Pro Spine

COMPREHENSIVE SPINE CARE

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DEAR PATIENT:

WE KNOW THAT FILLING OUT THIS LONG CONFIDENTIAL BACK PACKET IS A LOT OF WORK; HOWEVER, THE MORE INFORMATION YOU GIVE US, THE BETTER WE CAN HELP YOU.

♦ **INSTRUCTIONS**

1) **PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TO GIVE US TIME TO PROCESS YOUR PAPERWORK AND TO TAKE XRAYS.**
2) **BRING COMPLETED BACK PACKET (12 PAGE DOCUMENT).**
3) **BRING ANY CURRENT XRAYS, MRI FILMS, AND REPORTS.**

IF YOU DO NOT ARRIVE 30 MINUTES EARLY AND COME PREPARED WITH ALL COMPLETED PAPERWORK AND YOUR XRAYS AND/OR MRI'S (FILMS AND REPORTS), YOUR APPOINTMENT WILL BE RESCHEDULED BY MY STAFF.

PLEASE BE ASSURED THAT THIS INFORMATION IS CONFIDENTIAL.

IF YOU HAVE ANY QUESTIONS OR NEED ANY ASSISTANCE, PLEASE ASK.

THANK YOU FOR YOUR PATIENCE.

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CONFIDENTIAL PATIENT INFORMATION SHEET
HISTORY

DATE____________________ REFERRAL SOURCE_______________________________________

NAME____ AGE____________ SEX________

DATE OF BIRTH________________________WEIGHT_________________ HEIGHT_____________

RIGHT ☐ HANDED LEFT ☐

IS YOUR PROBLEM RELATED TO: ☐ JOB DATE___________
☐ ACCIDENT DATE___________
☐ NEITHER

PLEASE BRIEFLY DESCRIBE YOUR MAIN PROBLEM/COMPLAINT:

____

____

____

HOW LONG HAVE YOU HAD THIS PROBLEM?

