### History of Present Complaint

1. What is the reason for your visit? What type of symptoms are you experiencing?
   - Neck pain
   - Neck and arm pain
   - Weakness - Location
   - Low back pain
   - Low back and leg pain
   - Numbness - Location
   - Other pain - Describe


2. How long have you had your present symptoms?
   - Less than 1 month
   - 1 to 3 months
   - 3 to 6 months
   - 6 months to 1 year
   - More than 1 year

3. Please enter date when your present symptoms began and briefly give details of the injury, onset or event.
   Date: __________

4. Please indicate how your present symptoms began:
   - Occurred during an athletic activity
   - Occurred as a result of auto accident
   - Occurred while sitting
   - Occurred while bending
   - Other - Please describe

   - Occurred while lifting
   - Unknown
   - Occurred while working
   - Gradual onset

5. If the symptoms of your present pain have changed since the time of injury, please check the most appropriate statement:
   - My symptoms have remained the same
   - My symptoms are more severe
   - My symptoms are less severe

6. Are there any lawsuits pending or being contemplated relating to your injury?  
   - Yes  
   - No

7. Is the injury work related or covered by worker's compensation?  
   - Yes  
   - No

   If yes, please complete the section below. If no, please skip to the next page.

| Current Job Title: __________________________ | Employer: __________________________ |
| How long have you been in this position? ____ years ____ months |

<table>
<thead>
<tr>
<th>Prior Jobs</th>
<th>Job Title</th>
<th>Employer</th>
<th>Number of Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In your current job, how many hours do you spend:
- Sitting _____  
- Driving _____  
- Standing _____  
- Walking _____  
- Bending _____  
- Climbing _____

- Lifting _____  
- Twisting _____  
- Reaching above shoulder _____  
- Typing/computer _____

Maximum weight, which you lift or carry in your job? __________________________

Have you missed work as a result of your injury?  
   - Yes  
   - No  
   If yes, how long? _____

Are you currently working?  
   - Yes  
   - No  
If no, what date did you stop working? _______

Is there light duty work available at your job?  
   - Yes  
   - No

Are you currently working in light duty?  
   - Yes  
   - No
9. If you have pain, is it  □ Constant  □ Episodic

10. Location of most significant pain

11. Does pain radiate to  □ shoulder  □ arm  □ hand  □ buttock
    □ thigh  □ knee  □ foot  □ outside
    □ front  □ side of leg below knee  □ outside  □ top
    □ back  □ back of leg below knee  □ top
    □ side  □ front of leg below knee

**Ortho Pain Chart**

Mark the areas on the body image below where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

- Numbness =
- Pins & Needles =
- Burning =
- Stabbing =

Please indicate your pain level by circling the number that corresponds to your pain.

**Pain at its worst ▶**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;0&quot; = no pain to &quot;10&quot; = intolerable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pain at its best ▶**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;0&quot; = no pain to &quot;10&quot; = worst pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Which of the following best describes your pain or symptom ratio?
- 100% back/neck and 0% leg/arm pain or symptoms
- 75% back/neck and 25% leg/arm pain or symptoms
- 50% back/neck and 50% leg/arm pain or symptoms
- 25% back/neck and 75% leg/arm pain or symptoms
- 0% back/neck and 100% leg/arm pain or symptoms

3. Please choose letters (in second column) to answer the questions in column one.

   - How long can you sit? ________
     - A. Unable to tolerate
     - B. About 15 minutes only
     - C. About 30 minutes only
     - D. About 1 hour
     - E. Indefinitely

   - How long can you stand? ________
   - How long can you walk? ________

4. Which of the following activities change the nature of your pain?

<table>
<thead>
<tr>
<th>Aggravates Pain</th>
<th>Relieves Pain</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rising from sitting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leaning forward (brushing teeth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying on your side</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying on your back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying on your stomach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coughing/Sneezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bending forward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Treatments

Please indicate if you have undergone any of the following treatments listed and provide detail if appropriate.

Physical Therapy?  □ Yes  □ No  _____ times per week for _____ weeks.

Did you improve with physical therapy? ________________________________

Injection in your spine such as epidural steroid or facet block?

- Type __________________________ Date __________________________
  Did you get relief or improvement in your symptoms with this injection?  □ Yes  □ No

- Type __________________________ Date __________________________
  Did you get relief or improvement in your symptoms with this injection?  □ Yes  □ No

- ▶ TENS Unit  Helpful  □  Not Helpful  □  Not Used  □
- ▶ Traction  □
- ▶ Acupuncture  □
- ▶ Chiropractor  □
8. Please indicate whether or not you have had any of the following studies:
   ▶ Regular X-ray of spine  ☐ Yes  ☐ No
   ▶ CT Scan  ☐
   ▶ EMG/nerve conduction study  ☐
   ▶ CT Myelogram  ☐
   ▶ Discogram  ☐
   ▶ MRI  ☐
   ▶ Bone Scan  ☐

