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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)
- ☐ Electromyelogram (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

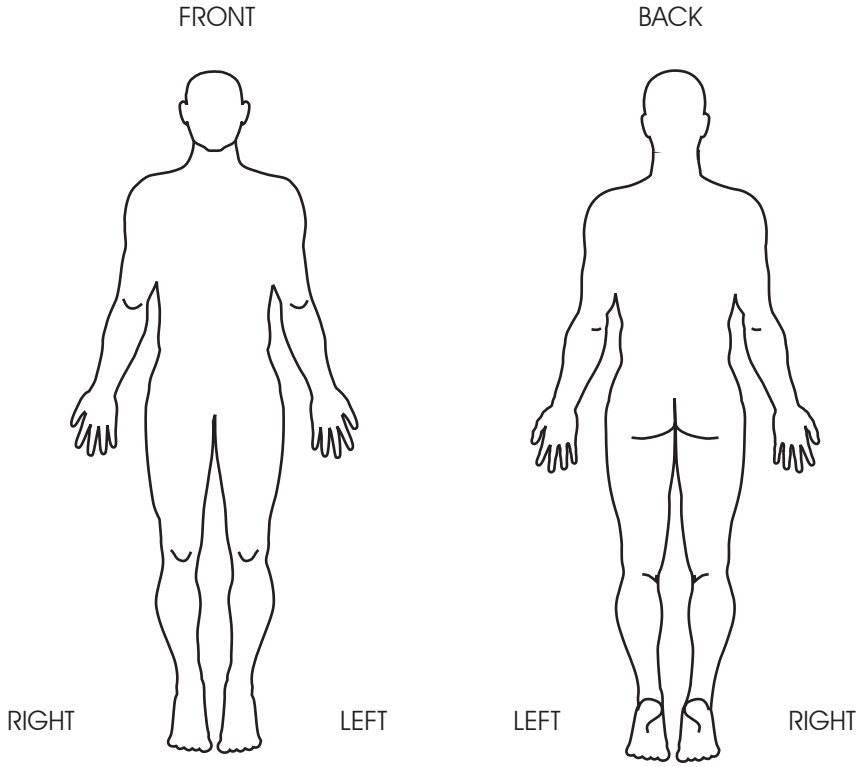
Aching/Pain
^ ^ ^

Numbness
= = =

Pins & Needles
ooo

Burning
xxx

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: _____