____

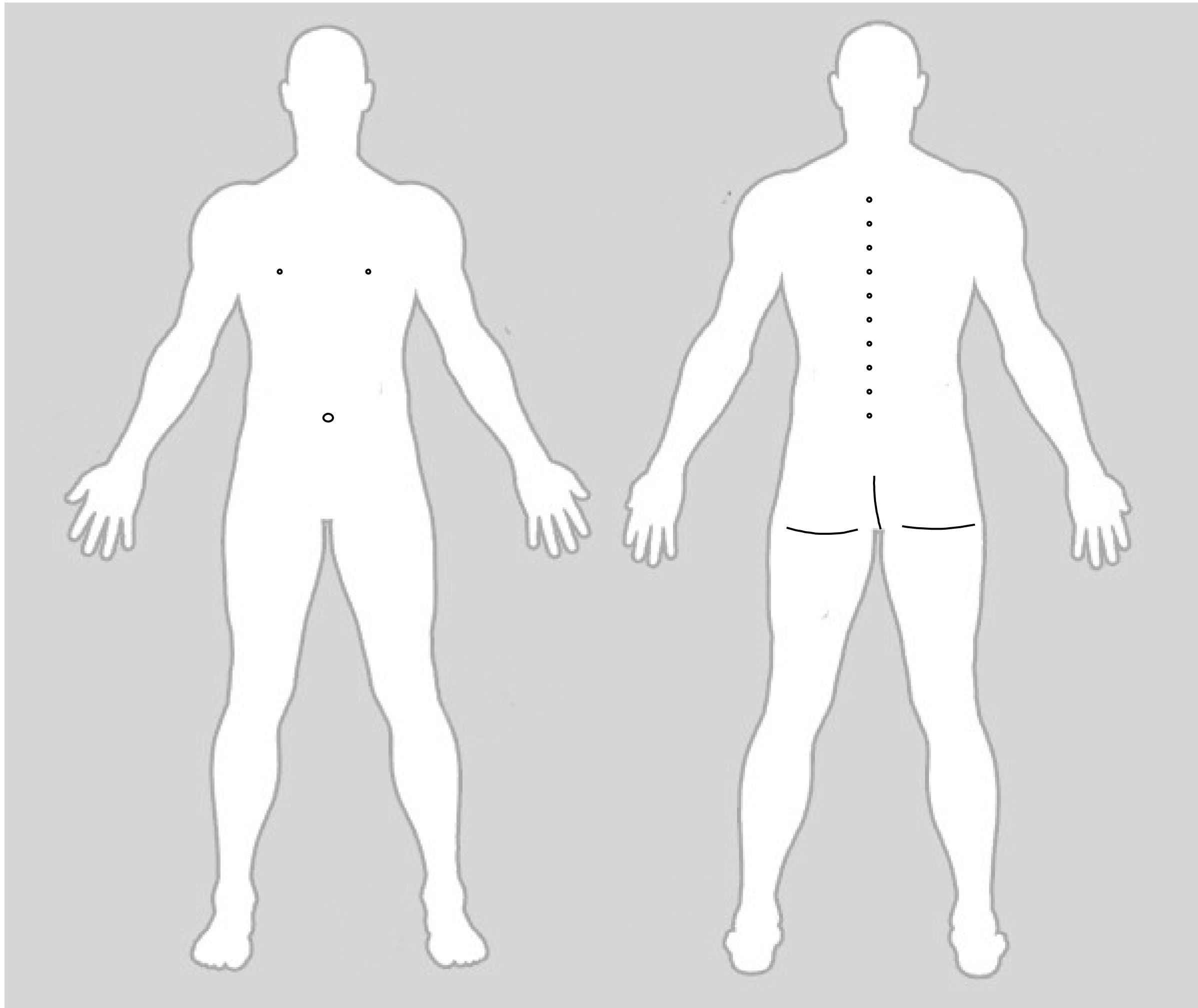
____

____

USING THE SYMBOLS BELOW, PLEASE DRAW IN THE LOCATION OF YOUR SYMPTOMS ON THE DIAGRAMS

XXXX = PAIN
0000 = NUMBNESS
//// = ACHING
**** = PINS AND NEEDLES

FRONT *BACK*



IF YOU HAVE ***NECK PAIN***, WHAT PERCENTAGE OF YOUR PAIN IS **NECK**____%
WHAT PERCENTAGE IS THE PAIN IN THE **ARM**____%?
(TOTAL = 100%)

IF YOU HAVE ***BACK PAIN***, WHAT PERCENTAGE OF YOUR PAIN IS **BACK**____%
WHAT PERCENTAGE IS **LEG**_____%?
(TOTAL = 100%)

MARK AN (X) ON THE LINE INDICATING THE USUAL DEGREE OF THE PAIN (**0** MEANS NO PAIN, **10** MEANS THE WORST PAIN IN YOUR LIFE.
(FOR EXAMPLE: TOOTHACHE, LABOR PAIN, KIDNEY STONE, ETC.)

0 1 2 3 4 5 6 7 8 9
10
____

LEAST WORST

WHAT POSITION ACTIVITY MAKES THE PAIN WORSE/BETTER?

	WORSE	BETTER	COMMENTS
BENDING			
BOWEL MOVEMENT			
COUGHING			
GENERAL ACTIVITY			
HOME REMEDIES			
LYING DOWN			
SITTING			
STANDING			
WALKING			

HOW LONG CAN YOU STAND WITH NO OR MINIMAL PAIN? ______ MINUTES

WALKING DISTANCE WITH NO OR MINIMAL PAIN:

0-50FT ______ 50-200FT_______ 200-500FT ______ 500+FT _______ ½ MILE+ __________

DO YOU NEED SUPPPORT TO HELPYOU WALK? YES___________ NO ____________

IF YES, WHAT KIND OF SUPPORT? ____

DO YOU WEAR A BACK OR NECK BRACE? YES___________ NO____________

IF YES, HOW LONG? ____

PLEASE LIST BELOW THE **PREVIOUS DOCTORS (MD, DO, CHIROPRACTOR)** YOU HAVE SEEN FOR YOUR MAIN PROBLEM:

