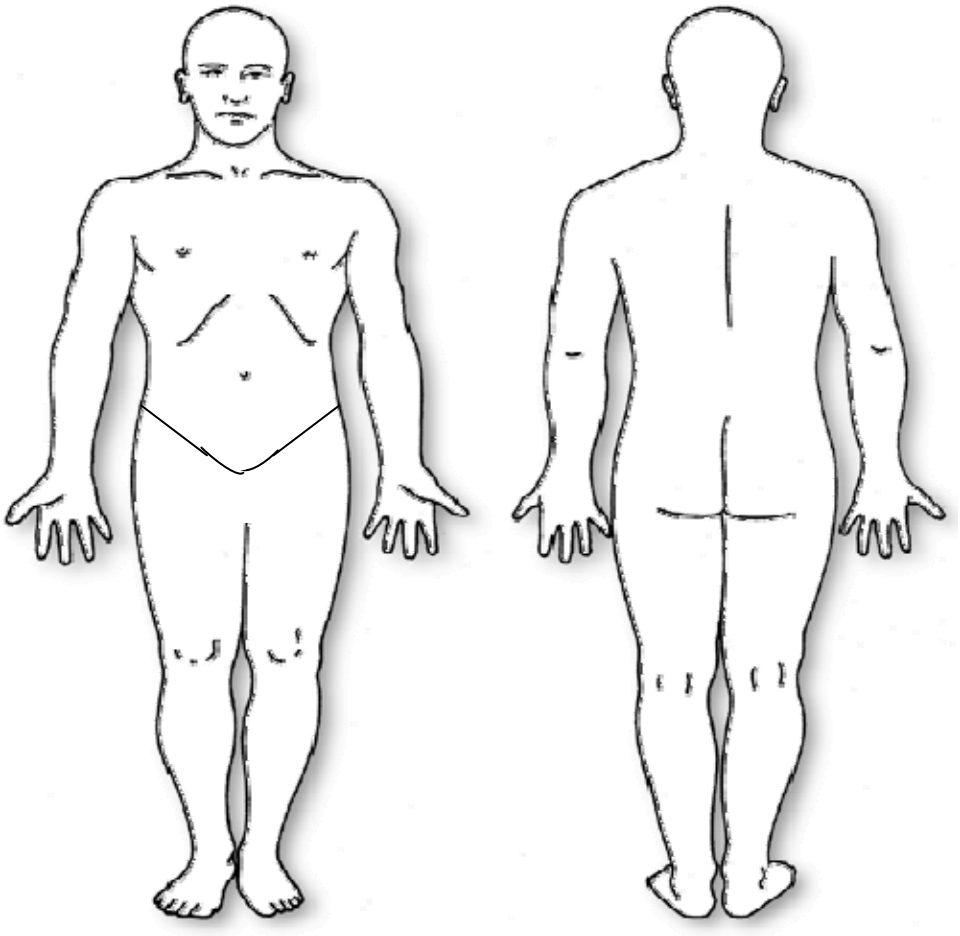
Alabama Orthopaedic Clinic, PC
SPINE FORM

Date: _____ **Account #_____**

Patient Name: _____ Male/Female Age: ___
Height: ___ Weight: ___Right Handed_____Left Handed_____
Referring Doctor:_____

1. **Please indicate your areas of pain on the figures below with *X*'s. Please indicate your areas of numbness, stabbing, burning, & tingling on the figures below with *O*'s.**



2. **How long have you had the problem(s)? _____**
   _____

3. **How have your symptom(s) changed over time? Better_____ Same_____ Worsened_____**

4. **What happened to produce the symptoms? _____**
   _____

5. If the problem is from an accident, please explain: _____
_____

6. Where is your pain primarily located? Neck_____ Arms_____ Back_____ Legs_____

7. Choose one of the following descriptions of your pain on an average day:
_____ Pain in my neck is more severe than pain in my arms or hands
_____ Pain in my arms/hands is more severe than in my neck
_____ Pain in my back is more severe than the pain down my legs/feet
_____ Pain down my legs/feet is more severe than pain in my back
a. Sharp b. Dull Toothache c. Burning
d. Stabbing e. Constant Ache f. Intermittent

