ROOM #:_____

NEW SPINE PATIENT

CarePoint NEUROSURGERY

Date Seen: _____ **Blood Pressure:**_____ **Pulse:** _____

Weight: _____ **Height:**_____ **O_2 Sats:** _____

For office use only above this line.

Patient Name:_____ **Date of Birth:** _____ **Age:** _____

Referring Physician:_____ **Insurance Carrier:**_____

Present Complaint or Problem:

How long (days, weeks, or years) has this complaint/problem been going on? _____

Most recent images for the problem you are being seen for today ..... ☐ MRI ☐ CT ☐ X-Rays ☐ None ☐ Other: _____

Where were these images done?..... ☐ Health Images ☐ Invision ☐ Resiliance ☐ Touchstone ☐ Other: _____

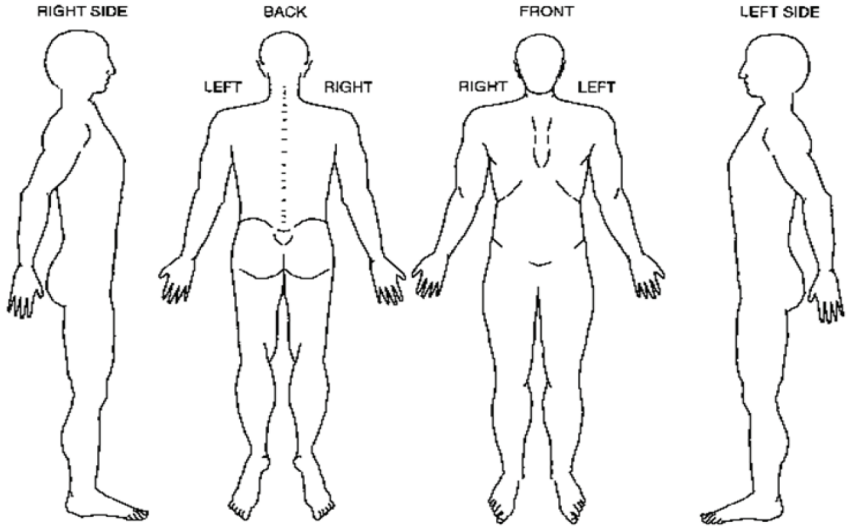
When were these images done? _____

Diagnostic Testing ..... ☐ EEG ☐ Other _____

Done by Dr:_____ **Date:**_____

Mark the area on the diagram where you feel your pain. Use the appropriate symbol below to describe your type of pain.

Ache = A
Burning = B
Numbness = N
Pins & Needles = P
Stabbing = S
Throbbing = T



Pain Score
0-10 Numerical Rating Score

Per the pain scale on the right:

What is your average daily pain?_____

Highest pain rating?_____

Lowest pain rating?_____

1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Worst Possible Pain

What activity makes your pain worse?

What activity or action makes your pain better?

Patient Name: _____

TREATMENTS TRIED TO DATE

I have had treatments for my current neck or back problem ..... ☐ No ☐ Yes

I have had the following treatments for my neck or back problem to date:

Neck or back brace: ..... ☐ No ☐ Yes - for how long: _____

If yes, it gave: ☐ No relief ☐ Mild relief ☐ Temporary relief ☐ Great relief

Chiropractic Care: ..... ☐ No ☐ Yes

If yes, it gave: ☐ No relief ☐ Mild relief ☐ Temporary relief ☐ Great relief

Physical Therapy: ..... ☐ No ☐ Yes - for how many sessions: _____

If yes, it gave: ☐ No relief ☐ Mild relief ☐ Temporary relief ☐ Great relief

Anti-inflammatory medications: ..... ☐ No ☐ Yes - for how long (i.e. days, weeks): _____

If yes, it gave: ☐ No relief ☐ Mild relief ☐ Temporary relief ☐ Great relief

Injections: ..... ☐ No ☐ Yes

If yes, what were the results: ☐ Worse ☐ Same/No change ☐ Mild relief ☐ Temporary relief ☐ Great relief

Injection	Date of Last Injection	Level(s)	# of Injections	% Improvement after Injection
Epidural Steroid (ESI)				
Facet				
Selective Nerve Root Block (SNRB)				
Trigger Point				
Other				

CERVICAL EVALUATION: If this is your main complaint.

