

# New Spine History Form

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
 BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ HEIGHT: \_\_\_\_ FT. \_\_\_\_ IN. WEIGHT: \_\_\_\_\_

A. 1. Requesting doctor-full name and address: \_\_\_\_\_  
 If not referred, how did you choose this office? \_\_\_\_\_

2. Internist or family doctor-full name and address: \_\_\_\_\_

3. Chief complaint  neck pain arm:  pain  numbness  weakness  
 (check all that apply):  back pain leg:  pain  numbness  weakness other \_\_\_\_\_

4. Your age: \_\_\_\_ Years \_\_\_\_ Months

5. Your sex:  Male  Female

6. How long has the pain (or your problem) been present? \_\_\_\_\_

7. Has your problem worsened recently?  No  Yes - How recently? \_\_\_\_\_

8. What started the pain (or problem)? \_\_\_\_\_

## B. For patients with NECK OR ARM pain, numbness, or weakness:

(If you are seeing the doctor for back or leg pain, go to "C")

1. What % of your pain is neck pain and what % is arm pain? (check appropriate box)

- neck 0%, arm 100%  neck 10%, arm 90%  neck 25%, arm 75%  neck 40%, arm 60%  
 neck 50%, arm 50%  neck 60%, arm 40%  neck 75%, arm 25%  neck 90%, arm 10%  
 neck 100%, arm 0%

2. There is  no arm pain  arm pain is as follows (check the appropriate box):

- a.  right 0%, left 100%  right 10%, left 90%  right 25%, left 75%  right 40%, left 60%  
 right 50%, left 50%  right 60%, left 40%  right 75%, left 25%  right 90%, left 10%  
 right 100%, left 0%

b. The arm pain is present in (check appropriate box):

- Right:**  upper back  shoulder  upper arm  forearm  hand/finger  
**Left:**  upper back  shoulder  upper arm  forearm  hand/finger

3. Raising the arm:  improves the pain  worsens the pain  does not affect the pain

4. Moving the neck:  improves the pain  worsens the pain  does not affect the pain

5. There is:  no weakness of the arms and hands  weakness of the (check appropriate box):

- Right:**  shoulder  upper arm  forearm  hand/finger  
**Left:**  shoulder  upper arm  forearm  hand/finger

6. There is:  no numbness of the arms and hands  numbness of the (check appropriate box):

- Right:**  upper arm  forearm  thumb  index finger  long finger  ring finger  small finger  
**Left:**  upper arm  forearm  thumb  index finger  long finger  ring finger  small finger

7. There ( is  is no) difficulty picking up small objects like coins or buttoning buttons.

8. There ( is  is no) problem with balance or tripping frequently.

9. There are ( frequent  occasional  no) headaches in the back of the head.

END OF NECK QUESTIONS-PLEASE GO TO "D"





**H. FAMILY HISTORY:** Check all that apply.  none apply

<input type="checkbox"/> stroke	<input type="checkbox"/> arthritis	<input type="checkbox"/> mental illness
<input type="checkbox"/> heart trouble	<input type="checkbox"/> gout	<input type="checkbox"/> kidney trouble or stones
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> seizures	<input type="checkbox"/> cancer
<input type="checkbox"/> diabetes	<input type="checkbox"/> spine problems	<input type="checkbox"/> bleeding disorders

alcoholism  
 other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I. MEDICATIONS YOU TAKE:**  None

\_\_\_\_\_  
 \_\_\_\_\_

**J. ALLERGIES TO MEDICATIONS:**  no known drug allergies

MEDICATION	Rash	Swelling wheezing or shock	Upset stomach	Unknown reaction	OTHER
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**K. SOCIAL HISTORY:**

1. Work status:  homemaker  retired  disabled  on leave  
 unemployed  working: \_\_\_ full-time \_\_\_ part-time  
 occupation: \_\_\_\_\_

2. Marital status:  married  single  co-habiting  
 widowed  divorced

3. Number of living children:  1  2  3  4  5  
 6  7  8  9  10

4. I live:  alone  with: \_\_\_\_\_

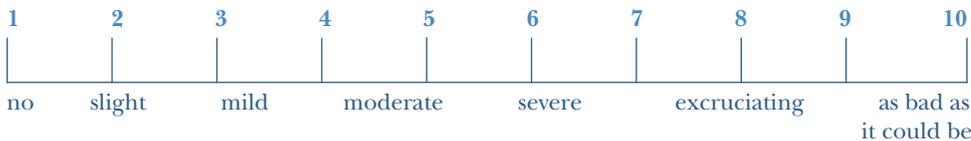
5. Tobacco use  never (skip to #6)  
 cigar  chew  pipe  cigarettes  
 \_\_\_\_\_ pack per day for \_\_\_\_\_ years.  
 quit-when? \_\_\_\_\_ after smoking  
 \_\_\_\_\_ packs per day for \_\_\_\_\_ years (total)

6. Alcohol:  Never or rare  
 social  frequently drunk (more than twice a week)  
 alcoholic  recovering alcoholic

7. Drug overuse/abuse:  never  currently  in the past

8. Because of this problem, I have filed or plan to file:  
 a lawsuit  a workers' compensation claim  
 neither a lawsuit nor workers' compensation claim

**MY PAIN / DISCOMFORT IS** (circle number)



\_\_\_\_\_  
 Doctor Signature Date

\_\_\_\_\_  
 Patient Signature Date

