SPINE & SCOLIOSIS SPECIALISTS
ADVANCED TREATMENT & SURGERY

2105 Braxton Lane, Suite 101 • Greensboro, NC 27408
4590 Premier Drive • High Point, NC 27265
Phone: (336) 333-6306 • Fax: (336) 333-6309

Date: _____

Patient Name:_____ Date of Birth:_____
(please print) (month/day/year)

Gender: ❑ Male ❑ Female Are you currently pregnant or nursing: ❑ Yes ❑ No

---

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

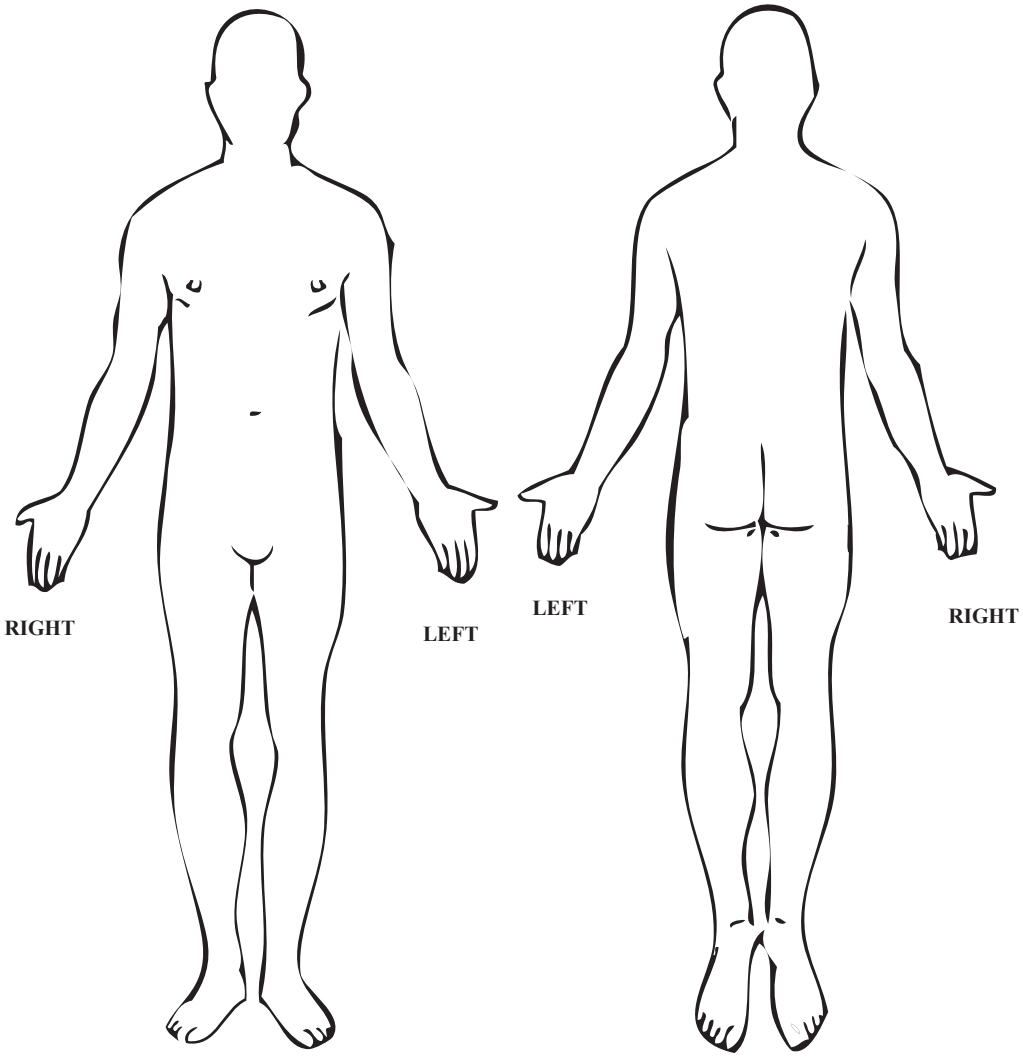
Ache
^^^^^
^^^^^
^^^^^

Numbness
OOOO
OOOO
OOOO

Pins & Needles
= = = =
= = = =
= = = =

Burning
XXXX
XXXX
XXXX

Stabbing
/ / / / /
/ / / / /
/ / / / /



Pain Description

How bad is your pain? Place an "X" (—X—) on each of the lines below to indicate your pain.