Out of 100% total, what is your:

Neck Pain: _____%
Right Arm Pain: _____%
Left Arm Pain: _____%
} TOTAL = 100%

Arm weakness: ☐ None ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/Fingers

Numbness and/or tingling: ☐ None ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/Fingers

Do you have difficulty picking up small objects like coins or buttoning a shirt or coat? ..... ☐ No ☐ Yes

Do you have problems with your balance and/or tripping? ..... ☐ No ☐ Yes

Do you have headaches in the back of your head? ..... ☐ No ☐ Yes

If yes, the headaches are: ☐ Daily ☐ Frequent ☐ Seldom ☐ Rarely

Do you have problems with loss of urinary continence? ..... ☐ No ☐ Yes

LUMBAR EVALUATION: If this is your main complaint.

Out of 100% total, what is your:

Back Pain: _____%
Right Leg Pain: _____%
Left Leg Pain: _____%
} TOTAL = 100%

How many minutes can you sit in one place without pain? _____

How many minutes can you walk without pain? _____

Leg weakness: ☐ None ☐ Thigh ☐ Calf ☐ Ankle ☐ Foot

Numbness and/or tingling: ☐ None ☐ Thigh ☐ Calf ☐ Foot ☐ Toes

Do you have problems with your balance and/or tripping? ..... ☐ No ☐ Yes

Do you have bowel or bladder problems? ..... ☐ No ☐ Yes

If yes, which one, or both? _____

Patient Name: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY USING (PLEASE PRINT NEATLY) If none, please place ✓ in box: ☐

Name and dose (i.e., 2 mg, 60 mg, etc)	How often (i.e., one tab daily, one tab twice daily, two at bedtime)

PAST MEDICAL HISTORY: Please ✓ in box next to any condition with which YOU have been diagnosed, or list other:

General Medical		Neurologic	Pertinent to Surgery
☐ Unremarkable / No medical problems	☐ Heart Disease	☐ Aneurysm	☐ Anticoagulation Therapy
☐ Anemia	☐ Hepatitis type: _____	☐ CVA/Stroke	☐ Bleeding Disorder
☐ Asthma	☐ HIV	☐ Brain Tumor	☐ Chronic Pain
☐ Atrial Fibrillation	☐ High cholesterol / lipids	☐ Hydrocephalus	☐ Clotting Disorder
☐ Autoimmune Disorder	☐ Hypertension / High Blood Pressure	☐ Migraines	☐ DVT
☐ BPH (prostate enlargement)	☐ Myocardial infarction / Heart Attack	☐ Multiple Sclerosis	☐ Hemophilia
☐ Cancer – type: _____	☐ Osteoarthritis	☐ Parkinson's Disease	☐ Narcotic use > 6 months
☐ COPD	☐ Osteoporosis	☐ Peripheral Neuropathy	☐ Problems w/ Anesthesia
☐ Depression	☐ Renal Disease	☐ Pituitary Tumor	☐ Pulmonary Embolism
☐ Diabetes	☐ Rheumatoid Arthritis	☐ Seizure Disorder	☐ Other: _____
☐ Fibromyalgia	☐ Sleep Apnea	☐ Spinal Cord Injury	
☐ GERD / Reflux	☐ Thyroid Disease: hypo or hyper	☐ TIA	
☐ Gout		☐ Traumatic Brain Injury	
		☐ Trigeminal Neuralgia	

Have you ever been *DIAGNOSED* by a physician with any other major health problem not listed above? ☐ **No** ☐ **Yes**

If yes, please list the diagnosis:

_____

_____

Patient Name: _____

ALLERGIES: Are you allergic to *ANY* medication, food, or non-medications (such as pollen, etc.)? ☐ No ☐ Yes
If yes, please list below.

Name of Medication / Food / Agent you are allergic to	Type of Reaction (i.e. rash, breathing problems, swelling, etc.)

