NORTHSIDE HOSPITAL
ORTHOPEDIC INSTITUTE

SPINE

Date:_____

Name:_____

Date of Birth:_____ Age:_____ Height:_____

Weight: _____ Sex: M / F Handedness: Right / Left

Primary Care Physician: _____

Who referred you? _____

COMPLAINT/PROBLEM TODAY:_____

Date of injury/Accident/Onset of problem _____

SYMPTOMS (circle all that apply):

Back Pain Neck Pain Arm Pain Leg Pain

1. **The pain has been present for:**
   _____ days _____ weeks _____ months _____ years
2. **Circle Pain Level TODAY:** 0 = none 10 = worst
   [----------]
   0 1 2 3 4 5 6 7 8 9 10
3. **Level of pain on worst day:** (0-10, 10=worst)_____
4. **Is the pain** *(circle)***?** constant **or** comes and goes
5. **Is the pain** *(circle all that apply)***?**
   Sharp Dull Stabbing Aching Burning Stiffness
6. **Does the pain go down the arms or legs?** Yes No **If yes:**
   Arms: Right Left Both
   Legs: Right Left Both
7. **Do you have weakness?** Yes No **If yes:**
   Arms: Right Left Both
   Legs: Right Left Both
8. **Do you have numbness?** Yes No **If yes:**
   Arms: Right Left Both
   Legs: Right Left Both
9. **Is the pain worse when** *(circle all that apply)***?**
   Sitting Standing Walking Bending Lifting
   Twisting Lying down Morning Night
10. **The pain is better when** *(circle all that apply)***?**
    Sitting Standing Walking Lying down
    Morning Night
11. **Does the pain wake you up at night?** Yes No
12. **Do you have fever, chills or sweats?** Yes No
13. **Do you have trouble standing for a long time?** Yes No
    If Yes: _____ minutes
14. **Do you have trouble walking for a long time?** Yes No
    If Yes: _____ minutes
15. **Any difficulty with bowel or bladder?** Yes No
    Describe:_____
16. **Do you drop things with your arms/ hands?** Yes No
17. **Are you clumsy with your hands?** Yes No

TREATMENT HISTORY: For Spine condition

Medications: Yes No **If Yes:**
Anti Inflammatory: Yes No _____
Muscle relaxants: Yes No _____
Pain Medicine: Yes No _____
_____
Other:_____

Have you had Physical Therapy: Yes No
When? _____
Chiropractic: Yes No When?_____
Home Exercises? Yes No _____

Have you had injections for spinal pain? Yes No
Epidural Steroid Injection? Yes No When?_____
Nerve Block? Yes No When? _____
Facet Block? Yes No When?_____

Have you had Spine Surgery? Yes No **If Yes**, what type?
_____
Names of Doctors that have treated you before for this problem:
_____

TESTS you have had (circle all that apply):

X-ray CT Scan MRI Myelogram Discogram
EMG/NCS DEXA Bone Scan

INJURY: Did you have an injury to cause pain? YES NO

Work Related? Yes No Date _____
Auto Accident? Yes No Date_____
Other type of injury:_____
Date of injury: _____
Litigation Pending? Yes No

SPINE - HISTORY OF PRESENT ILLNESS/INJURY

PREVIOUS EPISODES:

Have you had Neck Pain/Arm Numbness/Arm Weakness BEFORE this episode? Yes No

When? _____

Have you had Back Pain/Leg Numbness/Leg Weakness BEFORE this episode? Yes No

When? _____

OCCUPATIONAL HISTORY (circle all that apply):

