



## NEW PATIENT HISTORY

Please answer all of the following questions in as much detail as possible. You may select more than one answer per question. Feel free to add additional information in the margins. Please note that each page is double-sided. This information will help in getting an accurate appraisal of your problems and develop an appropriate plan of treatment. If you have any questions or difficulty, please ask for assistance. Thank you for taking your time to fill this out completely.

Your Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Today's Date: \_\_\_\_\_

Sex:  M  F S.S. #: \_\_\_\_\_ Medical Record #: \_\_\_\_\_ Doctor: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

A copy of your clinic note will be sent to this doctor unless you check this box. No

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Who referred you to our office? \_\_\_\_\_ Phone: \_\_\_\_\_

A copy of your clinic note will be sent to this doctor unless you check this box. No

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Insurance Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

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What happened to cause your injury or pain?

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What is your chief complaint?

- Neck Pain
- Upper Back Pain
- Lower Back Pain
- Right Leg Pain
- Left Leg Pain
- Pain in Both Legs
- Right Arm Pain
- Left Arm Pain
- Pain in Both Arms
- Scoliosis
- Other - Specify \_\_\_\_\_

How did the injury occur?

- None
- Motor Vehicle Accident - No Lawsuit
- Motor Vehicle Accident - Lawsuit Pending
- Motor Vehicle Accident - Lawsuit Complete
- Fall
- Sports or Recreation
- Job Related
- Other - Specify \_\_\_\_\_

Was the injury job related?

- Yes
- No

If motor vehicle accident, were you?

- Driver
- Front Seat Passenger
- Rear Seat Passenger
- Motorcycle Driver
- Motorcycle Passenger
- Truck Driver
- Truck Passenger
- Other - Specify \_\_\_\_\_

Were you wearing a seatbelt?

- Yes
- No

Other Injuries:

- Head
- Chest
- Extremities, Fracture
- Extremities, No Fracture
- Abdominal
- Other - Specify \_\_\_\_\_
- None

Did the pain start immediately or was there a delayed onset?

- Immediate
- Delayed 1-4 days
- Delayed 1-2 weeks
- Delayed 2-4 weeks
- Delayed 4-8 weeks

When did the pain start? \_\_\_\_\_  
Month / Day / Year

Since the pain/condition began has it:

- Improved
- Worsened
- Not changed
- Continued to come and go

What aggravates the pain?

- Walking
- Standing
- Sitting
- Lying down
- Activity in general
- Nothing in particular

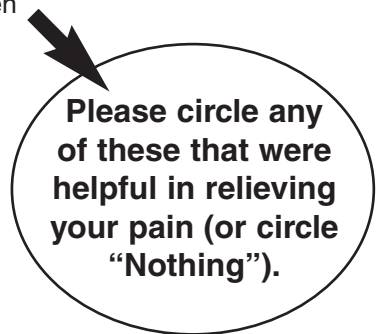
What makes the pain better?

- Sitting
- Lying down
- Walking
- Standing
- Nothing in particular

Have you tried any of the following for your pain?

Check all that apply, then

- Nothing
- Physical therapy
- Active exercise
- Heat
- Cold
- Manipulation
- TENS unit
- Spinal injections
- Surgery
- Pain Psychology
- Holistic or Alternative treatments
- Other - Specify \_\_\_\_\_



Do you participate in sports or athletics?

- Regularly 3x/week
- Regularly 2x/week
- Regularly 1x/week
- Irregularly
- None
- Medical Problems Prevent

The following lines represent pain of increasing intensity from "no pain" to "very severe pain."  
Draw a mark on the line to best describe:

Your pain right now:



The average intensity of your pain this week:



Your pain at its worst:



