HOUSTON SPINE INSTITUTE

Please check answers to questions that pertain to your problem. You may select more than one answer per questions. This information will help get an accurate appraisal of your problems, develop an appropriate plan of treatment, and will be included in your visit note. If you have any questions, please ask for assistance.

Referred By_____. Is this a second opinion? _____.

NAME: _____. DATE_____. Date of Birth_____

AGE_____SEX: ☐Male ☐Female ARE YOU: ☐Right Handed ☐Left Handed ☐Ambidextrous
OCCUPATION: _____

COMPLAINT: (What are you being seen for?)

- ☐ Neck Pain
- ☐ Neck pain with headaches
- ☐ Upper back Pain
- ☐ Lower Back Pain
- ☐ Right Leg pain
- ☐ Left Leg Pain
- ☐ Right Arm Pain
- ☐ Left Arm Pain
- ☐ Scoliosis
- ☐ Other

Do you Have Any:
☐Weakness
☐ Numbness
☐Tingling
☐If So Where? _____
Describe _____

If one or more of the above is chosen, which is the most problematic? _____

Which term best describes your neck/back pain?
☐ Sharp ☐ Stabbing ☐Burning ☐Like Electricity ☐Dull Ache ☐Pins and needles

Which term best describes your Arm/leg pain?
☐ Sharp ☐ Stabbing ☐Burning ☐Like Electricity ☐Dull Ache ☐Pins and needles

When did the problem start? _____

If problem was caused from an injury, what is the date of injury? _____
Was the injury Job related? ☐YES ☐NO

How did the injury occur?
☐No injury ☐Motor vehicle Accident – No litigation ☐ Motor vehicle Accident – Litigation pending
☐ Motor vehicle Accident – Litigation Complete ☐Fall ☐Sports or recreation ☐Job related
☐ Other_____

If motor vehicle accident, were you:

☐ Driver ☐ Front seat passenger ☐Rear Seat passenger ☐Motorcycle Driver ☐Other _____

Were you wearing a seat belt? ☐YES ☐NO
Other injuries due to this condition: ☐ None ☐ Yes, Explain _____
Please briefly explain the circumstances that led to your condition:

_____

_____

_____

_____

What treatments have you already received for this condition?
☐ Medications (list) _____
☐Physical Therapist (how many weeks?) _____ ☐Chiropractor (how long) _____
☐Epidural Injections: How Many injections? _____ When was the last Injection_____
☐ (Please list) Other_____

Since the pain/condition began it:
☐ Has improved ☐Has worsened ☐ Has stayed the same ☐ Fluctuates (comes and goes)

What time of the day is the pain most intense?
☐On first rise in the morning ☐ During the daytime or while at work ☐ At the end of the day before bedtime
☐ During the night

What aggravates the pain?
☐ Walking ☐ Standing ☐Sitting ☐Lying down ☐Activity in general ☐Stooping/bending Sharp
☐ Nothing in particular ☐ Other

What makes the pain better?
☐ Standing ☐Sitting ☐Lying down ☐Stooping/bending Sharp ☐Nothing in particular ☐Other

Does the pain awaken you from sleep?
☐ Never ☐Occasional ☐Frequently

Does the pain keep you from sleep?
☐ Never ☐Occasional ☐Frequently

Do you have any difficulty walking?
☐ No
☐ Yes, can walk unlimited distances
☐ Yes, can walk less than a mile
☐ Yes, can walk only 1-2 blocks
☐Yes, can walk less than 1 block
☐ Yes, non-ambulatory (cannot walk)

Is walking difficulty related to this problem?
☐ Yes
☐ No, Explain _____

Have you had any problems with bowel, bladder, or sexual functions since this condition began?
☐ No
☐ Yes: please explain_____

Have you had a previous back or neck problem?
☐ No
☐ Yes: please explain_____
Do you exercise regularly?
☐ No
☐ Yes: How often?_____

PAST MEDICAL/SURGICAL HISTORY

Do you have any of this medical conditions?

☐Diabetes	☐High blood pressure	☐Heart disease	☐Cancer/tumor	☐Ulcers
☐ Lung disease	☐ Circulation problems	☐High Cholesterol	☐Liver disease	☐Stroke
☐ Kidney disease	☐Hepatitis	☐Immune Disorder	☐ Seizure	☐Asthma
☐ Thyroid Disorder	☐Headaches	☐Osteoarthritis	☐Eye problems	
☐Mental Disorder	☐Rheumatoid Arthritis	☐Other _____		

Have you ever had neck or back (spine) Surgery?
☐No
☐ Yes: How Many? _____

Please list previous neck and back (spine) surgeries.

