The Advanced Spine Center

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NAME: ________________________ DATE: ____________

MRN#: ________________________ AGE: ____________

Please describe your problem: ____

____

____

____

____

When did this problem start?(approx): ____________
Have you had unexpected weight loss?:____________
Does the pain wake you from sleep?:____________
How far can you walk?(city blocks):____________

Was there an injury?: ____________
Did this injury result in a lawsuit?: ____________
Is your bladder/urine function normal?: ____________
Is your bowel/feces control normal?____________

PHYSICIAN ONLY:

Rad Pain- ____

N/P- ____

Weakness- ____

B/B / N/P to A/G- ____

Gait/Bal/Fine Motor Skills- ____

____

Meds- ____

PT / Chiropractic- ____

Injections- ____

Surgeries- ____

Studies- ____

____

PE- ____

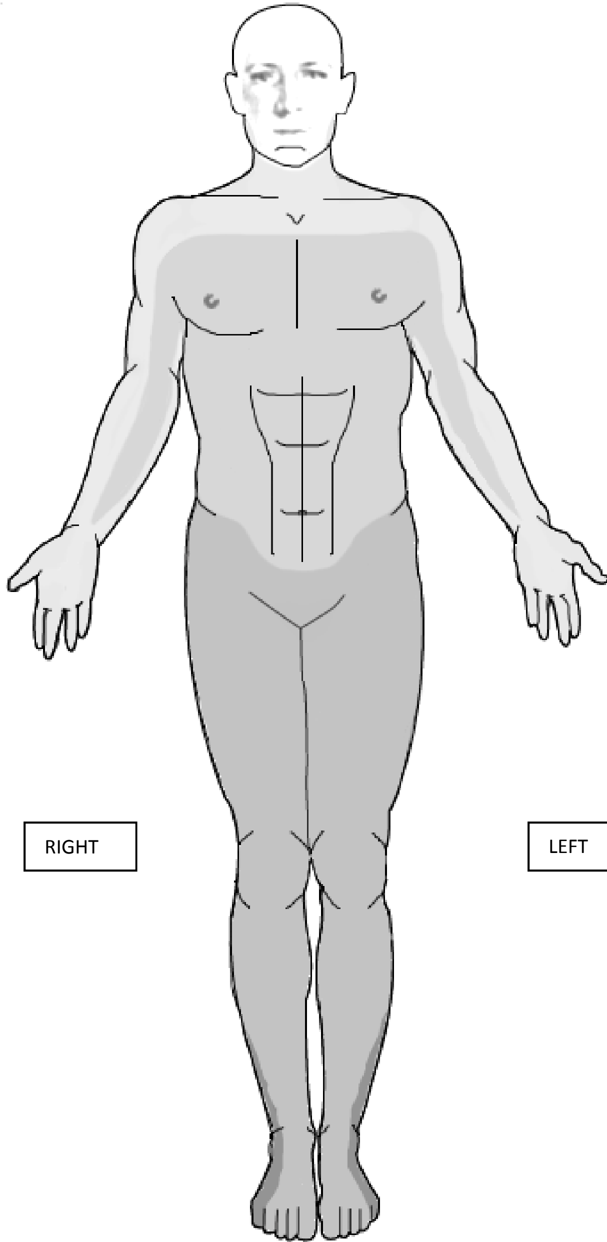
Assessment- ____

Plan: ____

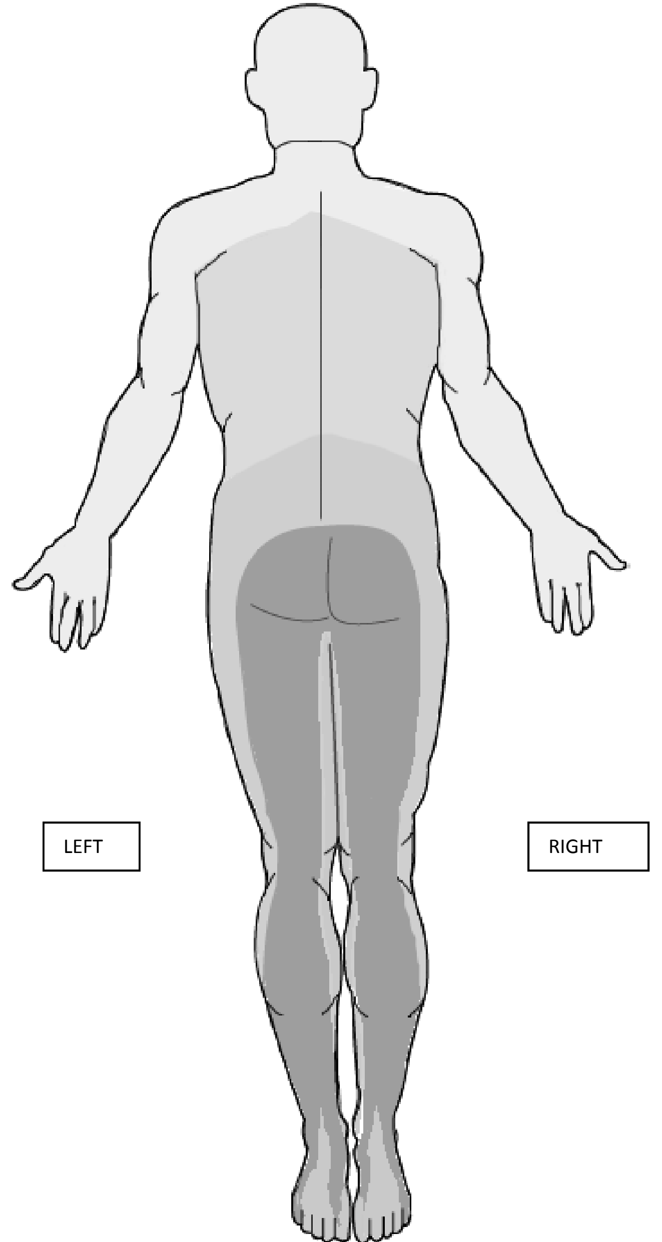
WHERE IS YOUR PAIN NOW?

