ADVANCED SPINE CENTER

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TODAY'S DATE: _____/_____/_____

●NEW PATIENT HISTORY FORM

Patient Name:		DOB: _____/_____/_____	
Preferred Pharmacy & Address:		Pharmacy Phone:	
Dominant Hand:	☐ Right Hand ☐ Left Hand ☐ Ambidextrous	Preferred Language:	☐ English ☐ Spanish ☐ Chinese ☐ Other
Race/Ethnicity:	☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Pacific Islander ☐ Hispanic ☐ Non-Hispanic ☐ Unknown/Other_____ ☐ Decline to Answer		
Referral Source:	☐ Physician:	☐ Other:	
Representation:	Are you being represented by an attorney? ☐ Yes ☐ No	If yes, name:	

● ALLERGIES

Medication Allergies: Do you have any allergies? ☐ Yes ☐ No ☐ NKDA
Please list all medication allergies. Also, include seasonal and food allergies.

_____

_____

● CHIEF COMPLAINT

☐ Neck ☐ Upper Back ☐ Shoulder ☐ Arm ☐ Hand ☐ Mid Back ☐ Low Back ☐ Hip ☐ Buttocks
☐ Lower Leg ☐ Tail Bone ☐ Fracture ☐ Other: _____

● MEDICATION HISTORY

Medications: Please list all medications you take on a regular basis:

_____

_____

Are you in Pain Management? ☐ Yes ☐ No If yes, providers name: _____

● VITALS

Height: _____ft. _____in. Weight: _____ lbs.

● FAMILY HISTORY Have any direct relatives had any of the following disorders?

Father	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problem	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer (Type):
Comments:				
Mother	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problem	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer (Type):
Comments:				
Sister/Brother: (Please indicate)	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problem	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer (Type):
Comments:				

● SOCIAL HISTORY ↓↓ CHECK BELOW ↓↓

Do you use tobacco?	☐ Current Everyday Smoker ☐ Former Smoker ☐ Never a Smoker ☐ Dip/Chew ☐Unknown
Do you drink alcohol?	☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Are you currently working?	☐ Yes ☐ No ☐ Retired ☐ Disabled ☐ Student
Please list work restrictions, if any:	
Employer:	Occupation:

● SURGICAL HISTORY

Select all previous hospitalizations/surgeries:

☐ Arthroscopy: Knee	☐ Right ☐ Left	☐ Total Knee Replacement	☐ Right ☐ Left
☐ Arthroscopy: Shoulder	☐ Right ☐ Left	☐ Total Shoulder Replacement	☐ Right ☐ Left
☐ Carpal Tunnel Release	☐ Right ☐ Left	☐ Spinal Surgery: Indicate Level:	
☐ Rotator Cuff Repair	☐ Right ☐ Left	☐ Neck:	☐ Back:
☐ Total Hip Replacement	☐ Right ☐ Left	☐ Appendectomy	☐ Hernia Repair
☐ Aneurysm (Brain) Surgery	☐ Aortic Bypass/Vascular Surgery		☐ LAP Band/Gastric
☐ Hysterectomy	☐ Heart Surgery		☐ Stents
☐ Mastectomy	☐ Malignancy/Cancer (type):		☐ Cesarean Surgery
☐ Cholecystectomy (Gallbladder)	☐ Plastic Surgery		☐ Cataract (Eye) Surgery
☐ Other Surgery:			☐ None

● PAST MEDICAL HISTORY

Do you have a personal history of any of the following? If so, please check below. If no, please state none.

☐ Aneurysm: Where:	☐ Emphysema	☐ Kidney Disease
☐ Angina (Chest Pain)	☐ Epilepsy	☐ Kidney Stones
☐ Arthritis: Type:	☐ Heart Attack	☐ MRSA Infection
☐ Asthma	☐ Hepatitis: Type:	☐ Pacemaker
☐ Bone or Joint Infections	☐ HIV/AIDS	☐ Phlebitis (Blood Clots)
☐ Cancer: Type:	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Chemo/Radiation	☐ Hypertension	☐ Reaction to Anesthesia
☐ COPD	☐ Hyperthyroidism	☐ Seizures
☐ Congestive Heart Failure	☐ Hypothyroidism	☐ Stomach Ulcers
☐ Diabetes: Type:	☐ Last A1C:	☐ Stroke-TIA
		☐ Tuberculosis
☐ Other		☐ None

● HISTORY OF PRESENT ILLNESS

Is your problem the result of an injury or accident?

