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ORTHOPAEDIC SURGERY

SPINE HISTORY FORM

Name: _____ Date: _____
Age: _____ Birthdate: _____ Sex: Male / Female Height: _____ Weight: _____
Occupation: _____
Primary Care Doctor: _____
Who referred you here?: _____

Chief Complaint (reason why you are here):

History of present problem:

Date problem began: _____

Is this a work-related or auto injury?: _____

Did problems begin following:

A fall Lifting Work injury Recreational injury Automobile accident No apparent cause

Where is the pain located?: _____

Is the pain: better same worse than when it started?

Describe the quality of pain: (e.g., burning, stabbing, throbbing) _____

Is the pain:

Constant Constant but worse with activity Intermittent (comes and goes) Intermittent, but worse with activity

What makes the pain worse?:

Walking Bending Sneezing Coughing Sitting Standing Other: _____

Is there a time of day when it is worse?: Yes No If yes, when?: Morning Evening Night

Does the pain wake you up at night?: Yes No

Do you have?: Fevers Chills Unexplained weight loss None of these

Do you have "pins and needles" in your feet/hands?: Yes No If yes, which?: Feet Hands

Do you have numbness in your feet/hands?: Yes No If yes, which?: Feet Hands

Do you have weakness in your arms or legs?: Yes No If yes, which?: Arms Legs

Do you have full control of your bowel and bladder?: Yes No If no, explain: _____

Are you able to perform your usual activities of daily living?: Yes No

Have you had surgery for this problem?: Yes No If so, describe date, surgeon & procedure: _____

Did surgery help? Yes No Explain: _____

CHECK ANY STUDIES YOU HAVE HAD FOR CURRENT PROBLEM:

- Diagnostic X-rays
- CT (computed tomography)
- Discogram
- Arthrogram/sonogram
- MRI (magnetic resonance imaging)
- Myelogram (x-ray w/spinal injury)
- Electromyogram (EMG)

CHECK ANY TREATMENTS YOU HAVE HAD FOR CURRENT PROBLEM:

How long did you have treatment?

- Physical Therapy _____
- Home strengthening/stretching _____
- Home exercises _____
- Acupuncture _____
- Chiropractic _____
- Epidural spine injections _____
- Massage _____
- Other (please explain) _____

Have any treatments ever made the pain better? Yes No

If yes, which treatment helped?: _____

PATIENT PAIN DRAWING

Mark the areas of your body where you feel the pain and/or sensations below, using the appropriate SYMBOL. Mark the areas where your pain radiates, include all affected areas.

SYMBOLS

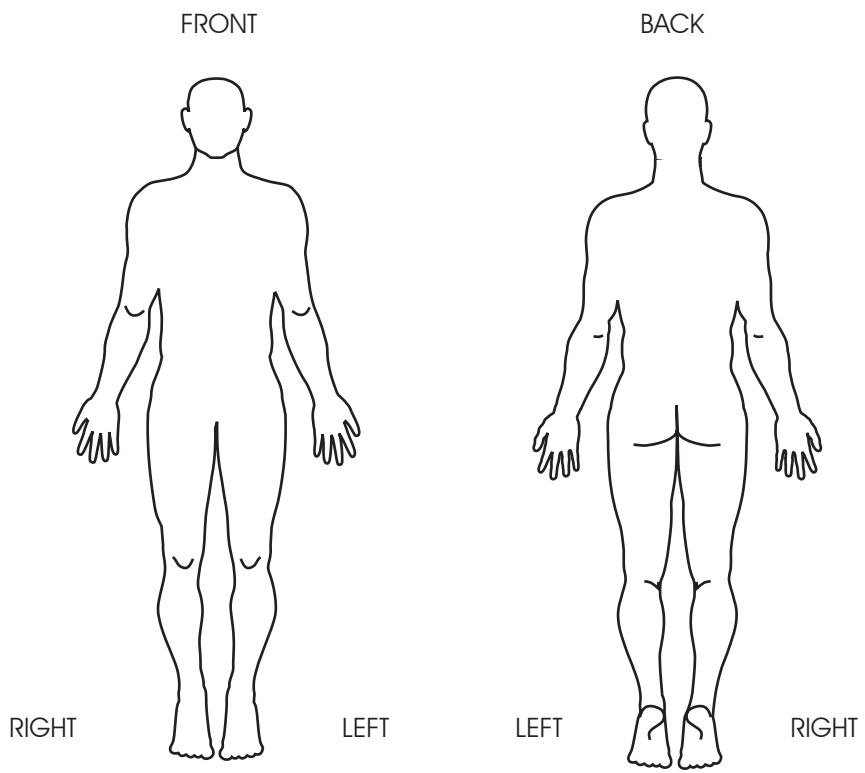
Aching/Pain
^ ^ ^

Numbness
= = =

Pins & Needles
o o o

Burning
x x x

Stabbing
/ / /



PAIN SCALE (MARK LINE)

This is a pain scale from "0" (no pain) to "10" (torture pain). Please choose a number that best fits your pain complaints for your "AVERAGE" pain and your "WORST" pain in whatever area(s) hurt.



Worst pain you've ever had		0	1	2	3	4	5	6	7	8	9	10
Current neck pain	AVERAGE	0	1	2	3	4	5	6	7	8	9	10
	WORST	0	1	2	3	4	5	6	7	8	9	10
Current arm pain	AVERAGE	0	1	2	3	4	5	6	7	8	9	10
	WORST	0	1	2	3	4	5	6	7	8	9	10
Current mid-back pain	AVERAGE	0	1	2	3	4	5	6	7	8	9	10
	WORST	0	1	2	3	4	5	6	7	8	9	10
Current low-back pain	AVERAGE	0	1	2	3	4	5	6	7	8	9	10
	WORST	0	1	2	3	4	5	6	7	8	9	10
Current leg pain	AVERAGE	0	1	2	3	4	5	6	7	8	9	10
	WORST	0	1	2	3	4	5	6	7	8	9	10

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____