MARTIN & SUHEY
ORTHOPEDICS

SPINE VISIT

Fax: (814) 235-0484
Email: plm@martinsuhey.com

Name: _____ Best Daytime Phone: _____

Referring Physician: _____ Phone: _____

Main spine problem/complaint:

How long have you had this problem?

Current Meds for this Problem (If any)

Allergies: _____ ☐ None:

What makes the pain worse?

What makes the pain better?

What testing have you had for this problem? ☐ X-ray ☐ CAT Scan ☐ Nerve Study ☐ Other _____

Where?: _____

What treatment (if any) have you tried? (Ex: Therapy, Injections, Brace, Etc)

Have you had any surgeries, or procedures, for this problem? ☐ Yes ☐ No

If Yes, what and by whom? _____

Has it been suggested, or do you feel, your spine problem may require surgery? ☐ Yes ☐ No

Which items listed would apply to you?

☐ Bowel Accidents ☐ Severe Night Pain ☐ Bladder Accidents ☐ Weight Loss ☐ Recent Infections

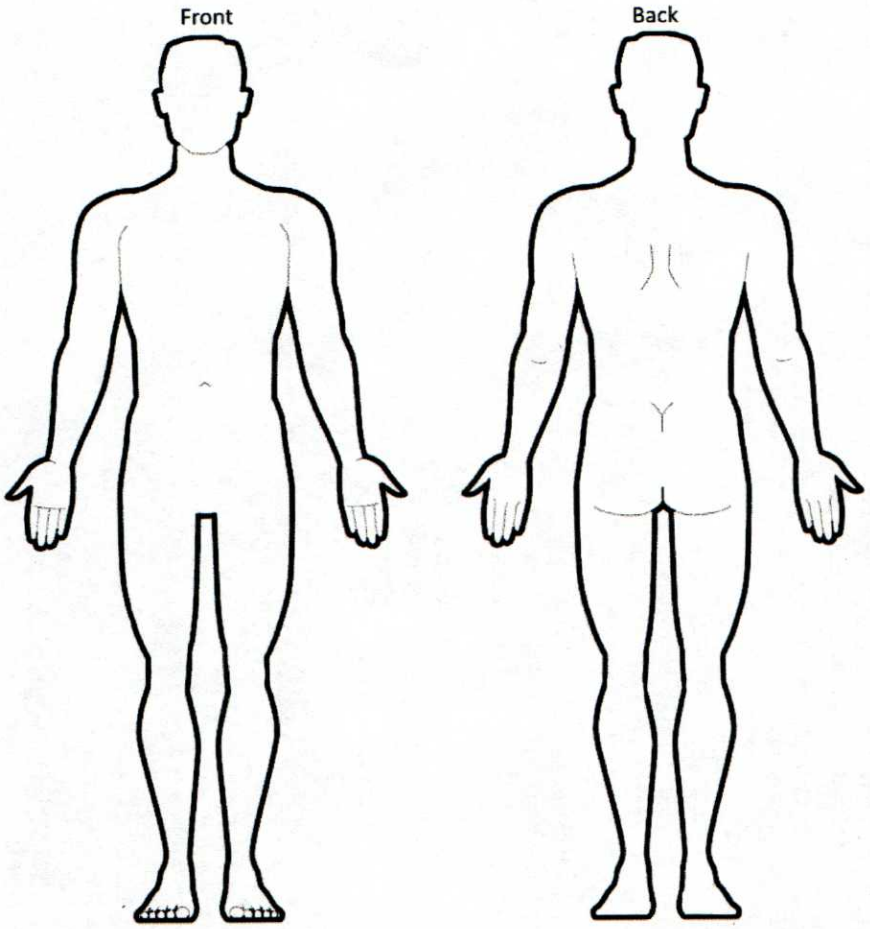
☐ Leg Weakness/Numbness ☐ Arm Weakness/Numbness ☐ Recent Fever/Chills

Have you ever been diagnosed with Cancer? ☐ Yes ☐ No

If so, Type of Cancer: _____

Pain Location

(Please mark the location(s) of your pain on the diagrams below)



Pain Severity: If filling in "interactive", print and manually circle your level of pain below

Circle your average level of pain over the *last month*

no pain 0 1 2 3 4 5 6 7 8 9 10 severe

Circle your current level of pain

no pain 0 1 2 3 4 5 6 7 8 9 10 severe

Patient Signature:_____ Date:_____

Physician Signature: _____ Date:_____