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Spine & Pain ASSOCIATES
Feel Better, Live Better
www.spineandpainassociates.com

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New Patient History Form

Date: _____ Medical Record Number (to be filled in by practice):_____

First Name: _____ Middle: _____ Last: _____

Name you wish to be called in the office: _____

Age: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____

Cell: _____ Email: _____

Race: ☐ White ☐ Hispanic ☐ African-American ☐ Asian ☐ Native American ☐ Other ☐ Decline

Primary Language (if not English): _____

Referred By: Whom may we thank for referring you to our practice?

☐ Physician: Name: _____

Address: _____

Phone: _____ Email: _____

☐ Friend: Name: _____

☐ Website: (please list which one) _____

☐ Insurance Company Listing: _____

☐ Other: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Advanced Directive: ☐ None ☐ Living Will ☐ Healthcare POA/Proxy: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Education: Highest education level achieved:

☐ Post graduate ☐ College graduate ☐ High school graduate/GED ☐ Other: _____

Employment: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Homemaker ☐ Disabled ☐ Unemployed

Work Restrictions: ☐ Yes ☐ No

Occupation: _____

Employer Name: _____

Address: _____

Name of Contact person: First: _____ Last: _____

Phone Number: _____ Fax Number: _____

Reason for Visit

Reason for Visit Today: _____

_____

Pain severity with 0 being no pain and 10 being severe pain:

Current - 0 1 2 3 4 5 6 7 8 9 10

Average pain over the last month: _____ Worst pain: _____ Least pain: _____

Onset

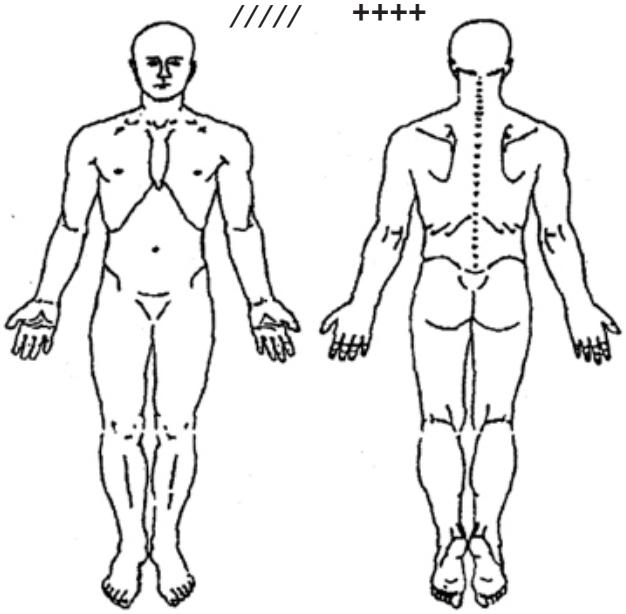
When did symptoms begin? _____

☐ Post-surgery ☐ Medical Illness ☐ Fall ☐ Auto Accident ☐ Work Injury/Date: _____

☐ Other: _____

Using the symbols given below, mark the area on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
ΔΔΔΔ	−−−−−	ooooo	xxxx	/////	++++



Neck pain % _____
Arm pain % _____
Total % _____

Back pain % _____
Leg pain % _____
Total % _____

Pain Quality – check all that apply
- ☐ Dull/Aching
- ☐ Numbness/Tingling
- ☐ Shooting/Stabbing
- ☐ Stinging/Burning/Hot
- ☐ Throbbing

Do the symptoms radiate? ☐ Yes ☐ No
If so, where? _____
_____

Additional symptoms
- ☐ Spasm
- ☐ Swelling
- ☐ Restless leg
- ☐ Loss of Balance
- ☐ Stiffness
- ☐ Itching
- ☐ Tenderness

Pain Pattern
Current pain began: ☐ Gradually ☐ Suddenly

Pain occurs: ☐ Constantly ☐ Occasionally ☐ Worse in morning ☐ Worse at night ☐ Worse with activity

Since pain began, it has: ☐ Decreased ☐ Increased ☐ Stayed the same

Pain is Worse with:
- ☐ Rest
- ☐ Bending Backward
- ☐ Coughing/Sneezing
- ☐ Twisting
- ☐ Walking
- ☐ Activity
- ☐ Overhead Activity
- ☐ Sit to Stand
- ☐ Turning Head
- ☐ Running
- ☐ Weather Change
- ☐ Climbing Steps
- ☐ Lying Down
- ☐ Sitting/Driving
- ☐ Other: _____
- ☐ Bending Forward
- ☐ Limb Position
- ☐ Lifting
- ☐ Standing

Pain Improves with:
- ☐ Rest
- ☐ Position change
- ☐ Activity
- ☐ TENs
- ☐ Cold
- ☐ Exercise
- ☐ Heat
- ☐ Massage
- ☐ Chiropractic

☐ Injections _____

☐ Medication _____

First Initial: _____ *Last Name:* _____

continued

Treatment History ☐ No prior treatments for current symptoms

Treatment	When, how long	Helped (Yes/No)	Facility/ Provider
Acupuncture			
Brace			
Chiropractor			
Injections			
Massage			
Physical Therapy			
TENs unit			
Other			