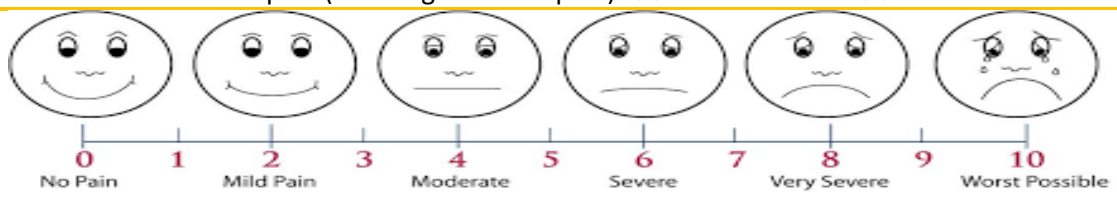
☐ No Injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery

Describe the onset: ☐ Acute (sudden) ☐ Chronic (3+ mo.)		
How long have the symptoms been present? # of ☐ Days ☐ Weeks ☐ Months ☐ Years		
Have you had a problem like this before?	☐ Yes ☐ No	If yes, when:
Have you been seen in the ER for this problem?	☐ Yes ☐ No	If yes, list ER:

What happened to you? Tell your story:

What do you want from today's visit?

● DESCRIBE YOUR PAIN Rate the pain (10 being the most pain): ↓↓ CIRCLE BELOW ↓↓

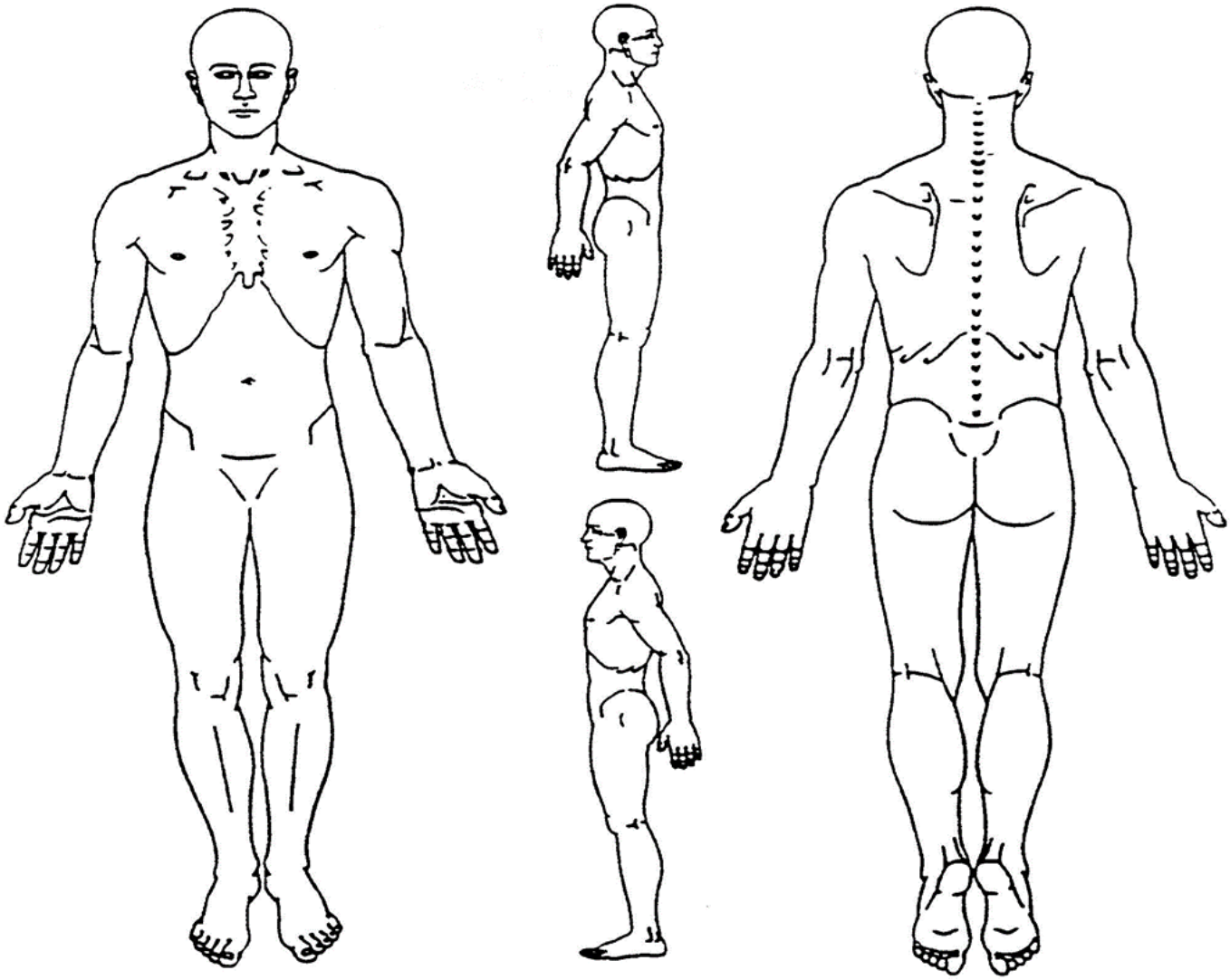


Do the symptoms keep you from sleep?	☐ Yes ☐ No	What is the timing of the symptoms?	☐ Constant ☐ Intermittent
What makes symptoms worse?	☐ Squatting ☐ Kneeling ☐ Sitting ☐ Driving ☐ Bending ☐ Twisting ☐ Moving ☐ Stairs ☐ Standing ☐ Running ☐ Lifting ☐ Walking ☐ Athletics ☐ Reaching Overhead ☐ Lying in Bed		
Are there any other symptoms associated with this problem?	☐ Redness ☐ Bruising ☐ Clicking ☐ Locking ☐ Swelling ☐ Limping ☐ Popping ☐ Instability ☐ Abnormal Balance ☐ Giving Away		