No Pain ---------- How bad is your **low back** pain? ---------- Worst Possible

No Pain ---------- How bad is your **leg** pain? ---------- Worst Possible

No Pain ---------- How bad is your **middle back** pain? ---------- Worst Possible

No Pain ---------- How bad is your **neck** pain? ---------- Worst Possible

No Pain ---------- How bad is your **arm** pain? ---------- Worst Possible

Do you have any of the following problems?

(Please indicate your answer with a check mark.)

Is your pain worse at night? ❑ Yes ❑ No
Does your pain awaken you from sleep? ❑ Yes ❑ No
Does coughing affect your pain? ❑ Yes ❑ No
Do your legs tire/hurt if you walk too far? ❑ Yes ❑ No
If YES, how far can you walk? ❑ Less than 1 block
❑ 1-3 blocks ❑ More than 3 blocks
Is this relieved by resting your legs? ❑ Yes ❑ No
Is this relieved by bending forward? ❑ Yes ❑ No

Bladder Control (urine):
❑ No problem
❑ Can't empty bladder
❑ Loss of urine (accidents)

Bowel Control:
❑ No problem
❑ Constipation
❑ Loss of control (accidents)

Onset of Symptoms

Approximately when did this pain begin? _____
What caused your current pain episode? _____
Is your pain the result of a Motor Vehicle Accident or Personal Injury? (legal term describing injury sustained to your person by negligence of another) ❑ Yes ❑ No
How did your current pain episode begin? ❑ Gradually ❑ Suddenly
Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same
Is your pain the result of a worker's compensation injury? ❑ Yes ❑ No
How long had you worked for your employer when you were injured? _____ years _____ months
Have you had a previous worker's compensation claim? ❑ Yes ❑ No If yes, number of claims ____

Please indicate if the following activity changes your level of pain:

ACTIVITY	INCREASE PAIN	DECREASE PAIN	NO CHANGE
Sitting	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Lying Down	❑	❑	❑
Changing Positions	❑	❑	❑
Leaning Forward	❑	❑	❑

What do you want to happen as a result of this visit?_____

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:
❑ Aggrenox ❑ Coumadin / Warfarin ❑ Effient ❑ Lovenox ❑ Plavix ❑ Pletal ❑ Pradaxa ❑ Prasugrel
❑ Ticlid ❑ Other_____

Please list all medications you are currently taking. Attach an additional sheet if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? ❑ Yes ❑ No

If so, please list all medications you are allergic to.

Medication Name	Allergic Reaction Type (Rash, Hives, wheezing, other)

Topical Allergies: ❑ Iodine ❑ Latex ❑ Tape Are you allergic to shellfish or contrast dye? ❑ Yes ❑ No

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medicine
❑ Cancer - Type _____
❑ Diabetes - Type I _____
❑ Diabetes - Type II _____
❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
❑ Headaches
❑ Migraines
❑ Head Injury
❑ Hyperthyroidism
❑ Hypothyroidism
❑ Glaucoma

Cardiovascular/Hematologic
❑ Anemia
❑ Bleeding Disorders
❑ Heart Attack
❑ High Blood Pressure
❑ High Cholesterol
❑ Mitral Valve Prolapse
❑ Murmur
❑ Phlebitis
❑ Poor Circulation
❑ Stroke
❑ Coronary Artery Disease

Respiratory
❑ Asthma
❑ Bronchitis
❑ Emphysema/COPD
❑ Pneumonia
❑ Tuberculosis
❑ Valley Fever

Gastrointestinal
❑ Bowel Incontinence
❑ GERD (Acid Reflux)
❑ Gastrointestinal Bleeding
❑ Constipation

Musculoskeletal
❑ Amputation
❑ Bursitis
❑ Carpal Tunnel Syndrome
❑ Chronic Low Back Pain
❑ Chronic Neck Pain
❑ Chronic Joint Pain
❑ Fibromyalgia
❑ Joint Injury
❑ Osteoarthritis
❑ Osteoporosis
❑ Phantom Limb Pain
❑ Rheumatoid Arthritis
❑ Tennis Elbow
❑ Vertebral Compression Fracture

Genitourinary/Nephrology
❑ Bladder Infection(s)
❑ Dialysis
❑ Kidney Infection(s)
❑ Kidney Stones
❑ Urinary Incontinence

Hepatic
❑ Hepatitis A (active / inactive / unsure)
❑ Hepatitis B (active / inactive / unsure)
❑ Hepatitis C (active / inactive / unsure)

