SEPA PAIN + SPINE

New Patient History / Eval Form

Patient Name:		**Date:**	**Gender: M / F**
Address:			
Date of Birth:	**Insurance Name:**	**Member ID:**	
Email:		**Phone Number:**	

REFERRING PHYSICIAN		**PRIMARY CARE PHYSICIAN**	
Name:		Name:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	

If not referred by a physician, how did you hear about our practice?

DESCRIBE YOUR PAIN

Main reason for visit:

How & when did the pain start?

Have you ever had this pain before? ☐Yes ☐No **If yes, how long ago?**

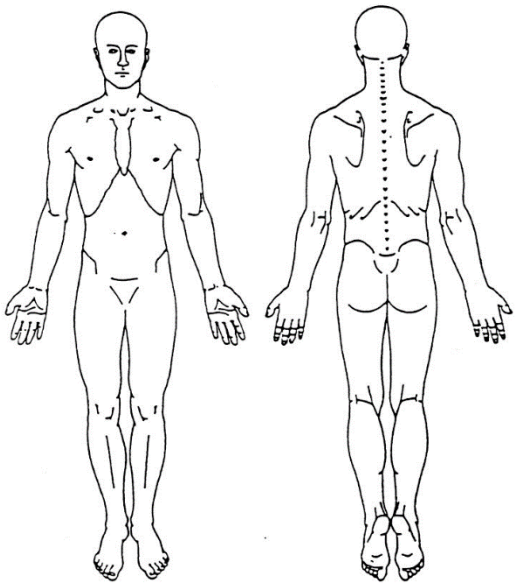
INSTRUCTIONS:

1. On the body diagram to the right, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.

2. On the line below, place an "X" to describe your present pain between the extremes of experiencing no pain at all to the worst pain you have ever felt.

No Pain — Worst Pain

1 — 10



Describe your pain (check all that apply):

☐Throbbing ☐Stabbing
☐Cramping ☐Aching
☐Shooting ☐Dull
☐Pressure ☐Spasms
☐Weakness ☐Constant
☐Intermittent ☐Hot/Burning
☐Tiring/Exhausting ☐Sharp
☐Numbness/Tingling
☐Other:

Pain is aggravated by (check all that apply):

☐Bending ☐Lifting
☐Exercise ☐Movement
☐Sitting ☐Standing
☐Walking ☐Lying Down
☐Changing position (sitting to standing)
☐Other:

Pain is alleviated by (check all that apply):

☐Bending ☐Mild Stretching
☐Ice ☐Hot Packs
☐TENS unit ☐Rest
☐Sitting ☐Lying Down
☐Other:

_____
Physician Initials

Do you have any of the following symptoms?	☐Bowel/Bladder incontinence ☐Muscle Weakness ☐Numbness/Tingling
List <u>all</u> medications you have used to treat this pain in the past:	

Have you had any of the following tests to evaluation your pain? (provide date & facility)

X-Rays: ☐No ☐Yes **MRI:** ☐No ☐Yes

CT Scan: ☐No ☐Yes **Myelogram:** ☐No ☐Yes

EMG: ☐No ☐Yes **Blood Tests:** ☐No ☐Yes

Bone Scan: ☐No ☐Yes **Discogram:** ☐No ☐Yes

Current/Previous Treatments for this Pain:

☐Epidural Steroid Injections

How many: _____ Type: _____ Date of last injection: _____

Facility/Physician _____

Relief: ☐None ☐Mild ☐Moderate ☐Excellent

Relief lasted: ____days _____weeks _____months _____years

☐Physical Therapy

How long was PT tried: ____days _____weeks _____months _____years

Frequency: _____ X per _____

Relief: ☐None ☐Mild ☐Moderate ☐Excellent

Relief lasted: ____days _____weeks _____months _____

☐ Chiropractic Therapy

How long was Chiro tried: ____days _____weeks _____months _____years

Frequency: _____ X per _____

Relief: ☐None ☐Mild ☐Moderate ☐Excellent

Relief lasted: ____days _____weeks _____months _____

☐ Massage Therapy

How long was Massage tried: _____days _____weeks _____months _____years

Frequency: _____ X per _____

Relief: ☐None ☐Mild ☐Moderate ☐Excellent

Relief lasted: _____days _____weeks _____months _____years

☐ Acupuncture

How long was Accu. tried: ____days _____weeks _____months _____years

Frequency: _____ X per _____

Relief: ☐None ☐Mild ☐Moderate ☐Excellent

Relief lasted: ____days _____weeks _____months _____

☐ Psychiatry / Psychology / Biofeedback

Providers Name: _____

Office Phone Number: _____

Explain: _____

_____

_____

_____
Physician Initials

CURRENT MEDICATIONS

List ALL medications you are currently taking (include prescriptions, over-the-counter, vitamins & supplements):