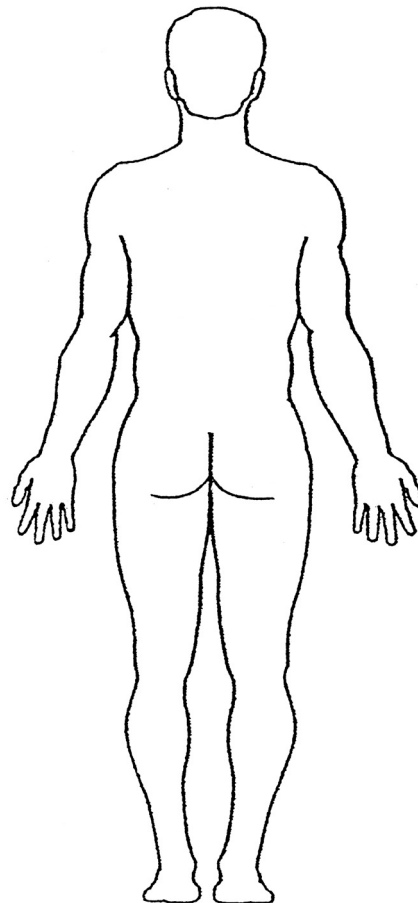
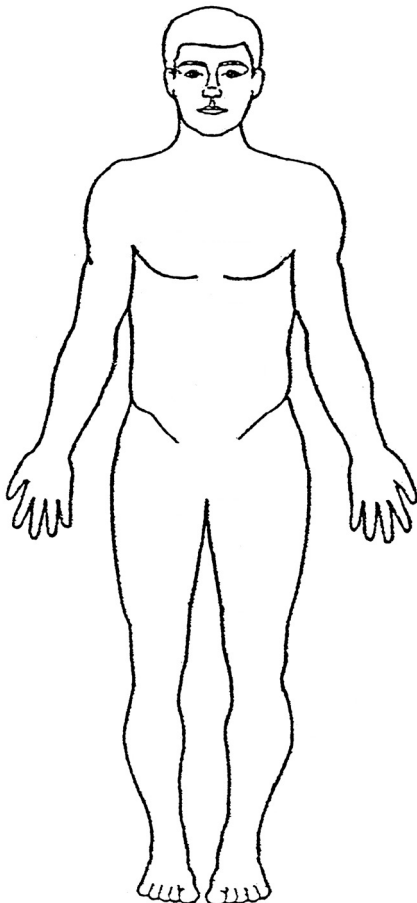
Your pain at its least:



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On the drawings below, please shade the area where you currently experience pain.



The following questions are designed to give the doctor information as to how your spine (back) pain has affected your ability to manage in every day life. Please answer every section, and **choose only the one box that applies to you**. Sometimes two of the statements in one section seem right, but please just mark the box that most closely describes your problems.

**Section 1 - Pain Intensity (choose only one)**

- I can tolerate the pain without having to use painkillers.
- The pain is bad, but I manage without painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on pain and I don't use them.

**Section 2 - Personal Care (choose only one)**

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes me extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

**Section 3 - Lifting (choose only one)**

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

**Section 4 - Walking (choose only one)**

- Pain does not prevent me walking any distance.
- Pain prevents me from walking for more than 1 mile.
- Pain prevents me from walking for more than 1/2 mile.
- Pain prevents me from walking for more than 1/4 mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

**Section 5 - Sitting (choose only one)**

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

**Section 6 - Standing (choose only one)**

- I can stand as long as I want without extra pain.
- I can stand as long as I want, but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

**Section 7 - Sleeping (choose only one)**

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets, I have less than 6 hours sleep.
- Even when I take tablets, I have less than 4 hours sleep.
- Even when I take tablets, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

**Section 8 - Sex Life (choose only one)**

- My sex life is normal and causes no extra pain.
- My sex life is normal, but causes some extra pain.
- My sex life is nearly normal, but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

**Section 9 - Social Life (choose only one)**

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

**Section 10 - Traveling (choose only one)**

- I can travel anywhere without extra pain.
- I can travel anywhere, but it gives me extra pain.
- Pain is bad, but I manage journeys over two hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to journeys of less than 30 minutes.
- Pain prevents me from traveling, except to the doctor or hospital.

Do you have any problems with bowel, bladder, or sexual functions?