Using the appropriate symbols, mark all of the areas on your body where you feel the sensations described below

PAIN x x x x   BURNING + + + +   TINGLING - - -   NUMBNESS o o o o



FRONT



BACK

My number one problem is:

____ back/neck pain   ____ arm/leg pain   ____ numbness/tingling   ____ weakness

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

GENERAL SYMPTONS: (CURRENTLY OR WITHIN THE LAST YEAR)

___CHILLS/SWEATS
___FEVER
___DIZZINESS
___HEADACHES
___RINGING IN EARS
___BLOOD IN URINE
___PAINFUL URINATION
___BLADDER/URINE ACCIDENTS
___BOWEL/FECAL ACCIDENTS

___DEPRESSION
___ANXIETY
___INSOMNIA
___LOSS OF APPETITE
___LOSS OF WEIGHT

___HIVES
___RASH
___ITCHING
___SORES
___EASY BRUISING

___STOMACH PAIN
___EXTREME THIRST
___NAUSEA
___BLOATING/GAS
___VOMITING BLOOD

MEN:
___ERECTILE DIFFICULTIES
___PENILE SORES
___PAINFUL INTERCOURSE

WOMEN:
___MENOPAUSE
___IRREGULAR MENSES
___PAINFUL INTERCOURSE

GENERAL CONDITIONS: (NOW OR IN THE PAST)

___CANCER
___HIGH BLOOD PRESSURE
___DIABETES
___RHEUMATOID DZ
___STROKE

___SEIZURES
___EMPHYSEMA
___ASTHMA
___GOUT
___STOMACH ULCERS

___BLEEDING DISORDER
___ANEMIA
___ANOREXIA/BULIMIA
___DEPRESSION
___PSYCHIATRIC CARE

___ALCOHOLISM
___DRUG DEPEND.
___SERIOUS INFEC.
___SEX. TRANS. DZ
___AIDS/HIV

PAST MEDICAL HISTORY: (PROBLEMS/CONDITIONS/DISEASES THAT YOU HAVE OR HAVE HAD IN THE PAST)

___HEART PROBLEMS
___LUNG
___KIDNEY
___LIVER
___NEUROLOGIC
___RHEUMATOID
___BOWEL
___THYROID
___GENITO-URINARY

____
____
____
____
____
____

ANTECEDENT HISTORY: (IF YES: PLEASE DESCRIBE AND GIVE DATES)

PRIOR WORKER'S COMPENSATION INJURIES: YES / NO ______________________________

____

PRIOR MOTOR VEHICLE ACCIDENTS: YES / NO ______________________________

____

PRIOR SYMPTOMS/STUDIES/TREATMENTS/CHIROPRACTOR VISITS: YES / NO ______________________________

____

PAST SURGICAL HISTORY:

SURGERY	DATE	SURGERY	DATE

MEDICATIONS: (CURRENTLY)

NAME DOSAGE NAME DOSAGE

____

____

____

____

____

____

____

PHARMACY NAME: ______________________ STREET: ______________________ TOWN: ____________

ALLERGIES: (ESPECIALLY TO MEDICATION)

MEDICATION REACTION MEDICATION REACTION

____

____

____

ARE YOU ALLERGIC TO: ❑ LATEX ❑ NICKEL ❑ NONE

SOCIAL HABITS:

DO YOU SMOKE? ❑ _____ HOW MUCH PER DAY? ____________________

DO YOU DRINK ALCOHOL? ❑_____ HOW MUCH/HOW OFTEN? ____________________

DO YOU USE OTHER DRUGS? ❑_____ 3RD WORLD COUNTRY TRAVEL? ____________________

FAMILY HISTORY:

ARE YOU MARRIED? ❑_____

HOW MANY CHILDREN DO YOU HAVE? _____ AGES: ____________________

DO ANY FAMILY MEMBERS HAVE OR HAVE HAD ANY SIGNIFICANT MEDICAL PROBLEMS? ____________________

____

OCCUPATIONAL HISTORY:

DO YOU CURRENTLY WORK? ❑_____ OCCUPATION: ____________________

WHO REFERRED YOU TO OUR OFFICE?____

WHO IS YOUR GENERAL PHYSICIAN? ____

TOWN: ____________________________

*** **WOMEN: IF YOU MAY BE PREGNANT BE SURE TO TELL THE DOCTOR OR THE TECHNICIAN PRIOR TO ANY X-RAYS.** ***

I CERTIFY THAT THE ABOVE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT'S SIGNATURE: ______________________ PHYSICIAN'S SIGNATURE: ______________________