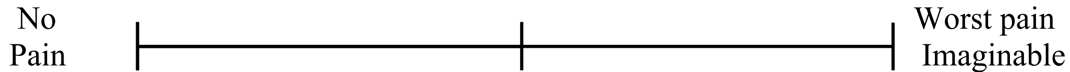
CDA Spine New Patient History

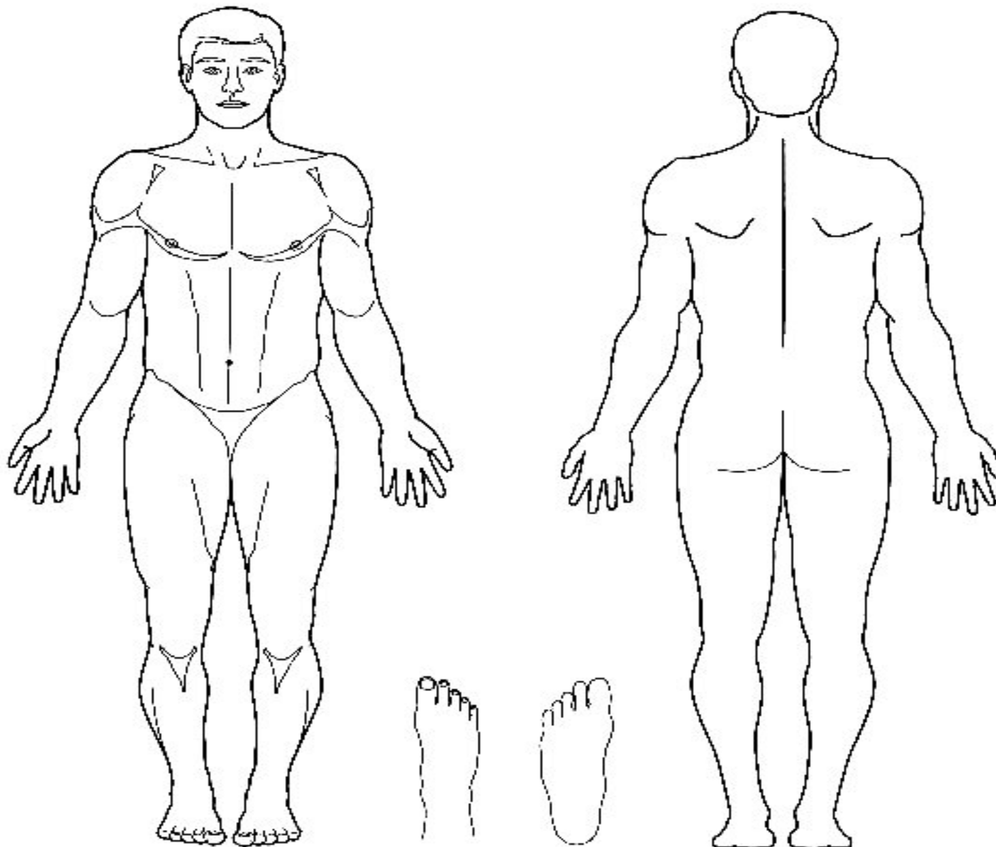
Name ____ Age ________
How did you find us? Chiropractor Therapist Friend/relative Internet
Doctor referral _______________ Other _________________

1. My current pain developed: Gradually Suddenly Date of onset ___/___/_____
Motor vehicle accident Attorney: ______________________________
Work injury: Date of injury _____/____/______

2. Please make a mark on the line below to show your average pain level over the past week.

No Pain  Worst pain Imaginable

Please use the following key to shade in the distribution of your pain on the figures:
Numbness ……….. **Pins and Needles** 00000000 **Pain** ///////////////



3. My pain is best described as (check all that apply): Constant Intermittent
Dull Sharp Throbbing Burning Tingling
Aching Stabbing Shooting Electrical

4. My pain is worse with (check all that apply): Bending forward Bending backward
Sitting Standing Walking Laying down
Looking up Looking down Turning left Turning right
Cough/ sneeze Lifting Pushing / pulling

5. My pain is better with: Laying down Sitting Standing Therapy
Changing positions Pain meds Ice Heat Nothing

6. Have you experienced **new** bowel or bladder leakage/accidents recently? Yes No

7. Have you had any of the following tests for the current problem in the last 2 years?
X-rays CT scan MRI EMG Bone scan
Diagnostic Spinal Injections (e.g. epidural, facet/sacroiliac joint block, discogram)

8. Have you tried the following treatments for my pain (Circle those that helped):
Physical Therapy Chiropractic Acupuncture Massage
Spinal Injections Home/gym exercises Surgery Traction

