Orthopedic Spine Associates LLC
The Northwest's Center for
Comprehensive Neck and Back Care

SPINE PATIENT HISTORY FORM

Name ______________________ **Age** __________

Occupation ______________________ **Date** __________

1. What date (roughly, at least) did your present pain start? ______________

2. Mechanism of pain onset:

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ Twisting
- ☐ Fall
- ☐ Bending
- ☐ Pulling
- ☐ Injured at work
- ☐ Auto accident
- ☐ Hit in back
- ☐ Sports
- ☐ No apparent cause

3. What activities make the pain worse?

- ☐ During exercise
- ☐ After exercise
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backward
- ☐ Coughing
- ☐ Sneezing

4. What reduces your pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Manipulation
- ☐ Physical therapy
- ☐ Pain pills
- ☐ Muscle relaxants
- ☐ Aspirin
- ☐ Other ______________
- ☐ Nothing

5. How long have you had any back pain? ________ **years** ________ **months** ________ **weeks**

How long have you had any leg pain? ________ **years** ________ **months** ________ **weeks**

6. Have you had any diagnostic studies other than x-rays? ☐ **yes** ☐ **no**

Have you had a CAT scan? ☐ yes ☐ no Date__________
Have you had the myelogram? ☐ yes ☐ no Date__________
Have you had an EMG? ☐ yes ☐ no Date__________
Have you had an MRI scan? ☐ yes ☐ no Date__________

7. Have you been in the hospital for your back problem? ☐ **yes** ☐ **no**

Number of times______________ Dates ______________

8. Have you had neck or back surgery? ☐ **yes** ☐ **no**

Number of times______________ Dates ______________

9. Have you been in the hospital with other medical problems? ☐ **yes** ☐ **no**

Number of times ______________ Describe ______________________________

10. Please list current medications ______________________________

____

____

____

11. Do you take antacids? ☐ **yes** ☐ **no**

12. General medical problems:

☐ Stomach problems, ulcer, etc.
☐ Diabetes
☐ Arthritis
☐ Gout
☐ Sexual difficulties
☐ Bowel or Bladder
☐ Cancer
☐ Heart
☐ Epilepsy
☐ Other ______________
☐ Loss of weight

13. Allergies? ☐ **yes** ☐ **no** Please list ______________________________

____

14. Do you smoke? ☐ **yes** ☐ **no** **How much?** ______________________________

15. Do you drink alcoholic beverages? ☐ **yes** ☐ **no** **How much?** ______________________________

16. What other types of doctors have you seen for this condition? ______________________________

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17. Do you want a report sent to your attorney? ☐ **yes** ☐ **no** ☐ **I have no attorney.**

18. Do you have any additional information which would be helpful to understand your problem?

____

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19. To be sure that paper work is filled out correctly, please check if appropriate:

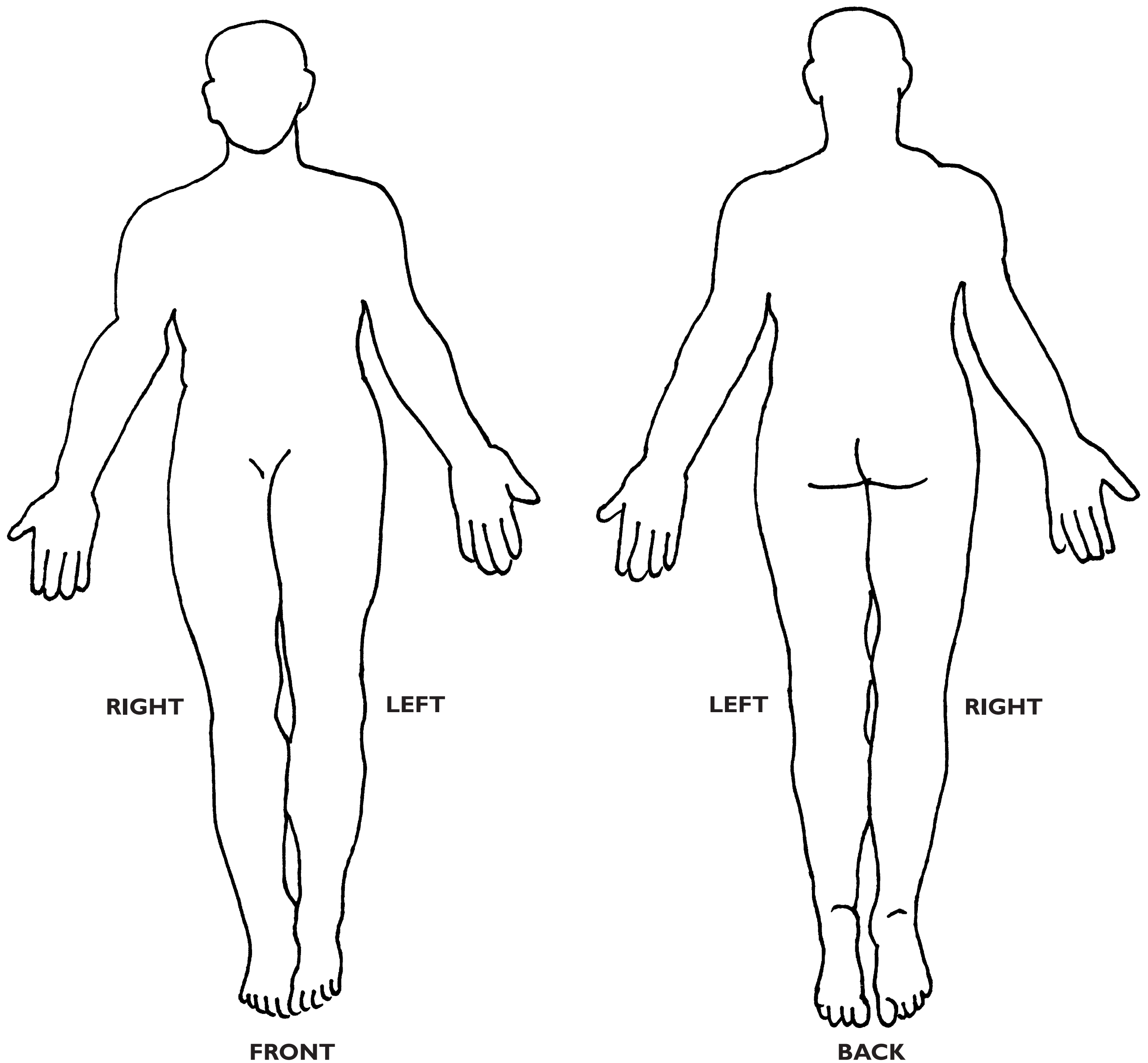
☐ On Workman's Compensation
☐ Receiving disablility income
☐ Legal proceeding pending
☐ Report should be sent to referring physician or family doctor
☐ Report sent to any other party

20. If you were referred by a previous patient, would you be willing to share their name with us so we can acknowledge them? Patient's name: ______________________________

Where is your pain now?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

^^^^ ^^^^ **Ache**	oooo oooo **Numbness**	==== ==== **Pins & Needles**	xxxx xxxx **Burning**	//// //// **Stabbing**



Please mark on the line:

How bad is your back pain now? No pain ——————————— Worst possible

How bad is your leg pain now? No pain ——————————— Worst possible