9. You have already provided us information about your present pain. Please give the approximate
dates of any other previous episodes of back problems and any treatment if applicable:

   Episode A: ___/___/___  Episode B: ___/___/___  Episode C: ___/___/___
   Treatment: ______________  Treatment: ______________  Treatment: ______________

10. Have you had spine surgery in the past?  ☐ Yes, How many times? _____  ☐ No
    If you answered “Yes”, please complete the following (types of surgery include laminectomy, decompression,
disc replacement, laminoplasty, fusion or unknown):

   Type of surgery  Date  Location/Surgeon
   ______________________  _________  ______________________
   ______________________  _________  ______________________

   Did you improve from your spine surgical procedure(s)?  ☐ Yes  ☐ No

Review of Systems

Please check any of the following symptoms that you have had in the past six months

Constitutional
☐ Night pain
☐ Night sweats
☐ Loss of appetite
☐ Fevers
☐ Weight Loss

Gastrointestinal
☐ Heartburn
☐ Blood in stool
☐ Constipation

Hematologic
☐ Easy Bleeding
☐ Bruising

ENT
☐ Difficulty swallowing
☐ Nose Bleeds

Cardiovascular
☐ Chest pain/Angina
☐ Palpitations/Irregular heartbeat
☐ Edema/Swelling

Respiratory
☐ Difficulty breathing
☐ Shortness of breath
☐ Chronic cough

Continued on next page...
Integumentary
- Rash
- Skin lesions

Psychiatric
- Depression
- Anxiety
- Mood swings

Genitourinary
- Difficulty with urination
- Burning with urination
- Impotence / Reduced sexual function

Neurologic
- Headaches
- Tremors
- Visual changes

Endocrine
- Heat/cold intolerance
- Rapid weight gain/loss

Immunologic
- Chronic infections
- Slow wound healing

** With your current symptoms, have you had loss of control of bowel or bladder function (incontinence)?
- Yes
- No

If yes, please describe


---

### Social History

Are you a cigarette smoker?
- Yes
- No, never
- Not currently, but I have smoked cigarettes in past

If current smoker, how much do you currently smoke per day?
____ packs/day OR ___ cigarettes/day for _____ years

If you are a former smoker how many cigarettes did you used to smoke?
____ packs/day OR ___ cigarettes/day for _____ years

Do you drink alcoholic beverages?
- Yes
- No, never
- Not currently, but I have in the past

If yes, please tell us your drinking habits:
I mostly drink (check all that apply)
- Beer
- Wine
- Liquor (mixed drinks/martinis)

Do you have alcoholic beverages daily?
- Yes
- No

If yes, how many drinks per day _____

Do you have alcoholic beverages weekly?
- Yes
- No

If yes, how many drinks per week _____

Do you have alcoholic beverages less than weekly, but at least monthly?
- Yes
- No

Are you married?
- Yes
- No

Do you have any children?
- Yes
- No

If yes, please list ages and gender


---

### Family History

Has anyone in your family had any of the following conditions?

Heart disease
- Yes
- No

Stroke
- Yes
- No

Cancer
- Yes
- No

(if yes, type: ________________)

Diabetes
- Yes
- No

Bleeding Complications
- Yes
- No

Anesthesia Problems
- Yes
- No
Medical History

Current height: _____ feet _____ inches  Current Weight: _________ lbs

Check any of the following illnesses that you have or have had in the past.

- High blood pressure
- High Cholesterol
- Asthma
- Stroke
- Lupus
- Anxiety
- Arthritis
- Diabeties
- GERD (reflux)
- COPD
- Heart attack
- Fibromyalgia
- Gout
- Atrial fibrillation
- Sleep apnea
- Cancer, what type
- Blood clot (pulmonary embolus or DVT)
- Parkinson's Disease
- Osteoporosis
- Thyroid disease
- Depression

Please list any and all other illnesses or injuries:

__________________________________________________________________________
__________________________________________________________________________

Do you have or have you ever had any of the following contagious or infections diseases?

- Hepatitis
- Tuberculosis
- HIV/AIDS

Other ____________________________

Are you or have you ever been under the care of a psychiatrist or psychologist?

- Yes  - No

If yes, what is or was the diagnosis ____________________________

List all previous surgeries (other than the back surgeries you have already discussed)

__________________________________________________________________________
__________________________________________________________________________

Medications

What medications and over the counter supplements do you take at the present time?

Please be as thorough as possible as this will go in your record. Attach a separate sheet if necessary.

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List any allergies to medications, latex or contrast dyes. Please include name and reaction.

- No known drug or latex allergies

__________________________________________________________________________
__________________________________________________________________________

FAILURE TO DISCLOSE ALL MEDICAL CONDITIONS and ALL MEDICATIONS COULD PUT YOUR HEALTH AT RISK, and MAY RESULT IN DISCHARGE FROM THIS PRACTICE.

I certify that all information provided is true and correct.

Signature ____________________________ Date ____________________________