How are you doing overall?		Do you have weakness?	☐ Yes ☐ No

▼▼ MUST FILL OUT ▼▼

Where exactly do you hurt? Use these symbols to mark. Please draw a line.

Numbness:	Pins & Needles:	Burning:	Aching:	Stabbing:
----------	OOOOOOOOO	^^^^^^^	XXXXXXX	⊗⊗⊗⊗⊗⊗
----------	OOOOOOOOO	^^^^^^^	XXXXXXX	⊗⊗⊗⊗⊗⊗



• **PRIOR TESTING:** Have you had any prior tests for this problem?

☐ None ☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG)

• **PRIOR TREATMENT**			
☐ Ice	☐ Improved	☐ Worsened	☐ Unchanged
☐ Heat	☐ Improved	☐ Worsened	☐ Unchanged
☐ Rest	☐ Improved	☐ Worsened	☐ Unchanged
☐ NSAID's	☐ Improved	☐ Worsened	☐ Unchanged
☐ Pain Medication	☐ Improved	☐ Worsened	☐ Unchanged
☐ Muscle Relaxers	☐ Improved	☐ Worsened	☐ Unchanged
☐ Chiropractor	☐ Improved	☐ Worsened	☐ Unchanged
☐ Physical Therapy	☐ Improved	☐ Worsened	☐ Unchanged
☐ Home Exercise Program	☐ Improved	☐ Worsened	☐ Unchanged
☐ Injections	☐ Improved	☐ Worsened	☐ Unchanged
☐ Bracing	☐ Improved	☐ Worsened	☐ Unchanged
☐ Tens Unit	☐ Improved	☐ Worsened	☐ Unchanged
☐ Surgery	☐ Improved	☐ Worsened	☐ Unchanged
☐ Other:			