Date	Place	Surgeon	Procedure
_____	_____	_____	_____
_____	_____	_____	_____

Please list other surgeries besides spine:

Date	Place	Surgeon	Procedure
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT MEDICATIONS:

Name	Dose	for what problem?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES:
☐ No known Drug Allergies? Including iodine/contrast dye or shellfish
☐ Yes, Please List_____

SOCIAL AND FAMILY HISTORY
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
How many Children do you have? _____
What is the highest level of education you have completed?
☐Some high School ☐High School ☐Trade School ☐College ☐Professional School
Do you smoke ☐No ☐Yes: packs per day_____?
Do you smoke pipe ☐No ☐Yes: how often? _____

Do you smoke ☐No ☐Yes: packs per day? _____
Do you use smokeless tobacco? ☐No ☐Yes: packs per day_____
Did you ever smoke regularly before? ☐No ☐Yes: packs per day_____
Current Employment Status:
☐ Regular ☐part time ☐retired ☐Unemployed ☐ Student ☐other _____

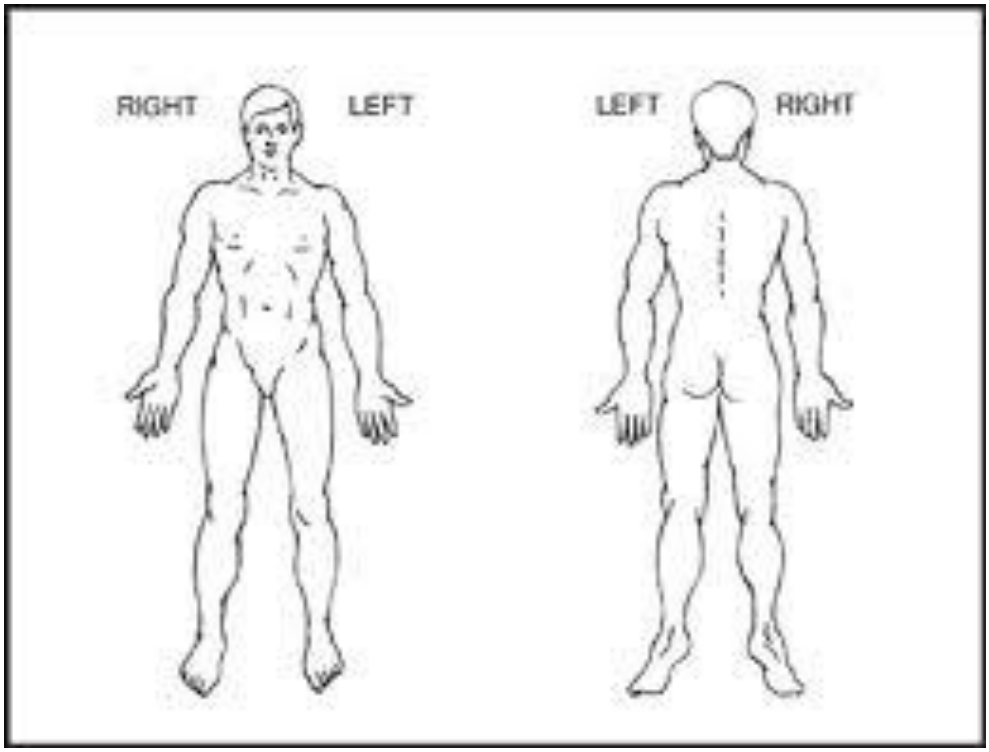
FAMILY HISTORY: Do you have any <u>family</u> history of any of these diseases? (Check all that are appropriate)
☐None ☐ neck or back problems ☐Diabetes ☐High blood pressure ☐Heart Disease
☐Stroke ☐Rheumatoid Arthritis ☐Cancer ☐Osteoarthritis ☐Scoliosis
☐Other _____

<u>REVIEW OF SYSTEMS (check all that appropriate)</u>

GENERAL:	☐ Weight gain	☐Weight loss	☐fever	☐ chills	☐night sweats
SKIN:	☐ Changes in Mole	☐Breast Lumps			
EYES:	☐ Loss of vision	☐Double vision			
ENT:	☐ Hearing loss	☐Nose bleeds			
GI:	☐ Nausea	☐Vomiting	☐Heartburn	☐ change in bowel habits	
RESPIRATORY:	☐ Coughing/Wheezing	☐Shortness of breath			
HEART:	☐ Chest pain	☐Palpitations	☐ fainting		
GU:	☐ Frequent urination	☐Blood in urine	☐Difficulty with Urination		
VASCULAR:	☐ Swelling in legs	☐Blood clots			
MUSCLE:	☐ Muscle weakness	☐Stiffness	☐ Joint pain		
PSCH:	☐ Anxiety	☐Depression	☐ Confusion	☐ Memory loss	

<u>PAIN ASSESMENT FORM</u>

Draw the location of your pain on the figures below.
For Symptoms of pain, fill in the affected area with the following pattern: xxxxxxxxxx
For symptoms of numbness and or tingling, fill in the affected area with the following pattern: ooooooooooo



Doctor Signature _____