MEDICAL HISTORY (check all that apply)

- ☐ Neck Pain
- ☐ Back Pain
- ☐ Compression Fractures
- ☐ Osteoporosis/Osteopenia
- ☐ Herniated Disc (location: _____)
- ☐ Headaches
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Arthritis
- ☐ Gout
- ☐ Cancer (Type:)
- ☐ Prostate Disease
- ☐ Breast Disease
- ☐ Bleeding Disorders
- ☐ Stroke
- ☐ Seizures
- ☐ Pneumonia
- ☐ Diabetes
  Circle: Type 1/Type 2
- ☐ Hepatitis
  Circle: A B C
- ☐ Heart Burn/Reflux
- ☐ Stomach Ulcers
- ☐ Heart Disease
- ☐ Angina
- ☐ COPD (Emphysema)
- ☐ Chronic Wounds
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Hearing Loss
- ☐ Thyroid Disease
  Circle: Low High
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Urinary Tract Infection
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Erectile Dysfunction
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Blood Clots
- ☐ Pulmonary Emboli
- ☐ Coronary artery Disease
- ☐ MI / Heart Attacks
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Other:

Allergies (all including medication, food), indicate reaction:

☐ _____ ☐ No Known Drug Allergies (NKDA)

_____

SURGICAL HISTORY (check all that apply)

- ☐ None
- ☐ Cervical Surgery
  Procedure: _____
  Surgeon: _____
  Year: _____
- ☐ Lumbar Surgery
  Procedure: _____
  Surgeon:_____
  Year: _____
- ☐ Thoracic Surgery
  Procedure: _____
  Surgeon: _____
  Year: _____
- ☐ Kyphoplasty
- ☐ Vertebroplasty
- ☐ Spinal Surgery
- ☐ Orthopedic / Joint
- ☐ Cataracts
- ☐ LASIK
- ☐ Endoscopy/Colonoscopy
- ☐ Tonsillectomy/Adenoidectomy
- ☐ Thyroidectomy
- ☐ Coronary Bypass
- ☐ Cardiac Stent
- ☐ Pacemaker
- ☐ Heart Valve
- ☐ Gall Bladder
- ☐ Hysterectomy
- ☐ C-Section
- ☐ Bowel/Stomach Resection
- ☐ Hernia
- ☐ Prostate surgery
- ☐ Other:

FAMILY HISTORY

Race (optional): ☐ Caucasian ☐ African American/Black ☐ Hispanic/Latino ☐ Asian ☐ Native American / Alaskan Native

	Relation	Age @ Diagnosis	Current Age
Back/Neck Problems			
Depression/Mood Disorders			
High Blood Pressure			
Diabetes			
Cancer (list type)			

_____
Physician Initials

Other			

Father: Alive: ☐Yes ☐No Current Age: Age at Death (if applicable): Cause of Death (if applicable): _____ Health Problems:	**Mother:** Alive: ☐Yes ☐No Current Age: Age at Death (if applicable): Cause of Death (if applicable): _____ Health Problems:
Brothers: ☐None ☐Yes #_____ Current Age(s): Age at Death (if applicable): Cause of Death (if applicable): _____ Health Problems:	**Sisters:** ☐None ☐Yes____ Current Age(s): Age at Death (if applicable): Cause of Death (if applicable): _____ Health Problems:

