

Premier Spine Care

GENERAL

Name _____

Date _____

1. Describe the date and precisely how your current pain began.

Date of

Injury: _____

2. What is your current occupation? Describe your work duties. How long have you been there?

Employer: _____

Job Title: _____

Ordinary

Duties: _____

Time with

Employer: _____

Current Employment Status:

- Regular Duty
- Light Duty
- Terminated
- Disabled
- Retired
- New Occupation
- Out of work over past ____ months

3. If your pain occurs at different locations, list them in order of severity. Place a 1 beside the location where most pain is centered, a 2 in the area second most troublesome. Keep going until options do not apply to you.

- headaches
- neck
- shoulder and/or arms
- between my shoulder blades
- low back
- buttocks and/or legs
- other

4. My pain began:

- suddenly
- over days to weeks
- over years
- constantly
- occasionally, about ____ hours a day
- infrequently, about ____ times a week
- rarely, about ____ times a month

5. Usually, my pain is worst (choose only one):

- when I first get up
- as the day progresses
- at night in bed
- at different times

6. Pain is increased by: (Check all that apply; star the worst activity related to your pain).

- bending/twisting your neck
- walking upstairs
- working overhead
- bending my back
- lifting
- twisting
- standing for a while
- sitting for a while
- coughing
- sneezing
- straining at stool
- getting in/out of a car or chair
- lying in bed

7. If pain occurs with walking, how far, or for how long can you go before the pain stops you (minutes or distance)?

8. Walking causes (describe location next to any items you choose):

- numbness
- weakness
- back pain
- leg pain
- unsteadiness/giving out of my legs
- lessening of pain

9. Have you had a Myelogram, CAT scan or MRI study in the recent past for this problem? (Circle those that apply).

10. My pain is improved by (check all that apply):

- rest
- heat
- lying down
- lying on my side

Pain is improved (continued):

- brace
- medications
- stretching
- nothing
- other: _____

11. If you have had any history of neck or low back pain in the past, please describe. How long did it take for your condition to improve?

12. List the physicians who have evaluated your condition. Please include address and phone number.

13. Is there any attorney involved in this case? If yes, please list name, address and phone number.

14. List any treatments that you have had for your current pain. Star those that have helped.

- none
- physical therapy
- chiropractic
- medications
- electrical stimulation/TENS unit
- local injections
- facet injections
- epidural steroid injections
- percutaneous or "band-aide" surgery
- open surgery
- exercises
- other _____

15. What tests have been completed prior to your visit?

- none
- CT Scan
- nerve studies
- functional capacity
- X-Rays
- MRI Scan
- myelogram
- discography

16. Do you plan to return to work? Y/N

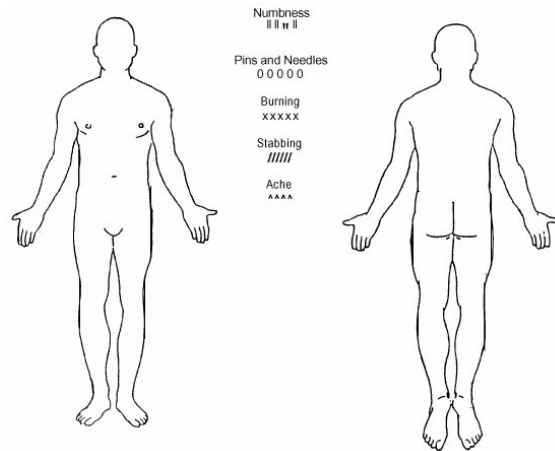
17. Other joints that bother me include my:

- hip
- shoulder
- other _____
- knee
- elbow

18. Do you feel that you have been harmed or possibly injured by some other person or part to cause your pain? Y/N

19. Please complete the pain drawing below.

Shade areas of pain and star areas of numbness.



20. Compared to a year ago, I have:

- lost _____ pounds
- gained _____ pounds
- remained the same weight

21. If you have had any change in bowel or bladder functions, please describe.

- frequent urination
- accidents involving urine
- starting or stopping a stream
- constipation
- narrowed caliber of stool
- blood in my stool
- accidents involving stool
- sexual function

22. What medications are you currently taking? Include over the counter medications and be complete!

23. List any allergies to medications and describe what type of reaction (rash, shortness of breath, nausea, anaphylaxis, etc.) occurs upon exposure.

24. List ALL previous and current medical conditions, surgeries, and abnormal studies.

SOCIAL HISTORY

25. I am currently

- Single
- Married
- Divorced
- Widow/Widower

26. I am

- Unemployed
- Employed
- Retired
- Disabled

27. I have ___ living children

28. There are ___ persons living in the household

29. My alcohol use is:

- never infrequent weekly daily

30. Do you smoke?

- Yes No Former smoker for ___ years

31. Highest level of education attained:

- Junior High High School
- College Technical Education
- Masters Post-Graduate

32. If there is any history of drug or alcohol abuse, please describe.

Review of Systems:

Please check all that apply:

- Reading Glasses Cataracts
- Sinus problems Dentures
- Decreased hearing Chest Pain
- Difficulty swallowing Ankle Swelling
- Shortness of breath Dizziness
- Heartburn/Reflux Dark Stools
- Blood in Stools Constipation
- Change in stool size Abdominal Pain
- Frequent Urination Accidents of Urine
- Urinary Burning/Pain Delay in Urination
- Joint Pain/Popping Surgery upon a Joint
- Abnormal Moles Frequent Rashes
- Loss of Sensation Fainting Spells
- Muscle Weakness Visual Changes
- Anxiety Bouts of Depression
- Insomnia Loss of Energy
- HIV/AIDS History of IV Drugs
- Hepatitis Allergic Reactions

To the best of my knowledge, the questions on this form have been answered correctly. I understand that providing incorrect answers can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform necessary services that I may require.

Patient Signature

Date