Consultations

Type of Consult	Provider	Date/Timeframe
Spine Surgeon		
Orthopedic Surgeon		
Pain Specialist		
Neurologist		
Rheumatologist		
Podiatrist		
Psychiatrist		
Psychologist		

Medications - Check all medications that you have tried for pain control

Over the counter

☐ Acetaminophen (Tylenol) ☐ Aspirin ☐ Ibuprofen ☐ Naprosyn ☐ Patches ☐ Creams/Ointments
☐ Other: _____

Muscle Relaxers

☐ Cyclobenzaprine (Flexeril) ☐ Methocarbamol (Robaxin) ☐ Baclofen ☐ Tizanidine (Zanaflex)
☐ Metaxolone (Skelaxin) ☐ Chlorzoxazone (Lorzone) ☐ Diazepam (Valium) ☐ Carisoprodol (Soma)

Neuromodulating

☐ Gabapentin (Neurontin) ☐ Horizant ☐ Gralise ☐ Amitriptyline (Elavil)
☐ Pregabalin (Lyrica) ☐ Duloxetine (Cymbalta) ☐ Other: _____

Opiates

☐ Codeine (e.g. Tyl #3) ☐ Tramadol (Ultram/Ultracet) ☐ Hydrocodone (Norco, Lortab, etc.)
☐ Oxycodone (Percocet, etc) ☐ Morphine Sulfate ☐ Hydromorphone (Dilaudid)
☐ Oxymorphone (Opana) ☐ Tapentadol (Nucynta)
☐ Long-Acting Opiates: _____ ☐ Other: _____

Diagnostic Tests/Imaging Studies ☐ None

Test	Body Site	Date	Facility
X-ray			
CT Scan			
Myelogram			
MRI			
DEXA Scan			
Bone Scan			
EMG/NCS			
Other			

Medical History

Medical Conditions – Check all conditions that have been diagnosed in the past

General/Medical
- ☐ Cancer – Type: _____
- ☐ Diabetes – Type: _____
- ☐ HIV/AIDS
- ☐ Hypothyroid
- ☐ Hyperthyroid

HEENT
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury

Cardiovascular
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Heart Attack (MI)
  When? _____
- ☐ High Blood Pressure (HTN)
- ☐ High Cholesterol
- ☐ Irregular Heart Beat

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Tuberculosis

Gastrointestinal
- ☐ Acid Reflux/GERD
- ☐ Bowel Incontinence
- ☐ Cirrhosis/Liver Failure
- ☐ Constipation
- ☐ Crohn's Disease/ Ulcerative Colitis
- ☐ GI Bleeding
  When? _____
- ☐ Hepatitis – Type: _____
- ☐ Irritable Bowel Syndrome (IBS)

Genitourinary/Kidney
- ☐ Bladder/Kidney Infections
- ☐ Chronic Kidney Disease
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Prostate Enlargement
- ☐ Urinary Incontinence

Hematologic
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Peripheral Vascular Disease

Neurologic
- ☐ Dementia/Alzheimer's
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Seizure/Epilepsy
- ☐ Spinal Cord Injury
- ☐ Stroke/TIA

Musculoskeletal
- ☐ Amputation/Phantom Limb Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Compression Fracture(s)
- ☐ Connective Tissue Disease
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Joint Disease/Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis

Psychiatric
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ Substance Abuse

Other: _____
_____
_____
_____

Medications

Please list all current medications, including over the counter medications, supplements and vitamins (may use another form if needed)

Medication	Dose	Frequency	Medication	Dose	Frequency

First Initial: _____ *Last Name:* _____

continued

Blood Thinners (Anticoagulants) Check all medications that you are currently taking ☐ Not on any blood thinners

☐ Aggrenox ☐ Coumadin (Warfarin) ☐ Effient ☐ Eliquis
☐ Lovenox ☐ Plavix ☐ Pradaxa ☐ Xarelto
☐ Other: _____

Drug Allergies ☐ No known drug allergies

Medication	Reaction

Are you allergic to any of the following?

☐ Betadine/Iodine ☐ Latex ☐ IV Contrast and/or Dye ☐ Shellfish ☐ Tape

Past Surgical History ☐ I have not had any surgical procedures

Abdominal Surgery:
☐ Appendectomy
☐ Gallbladder Removal
☐ Other: _____

Female Surgeries
☐ Caesarean Section
☐ Hysterectomy
☐ Laparoscopy
☐ Ovarian

Heart Surgery
☐ Aneurysm Repair
☐ Coronary Bypass
☐ Stent Placement
☐ Valve Replacement
☐ Other: _____

Joint Surgery
☐ Hip
☐ Knee
☐ Shoulder
☐ Other: _____

Spine/Back Surgery
☐ Discectomy (levels) _____
☐ Laminectomy _____
☐ Spinal Fusion (levels) _____
☐ Other: _____