SOCIAL HISTORY

Alcohol Use:	☐None	☐Yes Number of drinks: _____ per day Frequency: daily weekly monthly rarely Type of alcohol: _____
Tobacco Use:	☐None	☐Yes Smoke, or Other: _____ Amount: _____ per day Since: _____ ☐Quit Date Quit: _____
Other Recreational Drug Use:	☐None	☐Yes What drugs: _____ Frequency: daily weekly monthly rarely
Do you drive?	☐Yes ☐No	**Do you always wear a seatbelt?** ☐Yes ☐No ☐Sometimes
Do you exercise?	☐Yes ☐No	**If yes, how often?**
Work Status	☐Employed Full-time ☐Part-Time ☐Unemployed ☐Retired ☐Disabled Current/Former Occupation: Computer Scientist	
Are you on Disability?	☐Yes ☐No	
Marital Status	☐Married ☐Single ☐Widowed ☐Domestic Partnership	
With whom do you live?	☐Alone ☐Spouse ☐Child(ren) ☐Parents ☐Friends ☐Other:	
Do you have an attorney or legal action pending related to this pain/injury or any other health problems? ☐Yes ☐No If yes, please list attorney's name:		

REVIEW OF SYSTEMS (Check all that apply)				
General: ☐Weight loss or gain ☐Fatigue ☐Fever or chills ☐Weakness ☐Trouble Sleeping ☐Other:	**Skin:** ☐Rashes ☐Lumps ☐Itching/Dryness ☐Color changes ☐Hair/Nail changes ☐Other:	**Neck / Breasts:** ☐Lumps ☐Swollen glands ☐Pain or stiffness ☐Discharge ☐Breast-Feeding ☐Other:	**Vascular:** ☐Calf pain w/ walking ☐Leg cramping ☐Other:	**Hematologic:** ☐Easy bruising ☐Easy bleeding ☐Other:
Cardiovascular: ☐Chest pain or discomfort ☐Palpitations ☐Short of breath w/ activity ☐Difficulty breathing lying down ☐Swelling ☐Sudden awakening from sleep short of breath	**Respiratory:** ☐Cough ☐Sputum ☐Coughing up blood ☐Shortness of breath ☐Wheezing ☐Painful breathing ☐Other:	**HEENT:** ☐Headaches ☐Head injury ☐Earache ☐Decreased hearing ☐Vision loss/changes ☐Glaucoma ☐Cataracts ☐Nose – Stuffy/discharge	☐Hayfever, itching ☐Nose bleeds ☐Sinus pain ☐Sore throat ☐Dry mouth ☐Non-healing sores ☐Dentures ☐Thrush ☐Other:	**Endocrine:** ☐Heat/Cold intolerance ☐Sweating ☐Frequent urination ☐Thirst ☐Change in appetite ☐Other:
Gastrointestinal: ☐Difficulty swallowing ☐Change in appetite ☐Heartburn ☐Nausea ☐Change in bowel habits ☐Rectal bleeding ☐Constipation ☐Diarrhea ☐Yellow skin / eyes	**Urinary:** ☐Abnormal frequency ☐Abnormal urgency ☐Burning or pain ☐Blood in urine ☐Incontinence ☐Change in urinary strength ☐Other:	**Musculoskeletal:** ☐Muscle/Joint pain ☐Stiffness ☐Back pain ☐Redness of joints ☐Swelling of joints ☐Trauma ☐Other:	**Neurologic:** ☐Dizziness ☐Fainting ☐Seizures ☐Weakness ☐Numbness/Tingling ☐Tremors ☐Other:	**Psychiatric:** ☐Nervousness ☐Stress ☐Depression ☐Memory loss ☐Other: **OTHER:**

*** FOR PROVIDERS ONLY ***		
Reviewed Form: ☐ Current Problem/Treatments ☐ Medical/Surgical History ☐ Family History ☐ Social History ☐ Current Medications ☐ Radiology:_____ ☐ Other :_____		
Tests Reviewed: ☐MRI ☐CT Scan ☐EMG/NCS ☐X-Rays ☐Bone Scan ☐Other:		
PHYSICAL EXAM		
Height:	**Weight:**	**General Appearance:** ☐Normal ☐Abnormal:
Gait: ☐Normal ☐Antalgic		**Lungs:** ☐Clear ☐Wheezes ☐Rales
Gait: ☐Normal ☐Antalgic		**Heart:** ☐RRR ☐iRRR ☐Murmur
SLR: ☐RLE ☐LLE ☐Crossover		**Sensory:** ☐Normal ☐Decreased:
Motor: ☐Normal ☐Decreased:		**Trigger Pts:** ☐None ☐Present:
Diagnoses / ICD-10 Codes:		**Plan / Treatment:** _____ Physician/PA Signature (Print Last Name)

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Physician Initials