9. Have tried the following medications for my pain (Circle those that helped, X out those that didn't):
Anti-inflammatories (Ibuprofen, Aleve, Naproxen, Mobic, Celebrex, Diclofenac, Steroids)
Muscle relaxants (Soma, Flexeril, Carbamazepime, Zanaflex, Skelaxin, Robaxin, Methocarbamol)
Anti seizure drugs (Neurontin, Gabapentin, Lyrica)
Anti-depressants (Paxil, Zoloft, Nortriptyline, Amitriptyline)
Narcotics (Lortab, Hydrocodone, Oxycodone, Oxycontin, Ultram, Vicodin, Percocet, Methadone)

10. Medication Allergies: None Iodine Contrast dye Steroids Local Anesthetics
Latex Other: ____
Allergic Reaction that occurred**:** ____

11. Are you currently taking any blood thinning/anticoagulation medications? YES NO
(Coumadin, Warfarin, Pradaxa, Plavix, Aggrenox, Aspirin, Flax seed, Fish Oil etc.)

12. Pertinent Medications: ____________________ ________________ __________________
__________________ ____________________ ________________ __________________

13. Medical History:
Please check the following medical problems you have now, or have had:

Heart problems	Thyroid problems	Easy bleeding	Osteoarthritis
Asthma	Epilepsy	Colon disease	Ulcers
Diabetes	Migraines	Vascular problems	Kidney problems
Stroke	Depression	Hepatitis/HIV	Bladder problem
Anxiety	Osteoporosis	Fibromyalgia	Lung Disease
Anemia	High blood pressure	Rheumatoid arthritis	Cancer

Other:____

Have you had previous back or neck problems? □*Yes* □*No*
Have your received care from a mental health professional? □*Yes* □*No* □*Still seeing*_______________

14. Surgical History:
Spine surgery? None Neck/Cervical Mid-back/ Thoracic Spine Low back/lumbar
Orthopedic surgery? None Shoulder Elbow Wrist Hand Hip Knee Ankle Foot
Heart surgery or lung surgery? Yes No
Cardiac or peripheral stents? Yes No

17. Family History: Please check those illnesses that your family members have had

	Hypertension	Diabetes	Neurologic Problems	Heart Disease	Cancer	Arthritis
Father						
Mother						
Siblings						
Grandparents						

Father: *Living* *Deceased (Age)* ____ Mother *Living* *Deceased (Age)* ____

18. Social History:

Do you now, or did you ever smoke? No Yes Packs per day?_____ Quit?_________

Do you drink alcohol?___________ No Yes daily rarely

Do you now, or have you ever had a drug or alcohol problem? No Yes

Please explain:____

Marital Status: Single Married Divorced Widowed

19. Vocational History:

Employed Full Time Employed Part time Retired

Regular Duty Light Duty Disability (reason)_______________

Employer:____

Job Description:____

Years at current job: __________ Date last worked:___________

Rate your current job satisfaction: Very Satisfied Satisfied Indifferent Dissatisfied

Have you ever been on disability? No Yes: ___________________________________

How physically demanding is your job? Check one.

□*Very heavy (lifting > 100 pounds)* □*Heavy (lifting > 60 pounds)* □*Moderate (lifting > 30 pounds)*

□*Light (lifting > 10 pounds)* □*White collar (no lifting)*

20. Review of Systems:

Please check any of the symptoms you have had during the past year.

□*Fever*	□*Chills*	□*Unintentional weight loss of >10 #*	
□*Rashes*	□*Skin infections*	□*Itching of skin*	
□*Cataracts*	□*Glaucoma*	□*Double vision*	□*Loss of vision*
□*Ear infections*	□*Mouth sores*	□*Sore throat*	□*Nasal congestion*
□*Chest pain*	□*Leg swelling*	□*Irregular heart beat*	
□*Short of breath*	□*Cough*	□*Wheezing*	
□*Nausea*	□*Vomiting*	□*Abdominal pain*	
□*Blood in urine*	□*Painful urination*	□*Difficulty urinating*	
□*Dizziness*	□*Seizures*	□*Ringing in ears*	□*Memory loss*
□*Face numbness*	□*Arm numbness*	□*Leg numbness*	□*Sudden weakness*
□*Joint pain*	□*Muscle pain*	□*Difficulty walking*	
□*Depression*	□*Anxiety*	□*Hallucinations*	
□*High blood sugar*	□*Thyroid disorder*	□*Anemia*	

The information I have provided in this document is true and accurate to the best of my knowledge.

_____________________________________ _______________

Patient Signature Date