Neuropsychological
❑ Alcohol Abuse
❑ Alzheimer Disease
❑ Bipolar Disorder
❑ Depression
❑ Epilepsy
❑ Prescription Drug Abuse
❑ Multiple Sclerosis
❑ Paralysis
❑ Peripheral Neuropathy
❑ Schizophrenia
❑ Seizures
❑ Street Drugs
❑ Reflex Sympathetic Dystrophy/CRPS
❑ Other Diagnosed Conditions
_____
_____

Surgical History

List Any Past Surgeries and Date ❑ **None** ❑ **See Attached List**

_____

_____

_____

_____

_____

Family History

❑ **None** ❑ **Unknown/Adopted OR indicate if any of your blood relatives have had any of the following conditions**

❑ Bleeding Disorder	❑ Diabetes	❑ Muscle Disorders	❑ Respiratory Disease
❑ Blood Disease	❑ Heart Disease	❑ Nerve Disorders	❑ Rheumatiod Arthritis
❑ Cancer: type:_____	❑ High Blood Pressure	❑ Osteoarthritis	❑ Scoliosis
❑ Depression	❑ Kidney Disease	❑ Osteoporosis	❑ Other:_____

Social History

Tobacco Use: ❑ Non Smoker ❑ Former Smoker _____Year Quit ❑ Current Smoker _____# Packs/Day _____# Years
❑ Cigarette ❑ Cigar ❑ Smokeless Tobacco ❑ Other_____
Alcohol Use: ❑ Never ❑ Rarely ❑ Weekly ❑ Daily
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other
Level of education completed? ❑ High School ❑ 1–4 yrs College ❑ >4 yrs College

Work History

Do you work? ❑ Full-time ❑ Part-time ❑ Disabled ❑ Retired ❑ NA
Are you on Light Duty? ❑ Yes ❑ No ❑ NA
What is your occupation? _____
Do you enjoy your work? ❑ Yes ❑ No ❑ NA

Patient's Initials _____

Your Previous Treatment

Please indicate if you have received any of the following treatments for your pain condition, when the treatment occurred and whether the out come was positive (+) or negative (-)

Treatment	Approximate Month & Year	Result (+ or -)
Surgery 1		
2		
3		
Physical Therapy		
Chiropractic Treatment		
Injections in the Office		
Injections Guided by X-Ray ❑ Epidural Steroid Injection ❑ Facet Joint Injection ❑ Sacroiliac (SI) Joint Injection ❑ Hip Joint Injection ❑ Other		

Your Past Medical Providers

So that we may better evaluate your medical condition, we would like to have a complete record of your past medical history. Please list all of the medical providers you have seen for your pain so that we may request your records. We ask that his list be as complete as possible so that we may provide a proper treatment plan.

Medical Provider's Name:	Provider's Telephone #:
1. Primary Care Physician:	
2.	
3.	
4.	

For your current back/neck pain, please mark the boxes for the time frame that any test were done.

	< 6 mo	< 12 mo		< 6 mo	< 12 mo
X-rays	❑	❑	Myelogram	❑	❑
MRI scan	❑	❑	Discogram	❑	❑
CT scan	❑	❑	EMG/NCV (nerve test)	❑	❑

Review of Systems

Mark the following signs and/or symptoms you experience:

Constitutional:
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Night Sweats
- ❑ Weakness
- ❑ Weight Gain
- ❑ Weight Loss

HEENT:
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Difficulty or Pain with Swallowing
- ❑ Ear Drainage
- ❑ Facial Pain
- ❑ Headache
- ❑ Hearing Loss
- ❑ Hoarseness
- ❑ Nasal Congestion
- ❑ Ringing in Ears
- ❑ Vertigo
- ❑ Vision Loss

Respiratory:
- ❑ Chest Pain (Respiratory)
- ❑ Cough
- ❑ Recent Infections
- ❑ Known TB Exposure
- ❑ Wheezing
- ❑ Difficulty or Pain with Breathing

Cardiovascular:
- ❑ Chest Pain
- ❑ Heart Murmur
- ❑ Leg Swelling
- ❑ Syncope
- ❑ Irregular Heartbeat/ Palpitations

Gastrointestional:
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ Black Tarry Stools
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Jaundice
- ❑ Loss of Appetite
- ❑ Nausea
- ❑ Vomiting

Genitourinary:
- ❑ Pain with Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Urge Incontinence
- ❑ Urinary Incontinence

Metabolic/Endocrine:
- ❑ Cold Intolerant
- ❑ Hair Loss
- ❑ Heat Intolerant

Neurological:
- ❑ Difficulty Walking
- ❑ Dizziness
- ❑ Poor Coordination
- ❑ Memory Loss
- ❑ Muscle Weakness
- ❑ Seizures
- ❑ Tremors