Regular Duty Light Duty Not Working

Disabled Unemployed Retired Homemaker

Not working due to back/neck problems

Not working due to another health problem

Occupation: _____

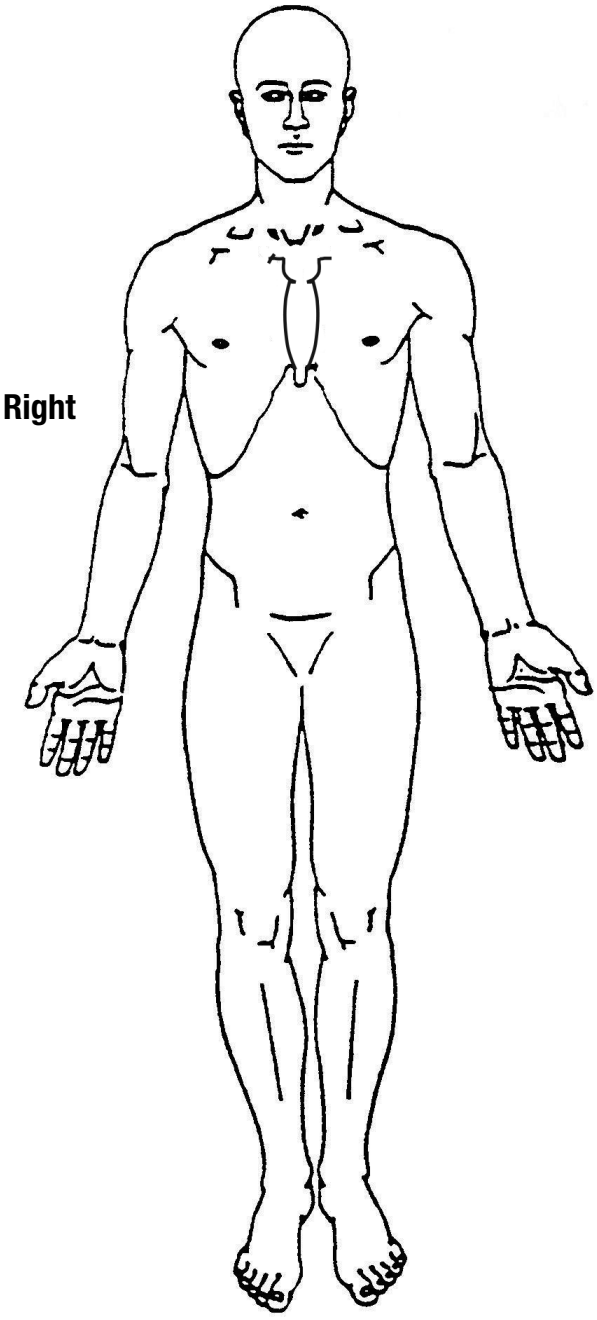
Employer: _____

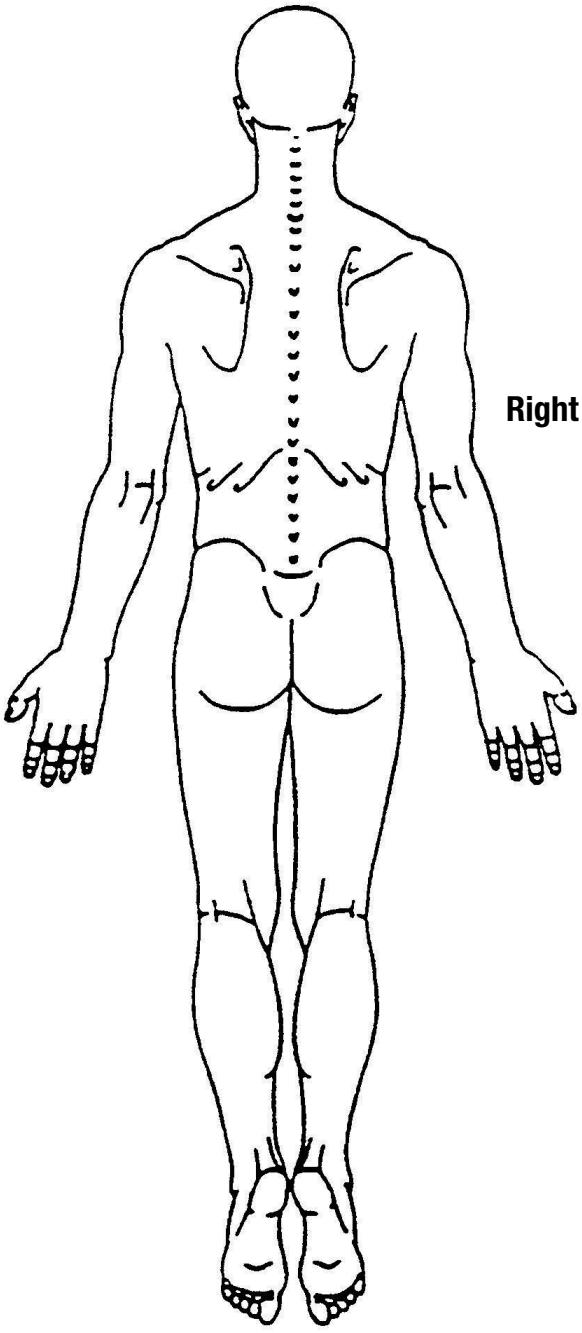
How long have you worked there? _____ Months _____ Years

