Anchorage Fracture & Orthopedic Clinic
The Strength of Experience
a division of OrthoAlaska

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"

C. For patients with BACK OR LEG PAIN, numbness, or weakness.
(If you are seeing the doctor for neck problems, please complete section "B")

1. What % of your pain is back pain and what % is leg or buttock pain? (check appropriate box):
☐ back 0%, leg 100% ☐ back 10%, leg 90% ☐ back 25%, leg 75% ☐ back 40%, leg 60%
☐ back 50%, leg 50% ☐ back 60%, leg 40% ☐ back 75%, leg 25% ☐ back 90%, leg 10%
☐ back 100%, leg 0%

2. There is ☐ no leg pain ☐ leg pain as follows (check appropriate box):
a. ☐ right 0%, left 100% ☐ right 10%, left 90% ☐ right 25%, left 75% ☐ right 60%, left 40%
☐ right 50%, left 50% ☐ right 60%, left 40% ☐ right 75%, left 25% ☐ right 90%, left 10%
☐ right 100%, left 0%
b. The pain is present in (check appropriate box):
Right: ☐ buttock ☐ thigh-front ☐ thigh-back ☐ calf ☐ foot
Left: ☐ buttock ☐ thigh-front ☐ thigh-back ☐ calf ☐ foot

3. There is: ☐ no weakness of the legs ☐ weakness of (check appropriate box):
Right: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ big toe
Left: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ big toe

4. There is: ☐ no numbness of the legs ☐ numbness of (check appropriate box):
Right: ☐ thigh ☐ calf ☐ foot
Left: ☐ thigh ☐ calf ☐ foot

5. The worst position for the pain is: ☐ sitting ☐ standing ☐ walking

6. How many minutes can you stand in one place without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

7. How many minutes can you walk without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

8. Lying down: ☐ Eases the pain ☐ Does not ease the pain ☐ Sometimes eases the pain

9. Bending forward: ☐ Increases the pain ☐ Decreases the pain ☐ Does not affect the pain

D. * * * ALL PATIENTS SHOULD ANSWER THE FOLLOWING * * *

1. Coughing or sneezing (☐ increases ☐ sometimes increases ☐ does not increase) the pain.

2. There is: ☐ no loss of bowel or bladder control ☐ loss of bowel or bladder control since _____

3. I have: ☐ not missed any work because of this problem ☐ missed (how much?) work _____

4. Treatments have included: ☐ No medicines, therapy, manipulations, injections, or braces.

Neck	Back		Neck	Back	
☐	☐	Physical therapy, exercise	☐	☐	Anti-inflammatory medications
☐	☐	Massage & ultrasound	☐	☐	Narcotic medication
☐	☐	Traction	☐	☐	Epidural steroid injections times-
☐	☐	Manipulation			which relieved the pain for (how long?) _____
☐	☐	TENS unit	☐	☐	Trigger point injections times-
☐	☐	Shoulder injections			which relieved the pain for (how long?) _____
☐	☐	Braces	☐	☐	Other _____

5. List pain medications and dose taken for your spine problem: ☐ None

Medication	Dose

6. Previous doctors seen about this problem: ☐ None

Doctor	Specialty	City (if not Anchorage)	Treatments

7. Tests done to evaluate your problem, dates, and location where they were done: ☐ None

	neck	back	#1 DATE WHERE	#2 DATE WHERE	#3 DATE WHERE
Plain X-rays	☐	☐			
Myelogram	☐	☐			
CT scan	☐	☐			
MRI scan	☐	☐			
EMGs	☐	☐			
Bone scan	☐	☐			

E. REVIEW OF SYSTEMS: Check all that apply.

☐ None apply

☐ Reading glasses
☐ Change of vision
☐ Loss of hearing
☐ Ear pain
☐ Hoarseness
☐ Nosebleeds
☐ Difficulty swallowing
☐ Morning cough
☐ Shortness of breath
☐ Fever or chills
☐ Heart to chest pain

☐ Abnormal heartbeat
☐ Swollen ankles
☐ Calf cramps w/walking
☐ Poor appetite
☐ Toothache
☐ Gum trouble
☐ Nausea or vomiting
☐ Stomach pain
☐ Ulcers
☐ Frequent belching
☐ Frequent diarrhea

☐ Frequent constipation
☐ Hemorrhoids
☐ Frequent urination
☐ Burning on urination
☐ Difficulty starting urination
☐ Up more than once/ night to urinate
☐ Frequent headaches
☐ Blackouts
☐ Seizures
☐ Frequent rash

☐ Hot or cold spells
☐ Recent weight change
☐ Nervous exhaustion

Women only:

☐ Irregular periods
☐ Vaginal discharge
☐ Frequent spotting

☐ Other _____

F. MEDICAL HISTORY: Check all that apply.

☐ None apply

☐ Heart attack
☐ Heart failure
☐ High blood pressure
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Ankylosing spondylitis
☐ Gout
☐ Osteoporosis

☐ Diabetes
☐ Stroke
☐ Seizures
☐ Mental illness
☐ Kidney stones
☐ Kidney failure
☐ Cancer
☐ Alcoholism

☐ Lung disease
☐ HIV
☐ AIDS
☐ Tuberculosis
☐ Asthma
☐ Blood clot in leg
☐ Blood clot in lung
☐ Stomach ulcers

☐ Liver trouble
☐ Hepatitis
☐ Thyroid trouble
☐ Bleeding disorders
☐ Anemia
☐ Serious injuries (explain)

☐ Other

G. SURGICAL HISTORY: Previous surgeries - list procedures, surgeon, and date.

Doctor Specialty City (if not Anchorage) Treatments

OPERATION	SURGEON	DATE

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

☐ stroke	☐ arthritis	☐ mental illness	☐ alcoholism
☐ heart trouble	☐ gout	☐ kidney trouble or stones	☐ other: _____
☐ high blood pressure	☐ seizures	☐ cancer	_____
☐ diabetes	☐ spine problems	☐ bleeding disorders	_____

I. MEDICATIONS YOU TAKE: ☐ None

_____

_____

J. ALLERGIES TO MEDICATIONS: ☐ no known drug allergies

MEDICATION	Rash	Swelling wheezing or shock	Upset stomach	Unknown reaction	OTHER
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____

K. SOCIAL HISTORY:

1. Work status: ☐ homemaker ☐ retired ☐ disabled ☐ on leave
☐ unemployed ☐ working: ___ full-time ___ part-time

occupation: _____

2. Marital status: ☐ married ☐ single ☐ co-habitating
☐ 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)

1 2 3 4 5 6 7 8 9 10

no slight mild moderate severe excruciating as bad as it could be

_____ _____
Doctor Signature Date

_____ _____
Patient Signature Date