Psychiatric:
- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia

Integumentary:
- ❑ Contact Allergy
- ❑ Itchy Skin
- ❑ Rash
- ❑ Skin Infections
- ❑ Skin Lesion

Hematologic:
- ❑ Bleeding
- ❑ Bruising

Immunological:
- ❑ Asthma
- ❑ Bee Sting Allergies
- ❑ Environmental Allergies
- ❑ Food Allergies
- ❑ Seasonal Allergies
- ❑ Latex Allergy

- ❑ None of these apply to me

Signature: _____ Date: _____

OSWESTRY DISABILITY INDEX

If you have LOW BACK pain, complete this page.
If you only have neck pain, skip this page.

Please Read: This questionnaire gives us information on how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark the one box in each section that most closely describes you today.

Section 1 – Pain Intensity
- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)
- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it is very painful.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help, but manage most of my personal care.
- ❑ I need help every day in most aspects of self care.
- ❑ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it causes extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking
- ❑ Pain does not prevent me from walking any distance.
- ❑ Pain prevents me walking more than 1 mile.
- ❑ Pain prevents me walking more than 1/2 mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
- ❑ I can sit still in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me sitting more than 1 hour.
- ❑ Pain prevents me sitting more than 1/2 hour.
- ❑ Pain prevents me sitting more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing
- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want, but it causes extra pain.
- ❑ Pain prevents me from standing for more than 1 hour.
- ❑ Pain prevents me from standing more than 1/2 hour.
- ❑ Pain prevents me from standing more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping
- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain I get less than 6 hours sleep nightly.
- ❑ Because of pain I get less than 4 hours sleep nightly.
- ❑ Because of pain I get less than 2 hours sleep nightly.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex Life (if applicable)
- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal, but causes some extra pain.
- ❑ My sex life is nearly normal, but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life
- ❑ My social life is normal and causes me no extra pain.
- ❑ My social life is normal, but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sports, etc.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling
- ❑ I can travel anywhere without extra pain.
- ❑ I can travel anywhere, but it causes me extra pain.
- ❑ Pain is bad, but I can manage journeys over 2 hours.
- ❑ Pain restricts me to journeys of less than 1 hour.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Patient's Initials _____

NECK DISABILITY INDEX

If you have NECK pain, complete this page.

Please Read: This questionnaire enables us to understand how much neck pain has affected your ability to manage everyday activities. Please answer every section. Mark the one box in each section that most closely describes you today.

Section 1 – Pain Intensity
- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)
- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help, but manage most of my personal care.
- ❑ I need help every day in most aspects of self care.
- ❑ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it causes extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage
- ❑ light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Reading
- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with slight pain in my neck.
- ❑ I can read as much as I want with moderate pain in my neck.
- ❑ I cannot read as much as I want because of moderate pain in my neck.
- ❑ I cannot read as much as I want because of severe pain in my neck.
- ❑ I cannot read at all.

Section 5 – Headaches
- ❑ I have no headache at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headache**s that come frequently.**
- ❑ I have headaches almost all the time.

Section 6 – Concentration
- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

Section 7 – Work
- ❑ I can do as much work as I want to.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Section 8 – Driving
- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I cannot drive my car at all.

Section 9 – Sleeping
- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation
- ❑ I am able to engage in all of my recreational activities with no neck pain at all.
- ❑ I am able to engage in all of my recreational activities with some pain in my neck.
- ❑ I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- ❑ I am able to engage in only a few of my usual recreational activities because of pain in my neck.
- ❑ I can hardly do any recreational activities because of pain in my neck.
- ❑ I cannot do any recreational activities at all.

Patient's Initials _____

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How did you hear about us? (Please check the appropriate box)

- ❑ Other patient Name_____
- ❑ By Doctor _____
- ❑ Website
- ❑ TV Ad
- ❑ Google Search
- ❑ Women's Journal
- ❑ Kernersville Magazine
- ❑ Kids Sports Play
- ❑ Henry Magazine
- ❑ Triad Magazine
- ❑ Newspaper
- ❑ High Point Hospital Hand Book
- ❑ Temple Emanuel Newsletter
- ❑ ABC TV 45 Website
- ❑ Outdoor Sign
- ❑ Spine Universe
- ❑ Spine Health
- ❑ Yellow Pages
- ❑ Attorney
- ❑ Website
- ❑ Triad Business Journal
- ❑ Other _____