NAME:	DATE:_		
Age: Gender:	le Hand Dominance	e □ Right □ Left	
Who referred you for evaluation?	ic Hand Dominano	s. I raght I bott	
Who referred you for evaluation? Who is your primary doctor?	Address:		
What is being examined today?	Which side? (R	ight/Left)	
DATE of accident, or How long have you had illness /	problem / symptoms?		
Please describe your injury:			
1 lease describe your injury.			
SYMPTOMS:			
Where is your pain? How long has it been there?	Have you experience	ed any of the following:	
Location Duration (wks / yrs)	□ Numbness / Tingling in arms; (L), (R)		
☐ Head	□ Numbness / Tingling in hands; (L), (R)		
□ Neck	□ Numbness / Tingling in legs; (L), (R)		
□ Shoulder L / R	□ Numbness / Tingling in feet; (L), (R)		
\square Arm L/R	☐ Weakness in legs; (L), (R)		
\square Hand L/R $\underline{\hspace{1cm}}$	☐ Weakness in arms		
☐ Mid Back	☐ Clumsiness of hands; (L), (R), (both)		
☐ Low Back	☐ Balance problems		
□ Buttocks L/R	□ Bladder problems	:	
\Box Hip L/R	☐ Bowel problems:		
□ Leg L/R	☐ Pain that wakes ye	ou from sleep (night pain)	
\Box Foot L/R	777h - 4 1	in hotton?	
***** 1	What makes your pa		
When having pain is it generally	☐ Sitting	□ Looking up/down□ Looking L / R	
☐ Mild discomfort			
□ Dull, achy pain	☐ Standing	_	
☐ Hard, aching pain, frequently worse	□ Walking□ Lifting	- ;	
☐ Severe pain, sharp/shooting at times	☐ Sleeping	•	
☐ Burning pain		☐ Heat	
□ Very severe, sharp, stabbing□ Extremely disabling	☐ Other (please des		
Extremely disabiling	- Other (prease des	01100)	
How often are you having pain?	What makes your pa		
☐ Rarely, if ever	\square Lying down	☐ Looking up/down	
☐ Occasional (If so, how often?)	☐ Sitting	☐ Looking L / R	
☐ Recurrent (few days every month)	☐ Standing	☐ Bending Forward	
☐ Frequent (more than half the time)	☐ Walking	☐ Bending Backwards	
☐ Very frequent (nearly every day)	☐ Lifting	☐ Sneeze / Cough	
☐ Constantly	☐ Sleeping	☐ Twisting	
How much of your pain is in your neck/back and		☐ Heat	
how much is in your arm/leg? (must total 100%)	☐ Other (please des	cribe):	
now inden is in your armineg: (must total 10070)	What time of day is	your pain usually worst?	
% neck/back +% arm/leg = 100%	☐ Morning	☐ Same all day	
	☐ Mid-day	☐ At night	
Rate your pain at is worst and at its best:	☐ Evening	_ · · · · · · · · · · · · · · · · · · ·	
($0 = \text{No pain}$, $10 = \text{Worst imaginable pain}$)	· ·		
(v 110 pain, 10 110 inaginative pain)		of your condition as:	
<u>9 1 2 3 4 5 6 7 8 9 10</u> at is worst	☐ Rapidly worse		
	☐ Slowly worse	☐ Slowly better	
2 3 4 5 6 7 8 9 10 at is best	☐ Unchanged		

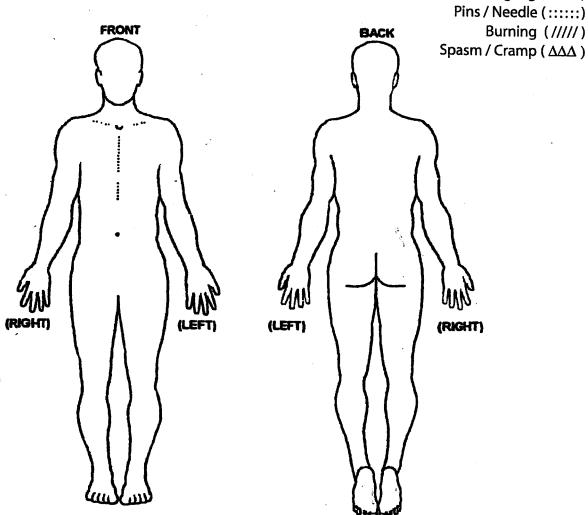
What treatment have you received?		What studies have been done on your spine?		
□ None	☐ Anti-inflammatory med	□ None	□ X-rays	
☐ Physical Therapy	☐ Muscle relaxants	□ MRI	☐ CT scan	
☐ Chiropractic	☐ Narcotic medications	☐ Myelogram	☐ Bone Scan	
☐ Traction	☐ Epidural injections	□ DEXA Scan	□ EMG	
☐ Acupuncture	☐ Other:			
Have you had previous spinal surgery? □ No □ Yes Did it help you? □ No □ Yes If yes, what type of surgery, who was the surgeon and when was it done?				

