Integrated Spine Care

Initial Visit Information

Date form completed:___________

Prior to your visit, please take a moment to answer each question and complete all areas that apply to your health. This information will be reviewed by the physician and will be useful in the evaluation and treatment of your condition.

Name:__________________________ **Date of Birth** __________ **Age:** _______ **Sex:** M / F

Phone Number: _______________________ **Handedness:** Right / Left / Both

Primary Care Physician:__________________________ **Referring Physician:** __________________________

Additional Physicians: ____

List other Physicians you have seen for this condition: ____________________________________

Reason for visit (Please describe your condition, when and how it started, what caused it; if you have pain- where is it? please describe) Also include Date Of Injury

Past Medical History:

List All Health Problems:	List All Surgeries: (month / year)	List Surgeons:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.

Have you ever had a major injury? Yes / No **If yes, please describe:**

Have you been placed on Disability? Yes / No **If yes, for what condition, when, please describe:**

Do you have any Drug, Latex, or Dye Allergies? Yes / No **If yes, list medication, reaction and when it last occurred.**

Medications: **(Please list ALL medications including: pain medications, vitamins, herbal and holistic supplements)**

Medication	Dosage	How many per day	Date started	Prescribing Physician

List additional medications on back of form.

Employment History:

Occupation: ________________________ **Employer:** ___________________________ **Years employed at present job** __________

Does your job involve lifting? Yes / No **Typical lifting weight:** ____________

Have you ever considered changing your job because of your spine problem? Yes / No

Have you missed work due to your condition? Yes / No **How much time have you missed work?** _________________

Are you working now? Yes / No **What is your present work status:** Full time/ Full Duty **or** restricted **?**

If restricted, describe restriction: ________________________________ **How long have you been on restricted status?** ______

If not working, when were you taken off work (by whom): ____

Social History:

Marital History: Single / Married / Divorced / Widowed **Number of children:** 0 / 1 / 2 / 3 / 4 / 5 ____

Education Completed: Elementary / High School / College / Advanced **Degree?** ________________

Do you use tobacco products: Yes / No **Type:** _________________

Amount: _________ **How many years have you used tobacco products?** _______________

Have you smoked in the past? Yes / No **Number of years smoked:** ______ **Year quit:** ________________

Do you drink Alcohol? Yes / No **Type and number of drinks per week:** _______________________________

Do you have a history of alcohol or drug abuse? Yes / No **If yes describe:** ______________________________

Have you ever had treatment to stop drinking? Yes / No **Date:** ___________________________________

Do you use or have you ever-used Street Drugs? Yes / No **Type:** ____________________ **How often:** ____________

Present Height: ________ **Weight:** ________ **Any recent weight loss or gain?** Yes/No **How much?** _______________

Do you exercise? Yes / No **Describe type and frequency:** ____

Do you have a special diet? Yes/No **Describe:** ____

Do you have any special activities or hobbies? If yes, please describe:

Family Health History:

Do medical problems run in your family? Yes / No / Unknown
If yes, please list family member(s) and medical problem(s):

Injury / Legal

Is your current condition related to a work injury? Yes / No / Unsure

Have you filed a worker's compensation claim? Yes / No **Is your claim contested by you employer**? Yes / No

Have you had a worker's compensation or previous injury claim at any time for prior problems? Yes / No
Please describe claim(s): ____

Regarding current condition, do you have personal injury claim? Yes / No

Name of Attorney handling your claim (if appropriate): ______________________________

Describe current injury or accident & date it occurred:

STRENGTH

Do you have weakness? Yes / No
Location and description:

Do you have to stop walking due to weakness? Yes / No

Do you have lack of bowel or bladder control? Yes / No

Do you have decrease in sexual function? Yes / No

SENSATION

Do you have loss of feeling or numbness? Yes / No
Location and description:

PAIN REVIEW

Do you presently have pain? Yes / No

Location and description:

Does the pain wake you from sleep? Yes / No

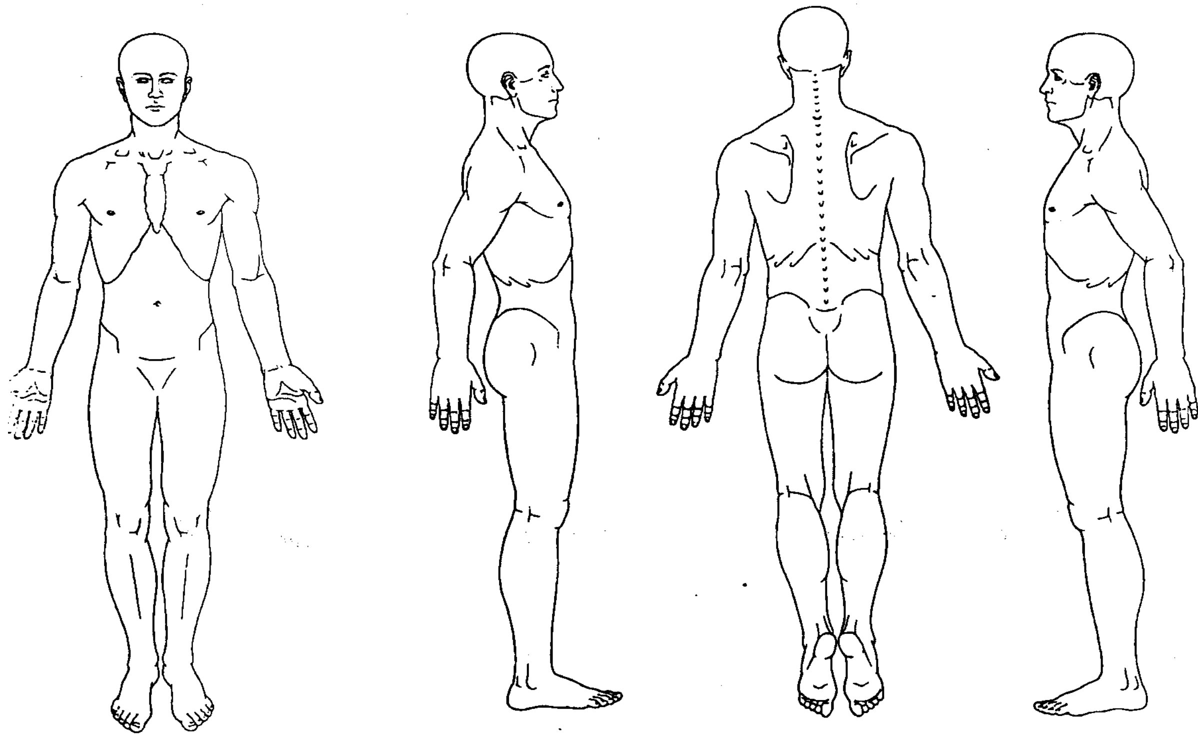
Factors that effect my pain: (check appropriate line)

	Better	Worse	No Different
1) With cough or sneeze	_____	_____	_________
2) Sitting	_____	_____	_________
3) Bending forward, as in brushing teeth	_____	_____	_________
4) Walking	_____	_____	_________
5) Prolonged Standing	_____	_____	_________
6) Lying flat on back	_____	_____	_________
7) Lying flat on stomach	_____	_____	_________
8) Lying on side with knees bent	_____	_____	_________
9) Lifting, reaching, or twisting	_____	_____	_________
10) Other (list)			
________________________	_____	_____	_________

Do you have difficulty walking or have to stop walking due to pain? Yes / No

Using the below codes, indicate the nature and location of your pain on the drawings:

Sharp/Stabbing pain ^^^^ Dull aching pain XXX Burning Pain ::::: Numbness/Tingling NNNN



Location and severity of pain:

Circle <u>range</u> of pain severity during the past week: 0 = no pain; 10 = severe pain for each region of the body you identified.

Document "x" on <u>usual level</u> of pain for the region of the body you identified.

Location of Pain:	**No Pain**					**Moderate Pain**					**Severe Pain**
______________	0	1	2	3	4	5	6	7	8	9	10
______________	0	1	2	3	4	5	6	7	8	9	10
______________	0	1	2	3	4	5	6	7	8	9	10
______________	0	1	2	3	4	5	6	7	8	9	10

Review of Systems

Please write number where appropriate. 1 – PRESENTLY HAVE 2 – HAVE HAD IN THE PAST YEAR

GENERAL
___ Allergy
___ Chills
___ Depression
___ Dizziness
___ Fainting
___ Fatigue
___ Fever
___ Sweats
___ Sleep loss
___ Weight gain
___ Weight loss
___Anxiety
___Depression
___ Nervousness

EARS, EYES, NOSE & THROAT
____Hoarseness
____Sinus infection
____Sinus headaches
____Sore throat
____Swallowing difficulties
____Hearing loss
____Ringing in the ears
____Visual changes
____Double Vision

RESPIRATORY
____Shortness of breath
____Wheezing
____Chronic cough
____History of bronchitis
____Coughing up blood
____History of asthma
____Lung Cancer
____Tuberculosis

MUSCULOSKELETAL
___ Arthritis – location:__________
____Poor posture
____Numbness/Tingling/Pain:
____Neck
____Shoulders
____Arms
____Elbows
____Hands
____Hips
____Legs
____Knees
____Feet
____Low back

NEUROLOGICAL
____Weakness – Location:________
____Memory problems
____Personality changes
____Balance difficulties
____Seizures
____Epilepsy disease
___Headaches
____History of stroke

SKIN
____Rash
____Hair loss
____Lumps in breast
____Skin cancer

HEMATOLOGY
____Anemia
____Bruise easily
____Bleeding tendencies

ALLERGIES
___Any Medications
___Latex Allergy / Sensitivity
___Contrast Dyes

GENITOURINARY
___Pregnant, or could be
____Blood in urine
____Frequent urination
____Loss of bladder control
____Difficult to urinate
____Painful urination
____Frequent nighttime urination
____Bladder or kidney infection
____Kidney stones
____Lack of menstrual cycle (females)
____Irregular menstrual cycle (females)
____Endometriosis (females)
____Uterine/cervical cancer (females)
____Unable to maintain erection (males)
____Prostate problems (males)
____Prostate cancer (males)

