Do not write, stamp, punch holes or affix a sticker in this area.

To reproduce, follow the printing instructions. Do not fold this form.

Direction of Feed

Spine

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY***.

Marking Instructions

Please use a #2 pencil.

Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH (Month / Day / Year)

AGE

REASON FOR VISIT

○ pain ○ weakness ○ numbness ○ post-op

AFFECTED SIDE

		left	right	both
neck	○			
back	○			
upper arm		○	○	○
hip		○	○	○
thigh		○	○	○
lower leg		○	○	○

Other location(s) of pain: _____

ONSET OF SYMPTOMS

Which best describes how your symptoms began?

○ due to an injury
○ gradual onset
○ sudden onset

How long ago did the symptoms begin?

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ >10 ○

○ days ago
○ weeks ago
○ months ago
○ years ago

If you do not remember when your symptoms began, please describe how long you have been experiencing the symptoms:

Over the last: 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16+ ○

○ weeks
○ months
○ years

TIMING

○ constant ○ occasional
○ intermittent ○ rare

other: _____

HOW DID YOUR PROBLEM START?

○ at home ○ non-vehicle accident
○ at work ○ motor vehicle accident
○ during athletic activities ○ no known cause

other: _____ _____

If you have had multiple injuries, please describe: _____

PAIN

How much pain are you experiencing... **0 = no pain** **10 = intolerable**

NOW: ☺ No Pain — 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ — ☹ Intolerable

AT ITS WORST: ☺ No Pain — 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ — ☹ Intolerable

Where is the pain the strongest or bothering you the most?

○ neck ○ left arm ○ left leg
○ back ○ right arm ○ right leg

Direction of Feed

Spine

Please answer every question

***STAFF:** Handwritten items must be entered **MANUALLY**.*

QUALITY

- ◯ sharp
- ◯ dull
- ◯ aching
- ◯ burning
- ◯ stabbing
- ◯ throbbing
- ◯ stinging
- **other:** _____

PROGRESSION

- ◯ worsening
- ◯ improving
- ◯ resolved
- ◯ unchanged
- **other:** _____

WHAT MAKES YOUR PAIN WORSE?

- ◯ **nothing makes the pain worse**
- ◯ turning head to the right
- ◯ turning head to the left
- ◯ using right arm
- ◯ using left arm
- ◯ flexing neck
- ◯ extending neck
- ◯ lying down
- ◯ walking
- ◯ standing
- ◯ sitting
- ◯ climbing stairs
- ◯ getting out of a chair
- ◯ bending forward
- ◯ bending backward
- ◯ coughing
- ◯ sneezing
- **other:** _____ _____ _____

WHAT MAKES YOUR PAIN BETTER?

- ◯ **nothing makes the pain better**
- ◯ stretching
- ◯ walking
- ◯ standing
- ◯ sitting
- ◯ lying down
- ◯ bending forward
- ◯ bending backward
- **other:** _____ _____ _____

TREATMENTS TRIED

Have you tried any of the following for today's problem?

- ◯ **none**
- ◯ changing activity
- ◯ TENS Unit
- ◯ cervical collar
- ◯ back brace
- ◯ Medrol / oral steroid
- ◯ sleeping pills
- ◯ Advil / ibuprofen
- ◯ Aleve / naproxen
- ◯ Tylenol / APAP
- ◯ prescription anti-inflammatory
- ◯ muscle relaxants
- ◯ anti-depressants
- ◯ Vicodin / hydrocodone
- ◯ Percocet / oxycodone
- ◯ other opioids
- ◯ other spine surgery
- **other:** _____

PRIOR EVALUATIONS

Have you gone to any of the following for today's problem?

- ◯ **none**
- ◯ urgent care
- ◯ emergency room
- ◯ chiropractor
- ◯ inpatient evaluation
- ◯ primary care provider
- ◯ other physician at this location
- ◯ other ortho physician
- ◯ other spine surgeon
- **other:** _____

PRIOR TESTS

Have you had any of the following for today's problem?

- ◯ EMG
- ◯ X-Ray
- ◯ CT Scan
- ◯ MRI
- ◯ Bone Scan
- **other:** _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	not at all	several days	more than half the days	nearly every day
Little interest or pleasure in doing things	◯	◯	◯	◯
Feeling down, depressed or hopeless	◯	◯	◯	◯

MOTOR VEHICLE ACCIDENT

Complete this section if today's problem is due to a motor vehicle accident.

Were you a driver or passenger in the accident?	◯ driver	◯ passenger
Where were you sitting in the car?	◯ front seat ◯ back seat	**other:** _____
Were you wearing a seatbelt?	◯ yes	◯ no
Were the airbags deployed?	◯ yes	◯ no
Did you lose consciousness?	◯ yes	◯ no
Was the car totaled?	◯ yes	◯ no
Did the police arrive at the scene?	◯ yes	◯ no
Were you able to drive as you left the scene?	◯ yes	◯ no
Were you taken to the hospital by ambulance?	◯ yes	◯ no

	<10 mph	10-25 mph	26-35 mph	36-45 mph	46-55 mph	56-75 mph	76-85 mph	>85 mph
How fast was YOUR CAR moving at the time of the accident?	◯	◯	◯	◯	◯	◯	◯	◯
How fast was THE OTHER CAR moving at the time of the accident?	◯	◯	◯	◯	◯	◯	◯	◯

Date that your neck / back pain began: _____

Date you first received medical attention: _____

WORK HISTORY

Are you currently working?

◯ no (If no, when did you last work?): _____ ◯ disabled

◯ yes ◯ retired

Are you currently on any work restrictions? ◯ no ◯ yes (please explain): _____

Occupation: _____ **Employer:** _____

CURRENT SYMPTOMS

Please mark all symptoms you are <u>CURRENTLY</u> experiencing.
Mark all that apply. If no symptoms in a category, please mark "NONE."

GENERAL	◯ trouble sleeping ◯ recent weight loss	◯ fatigue ◯ loss of appetite	◯ NONE
CARDIOVASCULAR	◯ chest pain	◯ palpitations	◯ NONE
SKIN	◯ frequent rashes ◯ skin ulcers	◯ lumps ◯ non-healing wound	◯ NONE
EAR / NOSE / THROAT	◯ hearing loss	◯ hoarseness ◯ trouble swallowing	◯ NONE
ENDOCRINE	◯ cold intolerance	◯ heat intolerance	◯ NONE
EYES	◯ vision loss	◯ blurred vision ◯ double vision	◯ NONE
GASTROINTESTINAL	◯ heartburn ◯ nausea	◯ vomiting ◯ blood in stool	◯ NONE
GENITOURINARY	◯ blood in urine	◯ painful urination	◯ NONE
HEMATOLOGIC / LYMPHATIC	◯ easy bruising	◯ easy bleeding	◯ NONE
NEUROLOGICAL	◯ headaches	◯ dizziness ◯ numbness	◯ NONE
PSYCHIATRIC	◯ feeling anxious	◯ feeling depressed	◯ NONE
RESPIRATORY	◯ chronic cough	◯ shortness of breath	◯ NONE