"/> Alcoholic		<input type="checkbox"/> Recovering Alcoholic	
Drug Use:	<input type="checkbox"/> Never	<input type="checkbox"/> In past	<input type="checkbox"/> Currently	<input type="checkbox"/> In treatment
	Types of Drugs:			

Please mark the areas on your body where you are having symptoms. Use the symbol "XXXX." Just to complete the picture, please draw your face.



New Spine Patient Medical and Surgical History

Review of Systems

Check all items that apply and describe below if necessary. Otherwise check "none."					NONE
<input type="checkbox"/> Constitutional:	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/>
<input type="checkbox"/> Eyes:	<input type="checkbox"/> Reading glasses	<input type="checkbox"/> Change of vision			<input type="checkbox"/>
<input type="checkbox"/> Ears:	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Vertigo (dizziness)		<input type="checkbox"/>
<input type="checkbox"/> Nose/Mouth/Throat:	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Tooth/gum trouble	<input type="checkbox"/>
<input type="checkbox"/> Lungs:	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Snoring	<input type="checkbox"/>
<input type="checkbox"/> Stomach:	<input type="checkbox"/> Nausea	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Stomach pain	<input type="checkbox"/>
<input type="checkbox"/> Bowels:	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Bloody stool	<input type="checkbox"/> Black stools	<input type="checkbox"/>
<input type="checkbox"/> Urinary Tract:	<input type="checkbox"/> Difficulty starting urination		<input type="checkbox"/> Frequent or burning urination		<input type="checkbox"/>
<input type="checkbox"/> Heart:	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Abnormal heart beat	<input type="checkbox"/> Swollen ankles	<input type="checkbox"/>
<input type="checkbox"/> Musculoskeletal:	<input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle pain	<input type="checkbox"/> Swelling	<input type="checkbox"/> Instability	<input type="checkbox"/> Stiffness	<input type="checkbox"/>
<input type="checkbox"/> Skin:	<input type="checkbox"/> Rashes <input type="checkbox"/> Poor healing	<input type="checkbox"/> Itching	<input type="checkbox"/> Skin changes	<input type="checkbox"/> Redness	<input type="checkbox"/>
<input type="checkbox"/> Neuropathy:	<input type="checkbox"/> Loss of feeling in:	<input type="checkbox"/> Hands	<input type="checkbox"/> Feet	<input type="checkbox"/> Numbness	<input type="checkbox"/>
<input type="checkbox"/> Neurologic:	<input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Uneasy gait	<input type="checkbox"/>
<input type="checkbox"/> Psychologic:	<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Frequent anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/>
<input type="checkbox"/> Blood:	<input type="checkbox"/> Bleeding/bruising	<input type="checkbox"/> Swollen lymph nodes	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Anemia	<input type="checkbox"/>
<input type="checkbox"/> Non-Drug Allergies:	<input type="checkbox"/> Foods	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Other:		<input type="checkbox"/>
<input type="checkbox"/> Description/Other:					

Accident/Injury Information Form

Name: _____ Doctor: _____

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? _____

Where did your accident/injury occur? _____

How did your accident/injury occur? _____

Will this accident/injury involve litigation currently or in the future? _____

My visit is not related to a motor vehicle accident, work-related injury, school injury, or any other injury for which another party is responsible.

Signature: _____ Date: _____

Thank you for your assistance.

Medical Information Release Form (HIPAA Release Form)

Patient Name: _____ Date of Birth: ____/____/____ MR #: _____

If minor, Parent/Guardian Name: _____

Release of Information

I authorize the release of information including diagnosis, records, test results, medication dosage changes, and billing/collection/claims information.

This information may be released to:

- Spouse/Name: _____
- Child(ren)/Name(s): _____
- Other: _____
- Information should not be released to anyone but me.

Messages

Please call: my home phone # _____ my cell phone # _____.

If unable to reach me:

- You can leave a detailed message.
- Please leave a message asking me to return your call.
- Don't leave messages on my voicemail.

The best time to get to me is (day of the week) _____ between (time) _____.

E-mail Messages/Portal

- Use my email or portal contact to send messages for me to contact the nurse for information.
- Use my email or portal contact to leave detailed messages and information.
 - Attach lab results to the email/portal message.

My email address is: _____

This Release of Information will remain in effect until terminated by me in writing. This version specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: _____

Date: _____

Witness: _____

Date: _____