

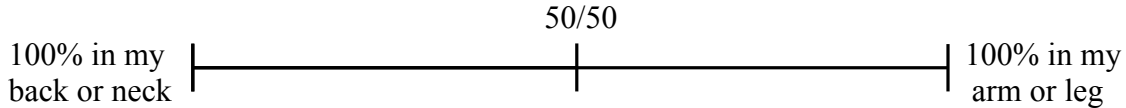
CDA Spine New Patient History

Name _____ Age _____ Today's Date _____
 Primary Care Physician _____ Consult requested by _____

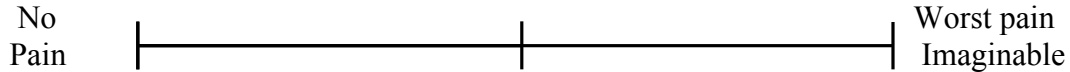
1. My current pain developed: Gradually Suddenly Date of onset ___/___/___
 Motor vehicle accident Attorney: _____
 Work injury: *If this is a work injury, please fill out the last page of this intake completely

2. My primary pain is located: _____

3. If you have back or neck pain, does it radiate into your arm/leg? Yes No

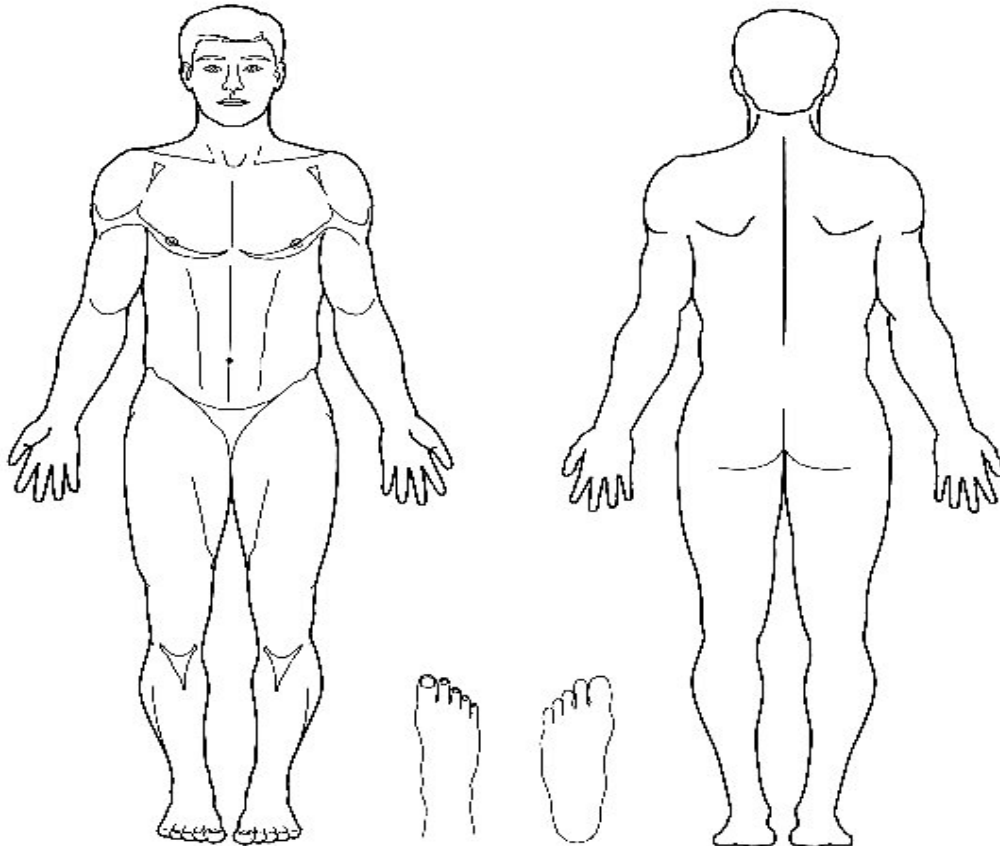


4. Please make a mark on the line below to show your average pain level over the past week.



Please use the following key to shade in the distribution of your pain on the figures:

Numbness **Pins and Needles** 00000000 **Pain** ///////////////



5. My pain is best described as (check all that apply):
- | | | | | |
|---------------------------------|-----------------------------------|------------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Constant | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Shooting | <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling |
| | | | <input type="checkbox"/> Electrical | |

6. 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
7. My pain is better with: Laying down Sitting Standing Therapy
 Changing positions Pain meds Ice Heat Nothing
8. Have you experienced **new** bowel or bladder incontinence recently? Yes No

9. Please list all other physicians you have seen for this problem:

Physician Name	City/State	Dates Seen	Reason Stopped Seeing

10. Have you had any of the following tests for the current problem? (date, location, and findings)

- X-rays _____
 CT scan _____
 MRI _____
 EMG _____
 Bone scan _____
 Diagnostic Spinal Injections (e.g. epidural, facet/sacroiliac joint block, discogram)

11. I have tried the following treatments for my pain (Circle those that helped, X out those that didn't):

- Physical Therapy Chiropractic Acupuncture Massage
 Spinal Injections Home/gym exercises Surgery Traction

12. I 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)

Allergies: None Iodine Contrast dye Steroids Local Anesthetics Latex

Other: _____

Allergic Reaction that occurred: _____

Current Medications and Dosages: _____

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

If yes, please describe? _____

Have you received care from a mental health professional? Yes No Still seeing _____

Surgical History (include approximate dates):

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

	Hypertension	Diabetes	Neurologic Problems	Heart Disease	Cancer	Arthritis
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Father Living Deceased (Age) _____

Brothers/Sisters #Living _____ #Deceased _____

Mother Living Deceased (Age) _____

Children #Living _____ #Deceased _____

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

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)

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

If this is a work related injury, please provide the following information. If not, then leave blank and sign at bottom of the page.

What is the date of your work injury? _____

Have you filed a claim yet? Yes No Has it been accepted? Yes No

State: _____ Claim # _____ Claims Manager: _____

Is there an attorney assisting you with this claim? Yes No Name: _____

Did you leave work after it happened? Yes No

Where else were you treated for this injury?

Physician Name	City/State	Dates Seen	Reason Stopped Seeing

How long have you been at your current job? _____

Are you currently working? Yes No If no, date last worked: _____

Do you have any current work restrictions? Yes No Restrictions: _____

Name of the physician who has placed you on work restrictions or off work: _____

Have you ever had a worker's compensation claim in the past: Yes No

Explain: _____

Do you have any past injuries in the same location as your work claim? Yes No

Explain: _____

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

Patient Signature

Date