

# Jacob D. Rozbruch, M.D.

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

**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**

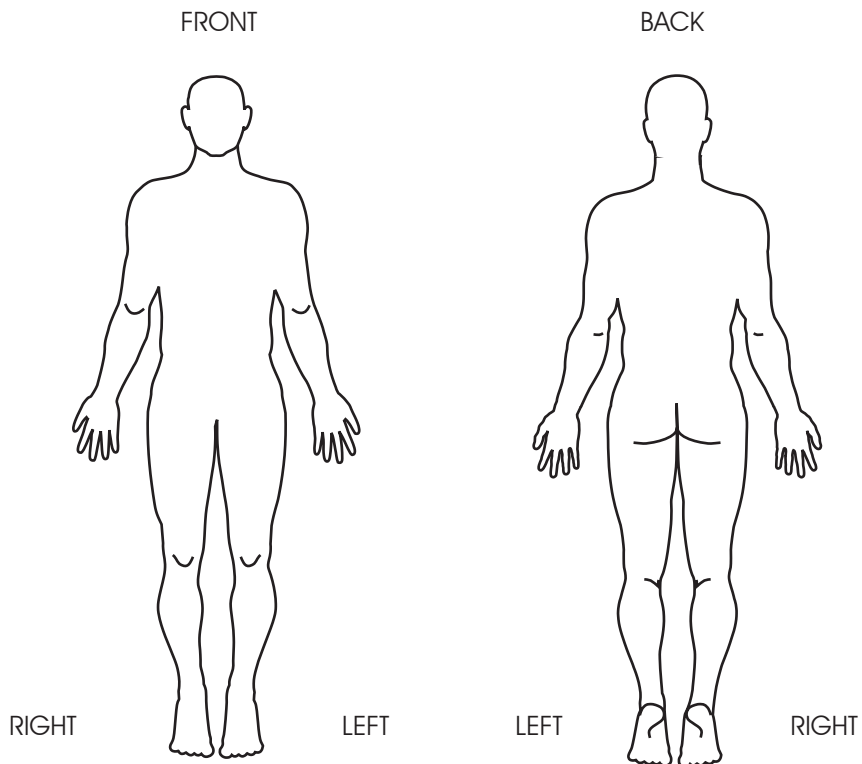
Aching/Pain  
^ ^ ^

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: \_\_\_\_\_