Spine and Pain Institute of Orange County

Office Use Only

Blood Pressure: _____
Heart Rate: _____
Temperature: _____
Height: _____
Weight: _____

Name: _____

D.O.B. _____Age _____

Who are your primary care physician & referring doctors?

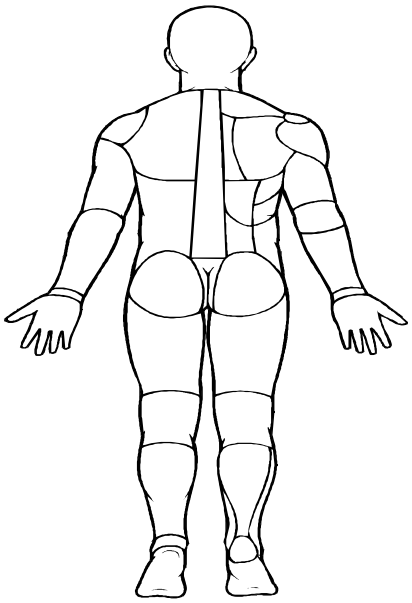
_____

What is the major reason you are coming to see the doctor (chief complaint):

_____

[ ]Right Handed [ ]Left Handed

Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.



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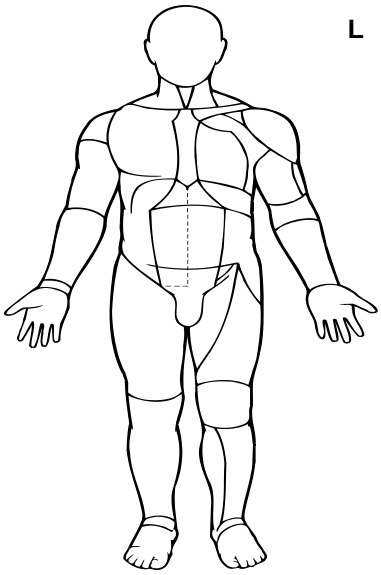

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Date of Onset of this pain?_____

What were you doing when the pain first started? _____

How long does the pain last? □ Constant □ Intermittent

QUALITY OF YOUR PAIN: (Please mark all that apply):

( ) Throbbing ( ) Cramping ( ) Pins and needles ( ) Aching ( ) Shooting
( ) Stabbing ( ) Sharp ( ) Hot-burning ( ) Other_____

Intensity of Pain

On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain, how would you rate your pain?

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse? Mark all that apply.
( ) Bending ( ) Lifting ( ) Sneezing/Coughing ( ) Walking ( ) Standing
( ) Sitting ( ) Other, please explain _____

What makes your pain better? Mark all that apply.
( ) Rest ( ) Activity/physical therapy ( ) Massage ( ) Heat
( ) Cold ( ) Lying in a fetal position ( ) Lying on your back
( ) Lying on back with pillows under your legs
( ) Medication(s), please list _____
( ) Other, please explain _____

How many blocks can you walk before needing to stop due to these symptoms?
____blocks ( )unlimited
Are these symptoms significantly affecting your quality of life and ability to perform activities of daily living? ( )Y ( )N
Do the symptoms wake you up at night? ( )Y ( )N
Have you noticed: ( )Change in handwriting ( ) Dropping of objects ( )Walking Imbalance
Do you have full control of your bowel and bladder? ( ) Yes ( ) No
If no, explain_____
Have you had surgery for this problem? ( )Yes ( )No
If yes, enter date(s),surgeon(s), and procedure(s):
_____
Did the surgery help?( )Yes ( ) No

TREATMENT HISTORY

Which of the following types of caregivers have you visited prior to your arrival here?
( ) Family Physician/Internist ( ) Spine Surgeon ( ) Orthopedic Surgeon ( ) Neurologist
( ) Rheumatologist ( ) Pain Management ( ) Chiropractor ( ) Acupuncturist ( ) Physical Therapist
( ) Other, please list_____

Which of the following tests have you undergone prior to your arrival here today?
( ) X-rays ( ) CAT scan ( ) MRI scan ( ) EMG test ( ) Myelogram

Please check the medications that you have tried for your pain in the past and their effectiveness. (0=no help, 10=very helpful)

	Tried Medication		
Name of medication	Yes	No	**Effectiveness (0-10)**
Tylenol/acetaminophen			
NSAID's: Motrin/Advil/Ibuprofen, etc			
Opioids: Vicodin/Norco/Oxycodone, etc			
Oral Steroids/Medrol dose pack			
Amitriptyline(Elavil), Nortriptyline(Pamelor), etc			
Muscle relaxants/Flexeril			
Neurontin/Topamax/Tegretol, etc			
Marijuana/Cocaine/Heroine/Other illicitdrugs			
Xanax/Ativan/Valium,etc			
Others, please list			

Dates of previous treatments:

( )Physical Therapy_____ Help?( ) Yes ( ) No
( )Epidural Steroid Injections_____ Help?( ) Yes ( ) No
( )Chiropractic _____ Help?( ) Yes ( ) No
( )Other_____ Help?( ) Yes ( ) No

PAST MEDICAL HISTORY

Drug and Food Allergies: _____

Please list the medications you are currently taking:

Name	Dosage	How Often?