- None
- No problems except for occasional constipation
- Difficulty controlling bladder functions
- History or urinary tract infections
- Sexual problems secondary to pain
- Physical problems with sexual function other than pain
- Other - Specify \_\_\_\_\_

Do you have any difficulty walking?

- No
- Yes, can walk less than a mile
- Yes, can walk only 1-2 blocks
- Yes, can walk unlimited distance
- Yes, non-ambulatory

Are you right or left handed?

- Right handed
- Left handed
- Ambidextrous

Are you:

- Married
- Single
- Divorced
- Widow/Widower
- Separated
- Other \_\_\_\_\_

With whom do you live?

- Living with spouse
- Living alone
- Living with children
- Living with parents
- Living in a community
- Other \_\_\_\_\_

How many times have you been married? \_\_\_\_\_

What is the highest grade you completed or degree you received? \_\_\_\_\_

What is your current work status?

- Regular Employment - No Restrictions
- Full - Time with Restrictions
- Part - Time by Choice
- Part - Time for Medical Reasons
- Retired by Choice
- Retired for Medical Reasons
- Unemployed - Looking for work with no restrictions
- Unemployed - Looking for light duty
- Unemployed
- Currently not working for medical reasons
- Student
- Other - Specify \_\_\_\_\_

Have you attempted to return to work since the onset of your pain?

- Yes - When did you attempt this return? \_\_\_\_\_
- No
- This does not apply to me.

When did you last work? \_\_\_\_\_

Please mark all of the following that apply to you.

Constitutional

- Low fever
- High fever
- Chills
- Loss of appetite
- Unexplained weight loss
- Unusual tiredness
- Insomnia
- Sedation

Eyes

- Blurred vision
- Double vision
- Abnormal vision
- Glasses
- Contact lenses

Ears, Nose, Mouth, Throat

- Ringing in ears
- Room spinning
- Dizziness
- Sinus pain
- Sinus drainage
- Mouth soars
- Sore throat

Cardiovascular

- High blood pressure
- Angina (chest pain)
- Trouble breathing
- Trouble breathing when flat
- Ankle swelling
- Heart attack
- Congestive heart failure
- Mitral valve prolapse
- Abnormal heart rhythm
- Heart murmur

Respiratory

- Heavy cough
- Cough up sputum
- Cough up blood
- Pneumonia
- Asthma

Neurological

- Fainting
- Epilepsy (seizures)
- Stroke
- Memory problems

Gastrointestinal

- Stomach pain
- Vomiting
- Vomiting Blood
- Vomiting "coffee grounds"
- Ulcers
- Hiatal hernia
- Constipation
- Diarrhea
- Change in bowel habits
- Blood in stool
- Black, tarry stools

Genitourinary

- Painful urination
- Blood in urine
- Vaginal discharge
- Discharge from penis
- Impotence
- Loss of sexual desire
- Painful sex
- Kidney problems
- One kidney
- Kidney failure
- Dialysis
- Kidney transplant
- Venereal disease
- Change in bladder habits
- Urgency
- Hesitancy

Musculoskeletal

- Painful joints
- Swollen joints
- Redness of joints
- Joint infection
- Bone infection
- Gout
- Osteoarthritis
- Rheumatoid arthritis
- Ankylosing spondylitis
- Osteoporosis
- Osteomalacia
- Sore muscles
- Muscle spasms

Integumentary (Skin)

- Skin sores
- Skin rash
- Itching
- Skin cancer

Psychiatric

- Depression
- Want to die
- Anxiety

Endocrine

- Diabetes
- Thyroid (too little)
- Thyroid (too much)

Hematologic/Lymphatic

- Unusual sweating
- Unusual bleeding
- Easy bruising
- Mass (lumps or bumps)
- Breast lump
- Swollen glands
- Anemia
- Infection
- HIV
- AIDS
- Hepatitis
- Cancer \_\_\_\_\_

*What type?*

Do any of your blood relatives have any of these diseases?