Other Common Surgeries
☐ Hemorrhoid Surgery
☐ Hernia Repair
☐ Thyroidectomy
☐ Tonsillectomy
☐ Vascular Surgery

Please list any other surgeries and dates (Attach an additional sheet if necessary):_____

_____

Family History ☐ I have no significant family medical history ☐ I am adopted and no medical history is available

☐ Anxiety/Depression ☐ Heart Disease/Stroke ☐ Liver Problems
☐ Arthritis ☐ Headaches ☐ Rheumatoid Arthritis
☐ Cancer ☐ High Blood Pressure ☐ Seizures
☐ Diabetes ☐ Kidney Problems ☐ Substance Abuse

Social History

Alcohol Use: ☐ Never ☐ Social Alcohol Use ☐ Daily ☐ History of Alcoholism

Smoker or Tobacco Use: ☐ Never ☐ Occasional ☐ Current User ☐ Former User

Drug Use: ☐ I have never used any drugs illegally

☐ I am currently using illegal drugs, list: _____

☐ I am currently using someone else's prescription medications, list _____

☐ I formerly used illegal drugs (not currently using), list _____

☐ I have abused narcotic or prescription medications in the past, list _____

_____

☐ I have been treated in a Detox program _____

Review of Systems

Constitutional/Systemic:

☐ Chills/Night Sweats
☐ Difficulty Sleeping
☐ Easy Bruising
☐ Fevers
☐ Weight Loss
☐ Weight Gain

Eyes/Ears/Nose/Throat/Neck:

☐ Allergies/Runny Nose
☐ Difficulty Hearing
☐ Earaches/Ringing
☐ Nosebleeds
☐ Recent Visual Changes
☐ Recurrent Sore Throats
☐ Sinus Problems

Endocrine:

☐ Fatigue/Low Energy
☐ Heat/Cold Intolerance
☐ Increased Thirst
☐ Low Libido

Cardiorespiratory:

☐ Chest Pain
☐ Edema/Swelling in the Feet
☐ High Blood Pressure
☐ Lightheadedness
☐ Palpitations
☐ Shortness of Breath

Gastrointestinal:

☐ Constipation
☐ Diarrhea
☐ Nausea/Vomiting
☐ Reflux

Genitourinary/Nephrology:

☐ Frequent Urination
☐ Incontinence
☐ Painful Urination
☐ Pelvic Pain

Neurological:

☐ Dizziness
☐ Headaches
☐ Imbalance
☐ Loss of Memory
☐ Numbness/Tingling
☐ Seizures
☐ Weakness

Psychiatric:

☐ Anxiety/Stress
☐ Depressed Mood
☐ Hallucinations
☐ Suicidal Planning
☐ Suicidal Thoughts

Global Pain Scale

For each question please indicate your level of pain by picking a number from 0 to 10

A) Your pain experience 0=No Pain – 10=Extreme Pain

	0	1	2	3	4	5	6	7	8	9	10
My current pain is											
During the past week my *best* pain has been											
During the past week my *worst* pain has been											
During the past week my *average* pain has been											
During the past 3 months my *average* pain has been											

Total Group A: _____

B) Your feelings about your pain 0=Strongly Disagree – 10=Strongly Agree

	0	1	2	3	4	5	6	7	8	9	10
Afraid											
Depressed											
Tired											
Anxious											
Stressed											

Total Group B: _____

C) How your pain has affected you during the past week 0=Strongly Disagree – 10=Strongly Agree

	0	1	2	3	4	5	6	7	8	9	10
Had trouble sleeping											
Had trouble feeling comfortable											
Was less independent (e.g. needed help with some tasks)											
Was unable to work or perform most "normal" tasks											
Needed to take some medication for my pain											

Total Group C: _____

D) During the past week I was NOT able to: 0=Strongly Disagree – 10=Strongly Agree

	0	1	2	3	4	5	6	7	8	9	10
Go to the store and/or go shopping											
Do housework or other domestic chores											
Enjoy my friends, family or social occasions											
Exercise – including walking											
Participate in recreational interests or hobbies											

Total Group D: _____

Total Score: _____

First Initial: _____ Last Name: _____

continued

Additional Patient Information

Patients are asked to read and sign off on the items listed below.

Patient Name: _____

_____ 1. **Rescheduled Appointments and No-Shows:** We understand that plans change and emergencies may arise. Please notify us as soon as possible if you need to cancel or reschedule your appointment. Spine & Pain Associates, PLLC has a cancellation policy of 1 business day. Although we do not charge a fee for a missed appointment or short-notice cancellation, repeated missed appointments or cancellations within 24 hours may lead to a cancellation fee.

_____ 2. **Property Damage:** Spine & Pain Associates expects normal wear and tear on office equipment and furniture. However, we will hold you financially responsible for repair or replacement for damage that you or those who accompany you to our office may cause to office property. We welcome children and ask that you supervise them to prevent damage to office property.

_____ 3. **Recording Devices:** We prohibit the use of recording devices of any kind without prior written consent from the Practice Manager or one of the practice owners.