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

NEW ORTHOPAEDIC PATIENT ASSESSMENT

Date: ____________________

Name: ____ DOB: __________________

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

1. When did the problem start? ______________________________
2. Were you seen at ER? ❑ Yes ❑ No If yes, which one? ______________________________
3. Did you have surgery for this problem? ❑ Yes ❑ No If so, when? ______________________
4. Location of pain ___________________ ❑ Right ❑ Left ❑ Both
5. How bad is your pain? Circle the number that indicates the level of your pain.

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain**

6. **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 ______

7. Please check the words that best describe your pain:

❑ Aching ❑ Burning ❑ Dull ❑ Numbness ❑ Sharp ❑ Shooting ❑ Stabbing
❑ Throbbing ❑ Cramping ❑ Radiating ❑ Stinging ❑ Swelling ❑ Weakness

8. Are you working? ❑ Full Duty ❑ Light Duty ❑ Not Working

9. Please check the activities that increase, decrease or do not change the pain for which we are treating you:

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

10. Mark the following signs and/or symptoms you experience:

Constitutional:
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Malaise
- ❑ Night sweats
- ❑ Weakness
- ❑ Weight gain
- ❑ Weight loss

HEENT:
- ❑ Blurred vision
- ❑ Double vision
- ❑ Dysphagia
- ❑ Ear drainage
- ❑ Facial pain
- ❑ Headache
- ❑ Hearing loss
- ❑ Hoarseness
- ❑ Nasal congestion
- ❑ Ringing in ears
- ❑ Vertigo
- ❑ Vision loss

Respiratory:
- ❑ Asthma
- ❑ Chest pain (respiratory)
- ❑ Cough
- ❑ Dyspnea
- ❑ Recent infections
- ❑ Known TB exposure
- ❑ Wheezing

Cardiovascular:
- ❑ Chest pain
- ❑ Cyanosis
- ❑ Heart murmur
- ❑ Leg swelling
- ❑ Syncope
- ❑ Irregular heartbeat/ palpitations

Gastrointestional:
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Black tarry stools
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Jaundice
- ❑ Loss of appetite
- ❑ Nausea
- ❑ Vomiting

Genitourinary:
- ❑ Dysuria
- ❑ Frequent urination
- ❑ Hematuria
- ❑ Urge incontinence
- ❑ Urinary incontinence

Metabolic/Endocrine:
- ❑ Cold intolerant
- ❑ Hair loss
- ❑ Heat intolerant

Neurological:
- ❑ Difficulty walking
- ❑ Dizziness
- ❑ Poor coordination
- ❑ Memory impairment
- ❑ Muscle weakness
- ❑ Paresthesia
- ❑ Seizures
- ❑ Tremors

Psychiatric:
- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia

Integumentary:
- ❑ Itchy skin
- ❑ Rash
- ❑ Skin infections
- ❑ Skin lesion

Hematologic:
- ❑ Bleeding
- ❑ Bruising

Immunological:
- ❑ Bee sting allergy
- ❑ Contact allergy
- ❑ Contact dermatitis
- ❑ Environmental allergies
- ❑ Food allergies
- ❑ Seasonal allergies

❑ None of these apply to me

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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
- ❑ Sleep Apnea
- ❑ 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
- ❑ Anxiety
- ❑ Other Diagnosed Conditions ____________________ ____________________

Surgical History

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

____
____
____
____
____

❑ **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	❑ Rheumatoid 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 ❑ Vaping ❑ 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 Signature ________________________________ Date: ____________________

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)	☐	☐

Veterans Rand 12 Item Health Survey (VR-12)

First name: ____________ Last name: ____________ Date of birth: ____________

The following questions ask for your views about your health—how you feel and how well you are able to do your usual activities. All kinds of people across the country are being asked these same questions. Their answers and yours will help to improve health care for everyone. There are no right or wrong answers; please choose the answer that ***BEST FITS YOUR LIFE RIGHT NOW.***

Answer each question by checking the best response.

In general, would you say your health is: ❐ Excellent ❐ Very good ❐ Good ❐ Fair ❐ Poor

The following questions are about activities you might do during a typical day. Does your health not limit you in these activities? If so, how much?	Yes Limited a lot	Yes Limited a little	No Not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?	❐	❐	❐
Climbing several flights of stairs?	❐	❐	❐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?	No None of the time	Yes A little of the time	Yes Some of the time	Yes Most of the time	Yes All of the time
Accomplished less than you would like:	❐	❐	❐	❐	❐
Were limited in the kind of work or other activities:	❐	❐	❐	❐	❐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?	No None of the time	Yes A little of the time	Yes Some of the time	Yes Most of the time	Yes All of the time
Accomplished less than you would like:	❐	❐	❐	❐	❐
Didn't do work or other activities as carefully as usual:	❐	❐	❐	❐	❐

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

❐ Not at all ❐ A little bit ❐ Moderately ❐ Quite a bit ❐ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks	All the time	Most of the time	A good bit of the time	Some of the time	A little of the time
Have you felt calm and peaceful?	❐	❐	❐	❐	❐
Did you have a lot of energy?	❐	❐	❐	❐	❐
Have you felt downhearted and blue?	❐	❐	❐	❐	❐

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

❐ All of the time ❐ Most of the time ❐ Some of the time ❐ A little of the time ❐ None of the time

Now, we'd like to ask you some questions about how your health may have changed.

Compared to one year ago:	Much better	Slightly better	About the same	Slightly worse	Much worse
How would you rate your physical health in general now:	❐	❐	❐	❐	❐
How would you rate your emotional problems:	❐	❐	❐	❐	❐

Your answers are important!
Thank you for completing this questionnaire!

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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 ________________________________