SPINE & SCOLIOSIS SPECIALISTS
ADVANCED TREATMENT & SURGERY

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NEW SPINE PATIENT FORM

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.

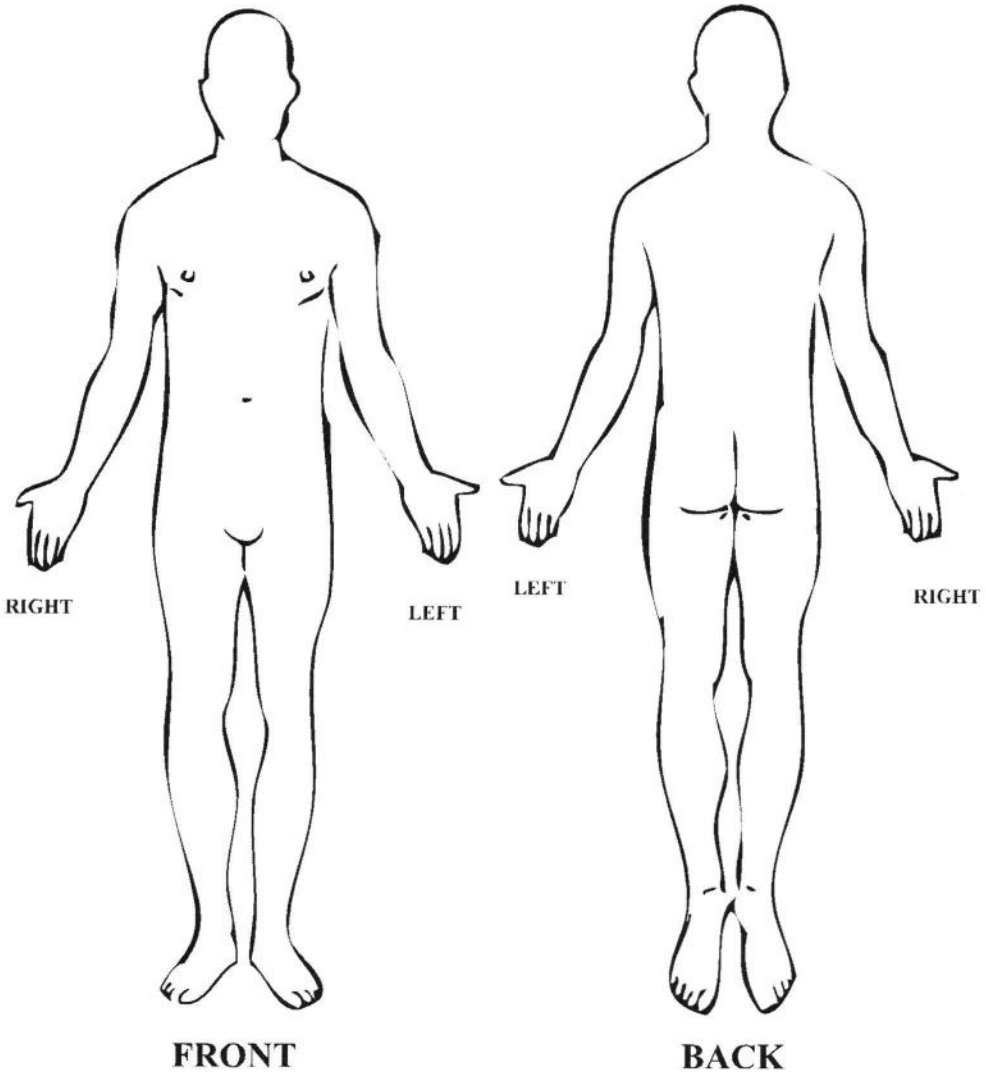
Ache
^^^^^
^^^^^
^^^^^

Numbness
OOOO
OOOO
OOOO

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

Burning
XXXX
XXXX
XXXX

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



GSSC-43, Rev. (03-19)

Pain Description

How bad is your pain? Circle the number that indicates the level of your pain.

	How bad is your **low back** pain?											
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible
	How bad is your **leg** pain?											
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible
	How bad is your **middle back** pain?											
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible
	How bad is your **neck** pain?											
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible
	How bad is your **arm** pain?											
No Pain	0	1	2	3	4	5	6	7	8	9	10	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 ❑ Brilinta ❑ Savaysa (Edoxaban) ❑ 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**

_____

_____

_____

_____

_____

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	❑ 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 Initials _____ 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)	❑	❑

Review of Systems

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

Signature: _____ Date: _____