Pharmacy Information:

Name of Pharmacy:_____
Phone number:_____
Address or cross streets_____
_____

List all **MEDICAL** problems:_____
_____

List all **SURGERIES** and their dates:_____
_____

SOCIAL HISTORY

Any use of tobacco (type and for how long?)_____
Any use of alcohol (type and for how long?)_____
Any use of recreational drugs (type and for how long?)_____
What type of work do you do?_____

Are you currently on disability: ( ) Yes ( )No
Any litigation involved for this condition ( ) Yes ( )No

Education:

Grade School High School College Post-Graduate Vocational Training

Marital Status:

Single Married Divorced Separated Widowed

FAMILY HISTORY

Mother: □ Living □ Deceased Age(s) _____ Health issues: _____

Father: □ Living □ Deceased Age(s) _____ Health issues: _____

Brother(s):#_____ □ Living □ Deceased Age(s) _____ Health issues: _____

Sister(s):#_____ □ Living □ Deceased Age(s) _____ Health issues: _____

REVIEW OF SYSTEMS

Please place a checkmark if you currently have any of the following symptoms. (Disregard the bold headings)

• **Constitutional**

( ) No Problems ( ) Fever ( ) Weight Loss ( ) Fatigue

• **Eyes**

( ) No Problems ( ) Blurred Vision ( ) Eye Redness ( ) Double Vision

( ) Vision Loss ( ) Eye Dryness ( ) Eye Pain

• **Ear/Nose/Throat**

( ) No Problems ( ) Trouble Hearing ( ) Ringing in the ear ( ) Loss of Balance

( ) Dizziness/Vertigo ( ) Ear Discharge ( ) Ear Pain

• **Cardiovascular**

( ) No Problems ( ) Chest Pain/Angina ( ) Irregular Heart Beat ( ) Fainting

( ) Limb Swelling ( ) Limb Pain on Walking

• **Respiratory**

( ) No Problems ( ) Trouble Breathing ( ) Chronic Cough ( ) Coughing Blood

• **Gastointestinal**

( ) No Problems ( ) Indigestion ( ) Nausea ( ) Vomiting ( ) Diarrhea

( ) Heart Burn ( ) Constipation ( ) Bloody Stools ( ) Abdominal Pain

• **Genitourinary**

( ) No Problems ( ) Incontinence ( ) Pain on Urination ( ) Blood in Urine

• **Musculoskeletal**

( ) No Problems ( ) Muscle Pain ( ) Muscle Cramp ( ) Neck Pain ( ) Back Pain

( ) Joint Swelling ( ) Joint Pain ( ) Joint Stiffness ( ) Muscle Twitches

• **Skin & Breast**

( ) No Problems ( ) Numbness ( ) Hair Loss ( ) Discoloration ( ) Tingling

( ) Sweating Change ( ) Nail Change

• **Neurologic**

( ) No Problems ( ) Headache ( ) Weakness ( ) Tremors ( ) Seizures

( ) Trouble with Memory/Concentration ( ) Blackouts ( ) Face Numbness/Pain

• **Psychiatric**

( ) No Problems ( ) Hallucinations ( ) Feeling Down ( ) Trouble Sleeping

( ) Suicidal Thoughts ( ) Inappropriate Crying/Laughing

• **Hematologic/Lymphatic**

( ) No Problems ( ) Abnormal Bleeding ( ) Anemia ( ) Lumps/Swellings

• **Allergic/Immunologic**

( ) No Problems ( ) Rash ( ) Joint Pain ( ) Dry Eyes +/- Mouth

• **Endocrinologic**

( ) No Problems ( ) Excessive Thirst ( ) Excessive Urination ( ) Heat/Cold Intolerance

Person completing this questionnaire_____Relationship to Patient_____

For office use: This questionnaire may be completed by the patient, relatives or ancillary staff provided that it is signed and dated by the treating physician. (Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent changes.)

Physician's Signature_____Date_____