PAIN DRAWING

Mark these drawings according to where you hurt (i.e., if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

Key: Stabbing /// Burning XXX Pins & Needs 000 Numbness === Aching +++





Past Medical History	
☐ High blood pressure	☐ Kidney disease ☐ Kidney stones
☐ Diabetes If yes, do you use insulin? _____	☐ HIV or AIDS ☐ Hepatitis Type _____
☐ Thyroid problems	☐ Tuberculosis ☐ Tick bite ☐ MRSA history
☐ Heart disease ☐ Heart attack ☐ Pacemaker	☐ Depression or psychiatric disorder
☐ Cancer Type?_____	☐ ADD/ADHD
☐ Blood clots (DVT/pulmonary embolism)	☐ Sickle cell anemia ☐ Anemia ☐ Bleeding problems
☐ Stroke ☐ Peripheral neuropathy	☐ Rheumatoid arthritis
☐ Rash/skin lesions	☐ Osteoporosis ☐ Osteoarthritis
☐ COPD ☐ Emphysema ☐ Asthma	☐ Seizures
☐ Concussion	☐ Trouble with anesthesia
☐ Reflux/GERD or ☐ Stomach ulcer	☐ Sleep apnea ☐ Use of CPAP
☐ Gout	☐ Other:_____

Family History (Please list family member) ☐ None
☐ High blood pressure
☐ Diabetes
☐ Heart disease
☐ Rheumatoid arthritis
☐ Cancer Type?_____
☐ Blood clots (DVT/pulmonary embolism)
☐ Bleeding problems
☐ Stroke
☐ Osteoporosis
☐ Asthma
☐ Trouble with anesthesia
☐ Other _____

Review of Systems				☐ None
Constitutional	☐ Fever	☐ Chills	☐ Weight loss	☐ Night sweats
Eyes	☐ Blurred vision	☐ Double vision	☐ Vision loss	
Ear/Nose/Throat	☐ Earache	☐ Hearing loss	☐ Throat pain	☐ Nose bleeds
Cardiovascular	☐ Chest pain	☐ Fast heart rate	☐ Palpitations	
Respiratory	☐ Cough	☐ Sleep apnea and ☐ Use of CPAP	☐ Difficulty breathing	☐ Wheezing
Gastrointestinal	☐ Nausea/vomiting	☐ Heartburn/ulcers	☐ Blood in stool	☐ Diarrhea
Genitourinary	☐ Painful urination	☐ Frequent urination	☐ Bladder/bowel changes	☐ Blood in urine
Musculoskeletal	☐ Joint stiffness	☐ Muscle aches	☐ Joint pain	☐ Muscle weakness
Skin	☐ Itching	☐ Skin lesion	☐ Skin rash	☐ Heat/cold tolerance
Neurologic	☐ Dizziness	☐ Vertigo	☐ Fainting	☐ Sensory/motor disturbances
Psychiatric	☐ Depression/Anxiety	☐ Drug/alcohol addiction	☐ Claustrophobic	☐ Sleep disorder ☐ Under care of Psychiatrist
Hematologic	☐ Easy bleeding	☐ Easy bruising	☐ Anemia	
Immunologic	☐ Hives	☐ Persistent infections		

List previous surgeries and dates: ☐ None

1. _____ Date:_____
2. _____ Date:_____

List current medications, dosages, and directions: ☐ None

1. _____ 3. _____
2. _____ 4. _____

List allergies and reactions: ☐ No known allergies

1. _____ 3. _____ ☐ **Latex** ☐ **Iodine**
2. _____ 4. _____ ☐ **Metal/Nickel**

Social History:

- Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
- Tobacco use: ☐ None ☐ Previous ☐ Current _____Amount/day
- Alcohol use: ☐ None ☐ Previous ☐ Current _____Amount/day
- Illegal drug use: ☐ None ☐ Previous ☐ Current If yes, what drug(s)? _____
- Physical Activity: How many days a week do you get moderate exercise? (e.g. Brisk walk) _____
  Duration: (e.g. Minutes) _____
- Are you currently **pregnant?**: ☐ Yes ☐ No **Nursing?**: ☐ Yes ☐ No
- Do you have any concerns about your safety?: ☐ Yes ☐ No

- **Flu shot** (this season): ☐ Yes (Date: _____) ☐ No ☐ Declined
- **Pneumonia shot** (if over 65): ☐ Yes (Date: _____) ☐ No

Signature:_____ Print name:_____ Date:_____

SPINE - HISTORY OF PRESENT ILLNESS/INJURY