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Direction of Feed

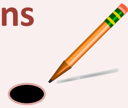
New Patient Spinal Care Form

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

How did you hear about us? ◯ word of mouth (e.g., friend / family) ◯ physician referred ◯ internet ◯ hospital / ER ◯ other

Preferred language: ◯ English ◯ Spanish ◯ German ◯ Italian ◯ Vietnamese ◯ Russian ◯ Serbian ◯ Mandarin ◯ Portuguese ◯ French ◯ Korean ◯ **other** (please specify): ____________

I have had a flu shot in the last 12 months. ◯ yes ◯ no

I am 65 years or older and have had a pneumonia vaccine. ◯ yes ◯ no ◯ **n/a** (under 65)

Please indicate if you have a pacemaker, hearing aid, or metal in your body. (If you have none of these, mark "**NONE**.")
◯ **NONE** ◯ metal ***If yes, where?*** ____________
◯ pacemaker ◯ hearing aid

Work status: ◯ working ◯ not working ◯ retired ◯ disabled

Are there any sporting or recreating activities that you would like to resume?

____

Do you have an advance directive?
◯ yes ***If yes, where is it kept?*** ◯ at home ◯ with attorney
◯ no ◯ with family ◯ with primary care provider

CURRENT PROBLEMS

When did your symptoms begin? (Please list approximate date): ____________

Your pain appeared with? ◯ slip or fall ◯ work injury ◯ lifting and bending ◯ other ***Brief description:*** ____________

The pain over time: ◯ comes and goes ◯ gradually worsens ◯ stays about the same

What positions / activities make the pain worse / better?

Worse	Better	
◯	◯	bending forward
◯	◯	standing
◯	◯	sitting
◯	◯	walking

Worse	Better	
◯	◯	cough / sneeze
◯	◯	driving
◯	◯	lying down

When do your symptoms worsen? ◯ morning ◯ evening ◯ after activities / work

Does the pain awaken you at night? ◯ yes ◯ no

Do you have any loss of bowel or bladder function? ◯ yes ◯ no

How far can you walk without much pain? ◯ around the house ◯ a few blocks ◯ less than a mile ◯ no limits

How long can you stand without much pain? ◯ minutes ◯ half an hour ◯ an hour ◯ no limits

Is your problem part of a: ◯ legal claim ◯ work comp claim ◯ disability claim

Who else have you seen for this problem? ◯ pain doctor ◯ surgeon ◯ primary care doctor ◯ physical therapist ◯ chiropractor ◯ **NONE**

What prior tests have you had for this problem? ◯ x-rays ◯ MRI ◯ myelogram ◯ discogram ◯ bone scan

What treatments have you had and have they helped?

No Effect	Worse	Better	
◯	◯	◯	NSAID / relaxants
◯	◯	◯	steroid pills
◯	◯	◯	physical therapy

No Effect	Worse	Better	
◯	◯	◯	manipulation (therapeutic manipulation / chiropractor / massage)
◯	◯	◯	pain medicine
◯	◯	◯	neurontin

Describe any spinal injections you have had. (e.g., when, how many, any effect):

____

Prior spinal surgery (when, where and by whom):

____

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SAMPLE

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Direction of Feed

New Patient Spinal Care Form

Please answer every question

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

REASON FOR TODAY'S VISIT

____

SOCIAL HISTORY

Are you exposed to secondhand smoke? ◯ no ◯ yes ◯ yes, outdoors only

Please describe your cigarette smoking status: ◯ never ◯ currently (every day) ◯ in the past ◯ currently (some days)

If you do smoke, how many packs per day? ◯ ½ ◯ 1 ½ ◯ >2
(If you smoked in the past, please include number you previously smoked.) ◯ 1 ◯ 2

Do you drink alcohol daily? ◯ yes ◯ no

Do you take illicit drugs? ◯ yes ◯ no

Who do you live with? ◯ spouse / partner ◯ parents ◯ siblings ◯ nursing home ◯ alone ◯ friends ◯ children ◯ retirement community

Do you have a metal allergy? ◯ no ◯ yes ***If yes, please explain:*** ______________________________

MEDICAL HISTORY

Physician's name: ______________________________ **Date of last physical:** ______________________________

Height:

Feet ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7

Inches ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11

Weight:

◯ 100 ◯ 200 ◯ 300 ◯ 400 ◯ 500 ◯ 600

Pounds ◯ 10 ◯ 20 ◯ 30 ◯ 40 ◯ 50 ◯ 60 ◯ 70 ◯ 80 ◯ 90

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9

Mark any medical problems that you have:

- ◯ **NONE**
- ◯ High Blood Pressure
- ◯ Heart Attack / Heart Disease
- ◯ Cancer
- ◯ Hepatitis
- ◯ Depression
- ◯ Ulcers
- ◯ Diabetes
- ◯ Blood Clots
- ◯ Thyroid Problems
- ◯ Lung Disease (Asthma, COPD)
- ◯ Rheumatoid Arthritis

List past surgeries: ______________________________

What medications do you regularly take?

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

List DRUG (medication) **allergies, if any:** ______________________________

◯ **I Have No Medical Allergies**

GENERAL REVIEW OF SYSTEMS

Please mark yes or no for current and unexplained symptoms:

Yes	No	
◯	◯	Recent Weight Loss
◯	◯	Fever / Night Sweats
◯	◯	Balance Problems
◯	◯	Chest Pain

Yes	No	
◯	◯	Shortness of Breath
◯	◯	Nausea / Vomiting
◯	◯	Blood in Stool
◯	◯	Painful Urination

Yes	No	
◯	◯	Blurred Vision
◯	◯	Memory Loss / Confusion
◯	◯	Rashes or Itching

FAMILY MEDICAL HISTORY

Please indicate if your MOTHER or FATHER have had any of the following:

Mother	Father	
◯	◯	Scoliosis
◯	◯	Neurologic Disease
◯	◯	Osteoporosis

Mother	Father	
◯	◯	Back Problems
◯	◯	Malignant Hyperthermia
◯	◯	**NONE**

◯ **Other:** ______________________________

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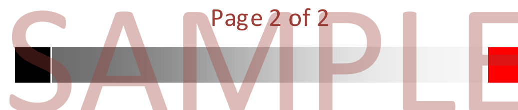

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