PHYSICIAN	SPECIALTY	DATES	TREATMENT

PLEASE INDICATE WHICH **DIAGNOSTIC TESTS** YOU HAVE HAD IN EVALUATION OF YOU MAIN COMPLAINT/PROBLEM (INCLUDE DATES):

TEST	DATE	TEST	DATE
PLAIN X-RAY		**EMG/NCV/SSEP**	
BONE SCAN		**ARTHROGRAM**	
MYELOGRAM		**MRI**	
CT SCAN		**DEXA SCAN**	
DISKOGRAM		**OTHER**	

PLEASE CHECK WITH ***TREATMENTS*** YOU HAVE HAD FOR YOUR MAIN PRBLEM/COMPLAINT AND INDICATE WHETHER THEY WERE HELPFUL:

TREATMENT	√	HELPFUL?	TREATMENT	√	HELPFUL?
ELECTRICAL STIMULATION			**MASSAGE**		
T.E.N.S			**POOL EXERCISES**		
ULTRASOUND			**HOME EXERCISES**		
HOT PACKS			**MANIPULATION**		
COLD			**ACUPUNCTURE**		
WHIRLPOOL			**INJECTIONS**		
OTHER					

PAST MEDICAL HISTORY

PLEASE CHECK IF YOU HAVE HAD ANY ONE OF THE FOLLOWING:

	√	COMMENTS		√	COMMENTS
BOWEL DISORDER			**PACEMAKER**		
CANCER (WHERE)			**POLIO**		
DEPRESSION			**PSORIASIS**		
DIABETES			**RHEUMATISM**		
HEART DISEASE			**SEIZURES**		
HIGH BLOOD PRESSURE			**SERIOUS INFECTION**		
KIDNEY DISEASE			**STROKE/TIA**		
LUNG DISEASE			**THYROID**		
MULTIPLE MYELOMA			**ULCERS**		

OTHER
OTHER

SURGICAL HISTORY

PLEASE LIST ANY SURGERY YOU HAVE HAD BY TYPE, DATE, AND OUTCOME:

TYPE	DATE	OUTCOME

DRUG ALLERGIES AND TYPES OF REACTIONS:

___

PLEASE LIST ALL CURRENT MEDICATIONS AS FOLLOWS:

NAME	DOSE (milligrams,grams)	HOW OFTEN? (How many times a day?)	HOW LONG?

ONLY MARK THE DRUGS THAT YOU HAVE PREVIOUSLY TAKEN AND IF THEY HELPED.

DRUG	HELP?	DRUG	HELP?	DRUG	HELP?
ASPIRIN		**LYRICA**		**RELAFEN**	
CELEBREX		**MOBIC**		**ROBAXIN**	
DARVOCET		**MOTRIN**		**SOMA**	
DAYPRO		**NAPROSYN**		**SKELAXIN**	
DEMEROL		**NEURONTIN**		**TYLENOL**	
ELAVIL		**NORFLEX**		**ULTRAM**	
FLEXERIL		**PERCOCET**		**VICODIN**	
IBUPROFEN		**PREDNISONE**			
LORTAB		**PROZAC**			

SOCIAL HISTORY & HABITS

OCCUPATION____

WORKING STATUS:

☐ FULL DUTY____

☐ LIGHT DUTY____

☐ OFF DUTY PER DOCTOR________________________________

☐ UNEMPLOYED____

☐ RETIRED____

IF YOU ARE NOT FULL DUTY:

HOW LONG HAVE YOU BEEN OFF WORK?____

HAVE YOU HAD A WORK CAPACITY ASSESSMENT?__________________________________

ARE YOU DISABLED THROUGH SOCIAL SECURITY? _________________________________

TOBACCO USE:

YES____ NO____ STARTED AGE/YEAR_________ STOPPED_____________

PLEASE INDICATE ***QUANTITY PER DAY*** ON THE FOLLOWING:

CIGARETTES________________________________

CIGARS_____________________________________

CHEWING TOBACCO (SNUFF) _________________

ALCOHOL USE: YES______ NO _______

PLEASE INDICATE ***QUANTITY PER DAY*** ON THE FOLLOWING:

BEER: ____________________________________

WINE: ____________________________________

DISTILLED SPIRITS: _______________________

HAVE YOU EVER BEEN TREATED FOR DRUG OR ALCOHOL ADDICTION? YES_____ NO_____

REVIEW OF SYSTEMS

PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

CONSTITUTIONAL

WEIGHT GAIN-LAST 6 MONTHS		WEIGHT LOSS-LAST 6 MONTHS		NIGHT SWEATS	
CHILLS		FEVER			

SKIN

EASY BLEEDING		ANY RASHES		EASY BLEEDING	

EYES, EARS, NOSE, AND THROAT

RECENT CHANGES IN VISION		RECENT CHANGES IN SMELL		ANY DIZZINESS?	
RECENT CHANGES IN HEARING		RECENT CHANGES IN TASTE			

RESPIRATORY

SHORT OF BREATHE		SPUTUM		WHEEZING	
COUGH		HISTORY OF TUBERCULOSIS			

CARDIOVASCULAR

CHEST PAIN		SHORTNESS OF BREATH WITH EXERCISE		FEET EDEMA	
PALPITATIONS		HEART MURMER			

GASTROINTESTINAL

NAUSEA		DIARRHEA		ABDOMINAL PAIN	
VOMITTING		INDIGESTION		BLOODY OR DARK STOOLS	

GENITO-URINARY

BLOOD IN URINE		UNABLE TO CONTROL BLADDER		RUSHING TO GO	
URINARY TRACT INFECTIONS		UNABLE TO CONTROL BOWEL MOVEMENT		NEED TO GO FREQUENTLY	

MUSCULOSKELETAL

CRAMPS		JOINT PAIN/SWELLING	
ATTACK OF WEAKNESS		MORNING STIFFNESS	

CENTRAL NERVOUS SYSTEM

POOR APPETITE		NUMBNESS/TINGLING FEET		CRYING SPELLS	
PROBLEM SLEEPING		NUMBNESS/TINGLING HANDS		CONVULSIONS	

REVIEW OF SYSTEMS (CONTINUE)

PLEASE WRITE IN DATE IF APPROPRIATE.

FEMALE

	DATE		DATE
ABNORMAL VAGINAL BLEEDING		HISTORY OF BREAST BIOPSY	
HISTORY OF NIPPLE DISCHARGE		HISTORY OF ENDOMETRIOSIS	

DATE OF LAST MENSTRUAL PERIOD: ___________________________

MALE

	DATE		DATE
HISTORY OF PROSTATITIS		DIFFICULTY URINATING	

DATE OF LAST PROSTATIC EXAM __________________________ RECTAL TEST: YES___ NO ___

RESULTS ____

PSA (PROSTATE BLOOD TEST) YES_____ NO ______ RESULTS _________________________________

FAMILY HISTORY

DESCRIBE CURRENT HEALTH, AGE, CAUSE OF DEATH, ILLNESS, DIABETES, CANCER, HYPERTENSION, ETC.

	AGE	ALIVE	DECEASED	MEDICAL HISTORY OR CAUSE OF DEATH
FATHER				
MOTHER				
SIBLING 1				
SIBLING 2				
SIBLING 3				
SIBLING 4				
SIBLING 5				
SIBLING 6				

*THE PRECEDING PATIENT INFORMATION PACKET HAS BEEN REVIEWED AND **DISCUSSED WITH MY PATIENT.**

DOCTOR'S SIGNATURE ____________________________________ DATE __________________________