PREVIOUS SPINE SURGERY

I have had previous spine surgery (neck or back)..... ☐ Yes, neck surg. ☐ Yes, back surg. ☐ No
Most recent neck or back surgery: _____ Date of surgery: _____
Surgeon: _____ Hospital: _____
Reason for surgery: _____
I have had previous spine surgery (neck or back)..... ☐ Yes, neck surg. ☐ Yes, back surg. ☐ No
Most recent neck or back surgery: _____ Date of surgery: _____
Surgeon: _____ Hospital: _____
Reason for surgery: _____

SURGICAL HISTORY: If you have had any surgery in the past, please list below:

_____

_____

_____

_____

_____

_____

FAMILY HISTORY: Please ✓ in box next to any condition in which a member of your immediate family only (i.e., mother, father, brother, sister) has been diagnosed: If unknown/adopted/none, please ✓ in appropriate box: ☐ Unknown ☐ Adopted ☐ None

☐ FH Alcoholism	☐ FH Cervical, Ovarian, or Uterine Cancer	☐ FH High Cholesterol	☐ FH Other Cancer
☐ FH Anemia	☐ FH Colon Cancer	☐ FH Kidney Disease	☐ FH Psychiatric Care
☐ FH Arthritis	☐ FH Depression	☐ FH Liver Disease	☐ FH Respiratory Disease
☐ FH Blood Clots	☐ FH Diabetes	☐ FH Lung Cancer	☐ FH Seizures
☐ FH Bowel Disease	☐ FH Heart Disease	☐ FH Melanoma/Skin Cancer	☐ FH Stroke
☐ FH Breast Cancer	☐ FH Hypertension/High BP	☐ FH Osteoporosis	☐ FH Thyroid Disease

Patient Name: _____

SOCIAL HISTORY

Do you currently use tobacco in any form?..... ☐ No ☐ Yes

If yes, do you smoke or chew tobacco? ..... ☐ Smoke ☐ Chew Number of packs per day: _____

If no, do you have a history of chewing/tobacco use? ☐ No ☐ Yes If yes, when did you quit?_____

Marital status: ..... ☐ Married ☐ Partner ☐ Single ☐ Divorced ☐ Widowed

Work status:..... ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Self-employed

What is or was your occupation? _____

Do you currently drink alcohol? ..... ☐ No ☐ Yes If yes, how much per week? _____

Do you currently use any recreational substances? .... ☐ No ☐ Yes If yes, what type and how often?_____

REVIEW OF SYSTEMS: Please ✓ in box next to any symptom in which you are currently experiencing:

General			
☐ Recent weight loss: # lbs _____	☐ Ringing in ears	☐ Nausea	☐ Rashes
☐ Recent weight gain: # lbs _____	☐ Chest pain	☐ Frequent indigestion	☐ Recent change in wart / mole
☐ Fever	☐ Palpitations	☐ Black, tarry or bloody stools	☐ Easy bleeding or bruising
☐ Night sweats	☐ Shortness of breath	☐ Difficulty urinating	☐ Depression
☐ Fatigue	☐ Swelling of feet or ankles	☐ Incontinence	☐ Anxiety
☐ Blurred vision	☐ Fainting	☐ Burning with urination	☐ Difficulty falling asleep
☐ Double vision	☐ Frequent cough	☐ Excessive thirst	☐ Early morning awakenings
☐ Blindness	☐ Difficulty breathing	☐ Unusual appetite	☐ Persistent feeling sad or blue
☐ Hearing loss	☐ Coughing up blood	☐ Frequent urination	☐ Loss of ability to enjoy life

Musculoskeletal		
☐ Back pain	☐ Joint swelling	☐ Shooting left arm pain
☐ Joint pain	☐ Leg cramps	☐ Shooting right leg pain
☐ Joint stiffness	☐ Shooting right arm pain	☐ Shooting left leg pain

Neurological		
☐ Fatigue	☐ Gait abnormality	☐ Seizure
☐ Weight loss	☐ Headache	☐ Tingling
☐ Balance difficulty	☐ Loss of sensation in a specific body area: _____	☐ Tremors
☐ Dizziness	☐ Loss of strength in a specific body area: _____	☐ Trouble with balance
☐ Fainting spells	☐ Numbness	☐ Trouble with coordination
☐ Falls	☐ Memory problems	

This Information is true and complete to the best of my knowledge:

_____ _____

Signature of Patient or Legal Guardian *Date*