GASTROINTESTINAL
____Bloody stool
____Constipation
____Diarrhea
____Excessive hunger
____Poor appetite
____Nausea/vomiting
____Gallbladder problems
____Liver disease
____Alcoholism
____Colon cancer

CARDIOVASCULAR
____High blood pressure
____Low blood pressure
____Chest pain or angina
____Heart attack
____Rapid heart rate
____Slow heart rate
____Palpitations of the heart
____Poor circulation
____Swelling of ankles
____Heart disease
____High cholesterol

ENDOCRINE
____Heat intolerance
___Cold intolerance
____History of thyroid disease
____History of diabetes

Red Flags

Yes No

____ ____ **Do you Have a History of Cancer?**

____ ____ **Do you have unexplained weight loss?**

____ ____ **Do you currently have and infection HIV, AIDS, Hepatitis?**

____ ____ **Do you have Immunosuppression, an impaired immune system?**

____ ____ **Have you had a major fall or accident recently and may have broken bones?**

____ ____ **Do you have numbness in your groin, genital, or rectal area?**

____ ____ **Do you have recent onset of bladder problems, incontinence, inability to urinate?**

____ ____ **Do you have recent onset of loss of bowel control, or severe weakness in the legs?**

Oswestry Disability Questionnaire

Patient Name __________________________________ Date_________________

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by **CIRCLE one number in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just circle the single number that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity

0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain is moderate at the moment
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

0 I can look after myself normally without causing extra pain
1 I can look after myself normally but it causes extra pain
2 It is painful to look after myself and I am slow and careful
3 I need some help but can manage most of my personal care
4 I need help every day in most aspects of self-care
5 I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it gives me extra pain
2 Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
3 Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
4 I can only lift very light weights
5 I cannot lift or carry anything

Section 4: Walking*

0 Pain does not prevent me walking any distance
1 Pain prevents me from walking more than 1mile
2 Pain prevents me from walking more than ½ mile
3 Pain prevents me from walking more than 100 yards
4 I can only walk using a stick or crutches
5 I am in bed most of the time

Section 5: Sitting

0 I can sit in any chair as long as I like
1 I can only sit in my favorite chair as long as I like
2 Pain prevents me sitting more than one hour
3 Pain prevents me from sitting more than 30 minutes
4 Pain prevents me from sitting more than 10 minutes
5 Pain prevents me from sitting at all

Section 6: Standing

0 I can stand as long as I want without extra pain
1 I can stand as long as I want but it gives me extra pain
2 Pain prevents me from standing for more than 1 hour
3 Pain prevents me from standing for more than 30 minutes
4 Pain prevents me from standing for more than 10 minutes
5 Pain prevents me from standing at all

Section 7: Sleeping

0 My sleep is never disturbed by pain
1 My sleep is occasionally disturbed by pain
2 Because of pain I have less than 6 hours sleep
3 Because of pain I have less than 4 hours sleep
4 Because of pain I have less than 2 hours sleep
5 Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

0 My sex life is normal and causes no extra pain
1 My sex life is normal but causes some extra pain
2 My sex life is nearly normal but is very painful
3 My sex life is severely restricted by pain
4 My sex life is nearly absent because of pain
5 Pain prevents any sex life at all

Section 9: Social Life

0 My social life is normal and gives me no extra pain
1 My social life is normal but increases the degree of pain
2 Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
3 Pain has restricted my social life and I do not go out as often
4 Pain has restricted my social life to my home
5 I have no social life because of pain

Section 10: Travelling

0 I can travel anywhere without pain
1 I can travel anywhere but it gives me extra pain
2 Pain is bad but I manage journeys over two hours
3 Pain restricts me to journeys of less than one hour
4 Pain restricts me to short necessary journeys under 30 minutes
5 Pain prevents me from traveling except to receive treatment

Check prior treatments and indicate results: (B = better; W = worse; NC = no change)

Chiropractic medicine _______ **Rehabilitation Specialist** _______

Pain Management Specialist _______ **Acupuncturist** _______

Physical Therapy:

TENS _____ Ultrasound ______ Whirlpool __________ Traction ________

Massage _____ Diathermy ______ Exercise _________

Have you had Steroid injections: Yes / No

Date of injection	Location/body region of injection	Duration of response
______________	________________________	__________________

In the past 2 weeks, how often have you been bothered by:

A. Little interest or pleasure in doing things

1. Not at all 2. Several days 3. More than half the days 4. Nearly every day

B. Feeling down, depressed, or hopeless

1. Not at all 2. Several days 3. More than half the days 4. Nearly every day

Previous testing	Location/hospital performed	Date	Results (if known)
Plain X-rays			
MRI			
CT Scan			
Myelogram			
EMG/NCS			
Discography			

Other:

The above information is complete and accurate to the best of my knowledge.

Patient signature____ Date_______________________________

Physician Section Only

I have reviewed the above information with the patient.

Physician review:____ ***Date:***_______________________

Red Flags: Present or Absent (circle one)