- None
- Back or neck problems
- Rheumatoid arthritis
- Cancer
- Coronary Artery Disease
- High blood pressure
- Lung problems
- Diabetes
- Kidney problems
- Ulcers
- Heart problems
- Gout
- Epilepsy (seizures)
- Stroke
- Thyroid (too little)
- Thyroid (too much)
- Anemia
- Other - Specify \_\_\_\_\_

Other Medical Problems:

Do you have any allergies?

No

Yes, please list: \_\_\_\_\_

Do you smoke?

Yes →

No



If you smoke, how many packs per day?

One

Five

Two

Six

Three

Seven

Four

Eight

How many years have you been smoking? \_\_\_\_\_

Did you ever smoke regularly before?

Yes →

No



If yes, how many packs per day?

One

Five

Two

Six

Three

Seven

Four

Eight

How many years did you smoke? \_\_\_\_\_

When did you last smoke? \_\_\_\_\_

Do you chew tobacco?

No

Yes, \_\_\_\_\_ times each day.

Do you dip snuff?

No

Yes, \_\_\_\_\_ times each day.

Do you smoke cigars?

No

Yes, \_\_\_\_\_ times each day.

Do you smoke a pipe?

No

Yes, \_\_\_\_\_ times each day.

How much caffeine do you consume in an average week?

I drink \_\_\_\_\_ cups/glasses of \_\_\_\_\_ each day.  
*number coffee / tea / soda*

How much alcohol do you consume in an average week?

None

Less than 6 drinks (beer, wine, etc.)

6-12 drinks

12-24 drinks

24-48 drinks

More than 48 drinks

Have you ever, or do you now, use any recreational drugs?

No, never

Yes, previously → *please list* \_\_\_\_\_

Yes, currently → *please list* \_\_\_\_\_

What other medications are you taking?  
For what medical problem? *Please Print*

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Have you ever had other episodes or injuries with your neck or back?

- No, never
- Yes, one → This episode or injury was in \_\_\_\_\_ (year).
- Yes, more than one → The first episode or injury was in \_\_\_\_\_ (year).  
This last episode or injury was in \_\_\_\_\_ (year).  
Total number of episodes or injuries: \_\_\_\_\_.  
Frequency of these episodes or injuries:
  - more than once a week
  - once a week
  - once a month
  - once a quarter (every three months)
  - once a year
  - less than once a year

Have you ever been involved in any legal proceedings related to this health matter?

- No
- Yes
  - Disability or social security
  - Workman's compensation
  - A motor vehicle crash
  - Medical malpractice
  - Other legal proceedings, *please describe*: \_\_\_\_\_

Have you ever been involved in any legal proceedings related to a previous health matter?

- No
- Yes
  - Disability or social security
  - Workman's compensation
  - A motor vehicle crash
  - Medical malpractice
  - Other legal proceedings, *please describe*: \_\_\_\_\_

What surgery have you had other than spine or back surgery?

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

Have you had any previous neck or back (spine) surgery?

- |                                     |                                     |
|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Yes, one   | <input type="checkbox"/> Yes, six   |
| <input type="checkbox"/> Yes, two   | <input type="checkbox"/> Yes, seven |
| <input type="checkbox"/> Yes, three | <input type="checkbox"/> Yes, eight |
| <input type="checkbox"/> Yes, four  | <input type="checkbox"/> Yes, nine  |
| <input type="checkbox"/> Yes, five  | <input type="checkbox"/> No         |

What surgery have you had other than spine or back surgery?

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

Have you had any of the following complications of surgery?

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Bleeding              | <input type="checkbox"/> Yes, six   |
| <input type="checkbox"/> Infection             | <input type="checkbox"/> Yes, seven |
| <input type="checkbox"/> Poor Wound Healing    | <input type="checkbox"/> Yes, eight |
| <input type="checkbox"/> Other - Specify _____ |                                     |

**Thank you for completing this questionnaire!**

<b><u>FOR OFFICE USE ONLY</u></b>	
Height: _____	INCHES Weight: _____
BP: _____ / _____	Pulse: _____ Respiration: _____