8. What activities make your pain worse? Lying_____ Standing _____ Coughing _____
Bending_____ Lifting _____ Sneezing _____ Sitting _____ Walking_____

9. What activities help your pain? Rest_____ Exercise_____ Sitting_____
Lying down_____ Meds_____ Others: _____

10. What type of job & on the job activities do you routinely perform? _____
_____

11. How much time have you been off work due to your problem? _____

12. Has any other doctor treated you for this condition? Yes_____ No_____
If Yes, who_____

13. Have you been placed in a brace for your condition? Yes_____ No_____

14. Have you had any physical therapy or chiropractic care as part of your treatment? Yes___
No_____ (If Yes, Where _____)

15. Have you developed any difficulty with you control of urine (bladder) &/or bowel movements? (Do you have accidents on your self?) Yes_____ No_____

16. Have you received an Epidural Steroid Block for neck, back, arm, or leg pain?
Yes___ (How many _____) By which doctor(s) _____ or NO_____

17. How do you rate your pain on a scale of 0-10? (0-no pain, 10-worst pain)
Neck Pain _____/10 daily Arm Pain _____/10 daily
Back Pain _____/10 daily Leg Pain _____/10 daily

18. Have you ever been told you have problems with your liver or kidneys? Yes_____ No_____

19. Have you ever been told you have (or had) Hepatitis or HIV/Aids? Yes_____ No_____
If Yes, do you know how you contracted the disease? _____

20. Have you ever been diagnosed by a doctor with a Medical Condition? Yes_____ No_____
If Yes, explain condition(s)_____
_____

21. Have you ever had any surgeries? Yes_____ No _____ If Yes, please list each procedure & Doctor _____
_____
_____

22. Have you ever had any Spinal surgeries? Yes_____ No_____ If Yes, please list & explain:
_____
_____
_____

23. Please list <u>all</u> daily medications you are currently taking for medical problems.
_____
_____
_____

24. Do you have any allergies to foods, medications, or seasonal allergies? Yes_____ No_____
If Yes, list allergies _____

25. Do you Smoke? Yes_____ (____ packs/day) No_____

26. Do you drink Alcohol? Yes_____ Daily ____Every Weekend ____Occasionally ____ No_____

27. Do any specific medical conditions run in your family such as High Blood Pressure, Diabetes, Heart Attack, Cancer, etc? Yes_____ No_____ Please List _____
_____
_____

28. Please check all symptoms you are experiencing:

Constitutional:	**_____Night-time fevers/chills**
	_____Severe weight loss/gain
	_____Worse night-time pains
Eyes:	**_____Blurry vision**
	_____Pain
	_____Infection
Ears/Nose/Throat:	**_____Hearing Aid**
	_____Chronic Sinus problems
	_____Swallowing difficulty
	_____Infection
Cardiovascular:	**_____Shortness of breath**
	_____Chest pain with activity or at rest
	_____Awakened at night with shortness of breath
	_____Sleep on 2 or more pillows at night

Respiratory:	**_____Shortness of breath**
	_____Wheezing
	_____Coughing with production of sputum
Gastrointestinal:	**_____Abdominal pain/cramps**
	_____Nausea/Vomiting/Diarrhea
Genitourinary:	**_____Frequent Urinary Tract Infections**
	_____Urinate more frequently
	_____Have trouble releasing urine or accidents on self
Musculoskeletal:	**_____Muscle aches & pains**
	_____Severe joint pain/stiffness
	_____Weakness of an arm/leg
	_____History of fractures
Integument:	**_____Skin infections**
	_____History of skin cancer
	_____Any prior skin wound infections after surgery
Neurological:	**_____Numbness or weakness of arm/leg**
	_____Burning pain running down arm/leg
	_____Any trouble with normal balance
	_____Any hand numbness that awakens you from sleep
	_____Any noticeable clumsiness or dropping of objects
Psychiatric:	**_____History of depression**
	_____Inpatient/Outpatient psychiatric treatment
Endocrine:	**_____History of hyperthyroidism**
	_____Any hormonal treatment
Hematologic:	**_____Treated for Anemia**
	_____History of Leukemia or Hodgkin's Disease
	_____History of free-bleeding with a minor cut