PAIN DRAWING:

Indicate where you are having symptoms by using the proper **symbols** and **arrows** to show where the pain goes or shoots. Be sure to show **ALL areas involved** and to indicate where the **PAIN IS WORST.**

Aching / Pain (XXX) Numbness / Tingling (000)

Burning (////) Spasm / Cramp ($\Delta\Delta\Delta$) (LEFT) (RIGHT)



Please indicate that you have completed this form truthfully and as accurately as possible by signing below:

PAST MEDICAL HISTORY: Please rate your general health		SOCIAL HISTORY: What is you occupation?		
□ Good	□ Poor	Are you presently e	mployed?	
		☐ Yes; when	re and for how	long
What medical prol	blems do you have?			
□ None		\square No; how \square	long since you	were
☐ Cancer (what ty	rne?)			
☐ Heart Disease	Pe.,			
	.e. pneumonia, asthma, COPD)	Are you married?	☐ Yes	□ No
- '	- ,			
☐ Liver Disease (i.e. jaundice, hepatitis)☐ Diabetes☐		Who do you live wi	ith?	***************************************
	aguma (hrimantanaian)			
	ssure (hypertension)	Do you smoke?		
☐ Rheumatic Feve		□ No		
☐ High cholestero		□ Yes;	pa	icks per day
☐ Anemia or bleed		· · · · · · · · · · · · · · · · · · ·		ears
☐ Thyroid Disease		\Box used to, b		
☐ Kidney Disease		_ asta to, o	ar quit	
☐ Urinary tract inf	fections	Do you drink alcoho	ol (heer wine	liquor)?
☐ Other serious He	ealth problems:		or (occi, winc,	iiquoi):
		□ 1es, now	much/often?	
PAST SURGICA	L HISTORY:	######################################		17.27.
Have you had any		TARKET STEERING	 .	
□ None	Providence surgery.	FAMILY HISTOR	KY:	
☐ Tonsillectomy				
☐ Appendectomy		Do any of the follow	-	
·		your family? If so,	please list fam	ily member:
☐ Cholecystectomy (Gallbladder)		□ None		
☐ Heart (bypass)		☐ Heart disease		
☐ Thyroid surgery		☐ Diabetes		
☐ Hip replacement		☐ Hypertension		
☐ Knee replaceme	ent	☐ High Cholesterol		
☐ Knee Arthrosco	ру	☐ Thyroid disease		
□ Pacemaker		_		
☐ Cancer surgery ((describe:)	☐ Renal (kidney) disease☐ Pulmonary (lung) disease		
☐ Other (list:)		☐ Liver dise		6E
· /	22000100		ease	
MEDICATIONS:	: □ None			
	ications that you take and dose:	☐ Spinal ste	nosis	
	•	☐ Scoliosis		
· · · · · · · · · · · · · · · · · · ·		☐ Osteoporo	osis	
		☐ Other seri	ous health pro	blems; list:
- при	4,000,000,000			
		Females only: Are	you pregnant?	
ALLERGIES:		What is your height	?	
	allergies and reactions:			
		How much do you v	weigh?	

Review of Systems:

Please check and describe any signs or symptoms which you are currently experiencing from any of the following organ systems. If none, please write "NONE". Please list any other problems you may be experiencing that you do not see listed. Constitutional Symptoms: ☐ Fever □ Chills ☐ Night Sweats ☐ Weight Loss ☐ Fatigue ☐ Appetite loss Eyes: ☐ Corrective lenses ☐ Cataracts ☐ Blurry Vision ☐ Double Vision Ears, Nose, Mouth, Throat: ☐ Hearing loss ☐ Sinus Congestion ☐ Hoarse voice ☐ Painful/Difficulty swallowing <u>Cardiovascular</u> (Heart, circulation): ☐ Chest pain ☐ Cool extremities (poor circulation) ☐ Cold sensitivity Respiratory (Lungs): ☐ Shortness of breath ☐ Painful breathing ☐ Wheezing ☐ Cancer Genitourinary (i.e. urinary tract infection, prostate): ☐ Urinary frequency ☐ Urinary incontinence ☐ Painful urination ☐ Sexual dysfunction ☐ Enlarged prostate ☐ Cancer Gastrointestinal: Musculoskeletal: ☐ Reflux □ Ulcers ☐ Cancer ☐ Joint pain, where? □ Diarrhea ☐ Constipation ☐ Bloody stool ☐ Joint swelling □ Nausea □ Vomiting ☐ Joint stiffness ☐ Fibromyalgia Skin/Breast: Psychiatric: ☐ Cancer, where?_____ what type?_____ ☐ Depression ☐ Manic ☐ Lumps or masses, where? ☐ Eating Disorder ☐ Rashes Neurological: ☐ Trouble speaking ☐ Peripheral nerve disorder, list? ☐ Stroke ☐ Balance problems ☐ Seizures ☐ Tremor ☐ Reflex Sympathetic Dystrophy Endocrine: Hematologic/Lymphatic: ☐ Hypoglycemia ☐ Thyroid ☐ Diabetes ☐ Clotting disorder ☐ Anemia ☐ Parathyroid ☐ Adrenal ☐ Osteoporosis ☐ Platelet disorder ☐ Sickle Cell ☐ Lymphedema Immunologic: ☐ Swollen lymph nodes, where?_____ ☐ Lupus ☐ Rheumatoid ☐ Tender lymph nodes, where?_____

Financial Interest Consent

I,(patien	nt), acknowledge and accept
that my physician may have a f	-
surgery centers, imaging center	, 1
surgical devices that he/she cho	ooses to utilize. I hereby
recognize my right to choose an	nother physician or request
the services of another facility	or device be used.
SIGNATURE	DATE