• **DESCRIPTION OF THE SYMPTOMS:** Please check description(s) pertaining to your chief complaint		
Neck:	☐ Right ☐ Left	☐ Pain ☐ Burning ☐ Stiffness ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Dull ☐ Shooting ☐ Numbness/Tingling
Upper Back:	☐ Right ☐ Left	☐ Pain ☐ Burning ☐ Stiffness ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Dull ☐ Shooting ☐ Numbness/Tingling
Shoulder:	☐ Right ☐ Left	☐ Pain ☐ Burning ☐ Stiffness ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Dull ☐ Shooting ☐ Numbness/Tingling
Arm:	☐ Right ☐ Left	☐ Pain ☐ Burning ☐ Stiffness ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Dull ☐ Shooting ☐ Numbness/Tingling
Hand:	☐ Right ☐ Left	☐ Pain ☐ Burning ☐ Stiffness ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Dull ☐ Shooting ☐ Numbness/Tingling
Mid Back:	☐ Right ☐ Left	☐ Pain ☐ Burning ☐ Stiffness ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Dull ☐ Shooting ☐ Numbness/Tingling
Low Back:	☐ Right ☐ Left	☐ Pain ☐ Burning ☐ Stiffness ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Dull ☐ Shooting ☐ Numbness/Tingling
Hip:	☐ Right ☐ Left	☐ Pain ☐ Burning ☐ Stiffness ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Dull ☐ Shooting ☐ Numbness/Tingling
Buttocks:	☐ Right ☐ Left	☐ Pain ☐ Burning ☐ Stiffness ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Dull ☐ Shooting ☐ Numbness/Tingling
Lower Leg:	☐ Right ☐ Left	☐ Pain ☐ Burning ☐ Stiffness ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Dull ☐ Shooting ☐ Numbness/Tingling
Tail Bone:	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	Describe:
Pain Radiates:	☐ Yes ☐ No	If yes, from/to: (ex. Low back to right leg):

• **REVIEW OF SYSTEMS** **Please indicate if you have experienced any of the following symptoms in the last 6 months**

CONSTITUTIONAL:		☐ **NONE**
☐ Significant weight gain	☐ Significant weight loss	☐ Night Sweats
☐ Weight gain: _____ lbs.	☐ Weight loss: _____ lbs.	☐ Exercise Intolerance

EYES:				☐ **NONE**
☐ Double Vision	☐ Vision Change	☐ Vision Loss	☐ Blurred Vision	☐ Wears glasses and contact lenses

ENMT (Ears, Nose, Mouth/Throat):					☐ **NONE**
☐ Difficulty Hearing	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐ Sore Throat	☐ Snoring

CARDIOVASCULAR: ☐ **NONE**

☐ Palpitations	☐ Chest Pain on Exertion	☐ Heart Murmur	☐ No Treating Cardiologist

☐ Cardiologist: _____

Phone #: _____

RESPIRATORY:				**☐ NONE**
☐ C-Pap	☐ Chronic Cough	☐ Pneumonia	☐ Sleep Apnea	☐ Shortness of Breath

GASTROINTESTINAL:					**☐ NONE**
☐ Nausea	☐ Heartburn	☐ Vomiting	☐ Loss of Appetite	☐ Constipation	☐ Blood in Stool

GENITOURINARY:			**☐ NONE**
☐ Kidney Problems	☐ Painful Urination	☐ Incontinence	☐ Blood in Urine

☐ Bowel/Bladder Changes: _____

MUSCULOSKELETAL:			**☐ NONE**
☐ Osteoporosis	☐ Muscle Weakness	☐ Fractures	☐ Difficulty Walking

SKIN:					**☐ NONE**
☐ Lumps	☐ Lacerations	☐ Frequent Rashes	☐ Psoriasis	☐ Skin Ulcers	☐ Jaundice

NEUROLOGIC:					**☐ NONE**
☐ Loss of Coordination	☐ Frequent Falls	☐ Dizziness	☐ Numbness	☐ Headaches	☐ Migraines

PSYCHIATRIC:				**☐ NONE**
☐ Sleep Disorder	☐ Depression	☐ Illicit Drug Use	☐ Anxiety	☐ Drug/Alcohol Addiction

ENDOCRINE:		**☐ NONE**
☐ Heat/Cold Intolerance	☐ Fever	☐ Fatigue

HEMATOLOGIC:			**☐ NONE**
☐ Anemia	☐ Easy Bleeding	☐ Phlebitis (Clots)	☐ Easy Bruising

Patient Signature: _____ Date: _____