CALIFORNIA ORTHOPEDICS & SPINE

Spine Center
New Patient Form

Last Name	First Name	Middle Name
Age:_____	✓ Hand Dominance ❑Right ❑Left	✓ Gender ❑Male ❑Female

Carefully read the following definitions	*Definitions*	
	Pain Levels	The level of pain you have had <u>on average</u> since your problem began
	Neck Pain	"Neck" includes middle of neck, upper shoulders, between shoulder blades
	Arm Pain	"Arm" includes shoulder, arm, or hand
	Back Pain	"Back" includes pain <u>above</u> the belt line across the lower back
	Leg Pain	"Leg" includes areas <u>below</u> the belt line including the buttock, legs, or feet

<u>Describe your condition:</u> In your own words, note the following: 1) What happened to you?; 2) What you feel?; 3) What caused it?; 4) How it changed over time?

_____
_____
_____
_____
_____
_____
_____
_____
_____

What was the approximate date your problem started?	

✓ **Have you had any of these diagnostic studies**	No	Yes	Date
Xrays of injured area			
MRI (magnetic resonance imaging)			
CT (computed tomography) scan			
Myelogram (x-ray with dye injection)			
Electromyogram (EMG)			
Discogram			
Arthrogram of sonogram			

Did your problem begin with a car accident?			No		Yes
If yes:	Were you the driver? ❑No ❑Yes		Were you wearing a seatbelt? ❑No ❑Yes		Did you pass out? ❑No ❑Yes

✓ To be sure all paperwork is filled out correctly, please check appropriate	Yes		Yes
On Workman's Compensation		Report should be sent to Referring Physician or Family Physician	
Receiving Disability Income		Report should be sent to another party: Name and Address:_____	
Legal Proceeding Pending		_____	

For a total of 100%, what % is back pain and what % is leg?	% Low Back Pain		% Leg Pain	
(i.e. 30% low back pain with 70% leg pain)		+		=100%
For a total of 100%, what % is neck pain and what % is arm?	% Neck Pain		% Arm Pain	
(i.e. 20% neck pain with 80% arm pain)		+		=100%

✓ **Your <u>average</u> level of pain**	0	1	2	3	4	5	6	7	8	9	10
	←Less Pain							Worse Pain →			
Neck Pain											
Right Arm Pain											
Left Arm Pain											
Low Back Pain											
Right Leg Pain											
Left Leg Pain											
✓ **Your level of pain right now**											

✓ **Describe the quality and severity of your pain?**					
	Throbbing		Gnawing		Splitting
	Shooting		Hot-Burning		Tiring/Exhausting
	Stabbing		Aching		Sickening
	Sharp		Heavy		Fearful
	Cramping		Tender		Punishing-Cruel

Using the symbols, mark the location and type of pain on the diagrams

If you have pain into the lower leg, feet, or hands, make sure you note it

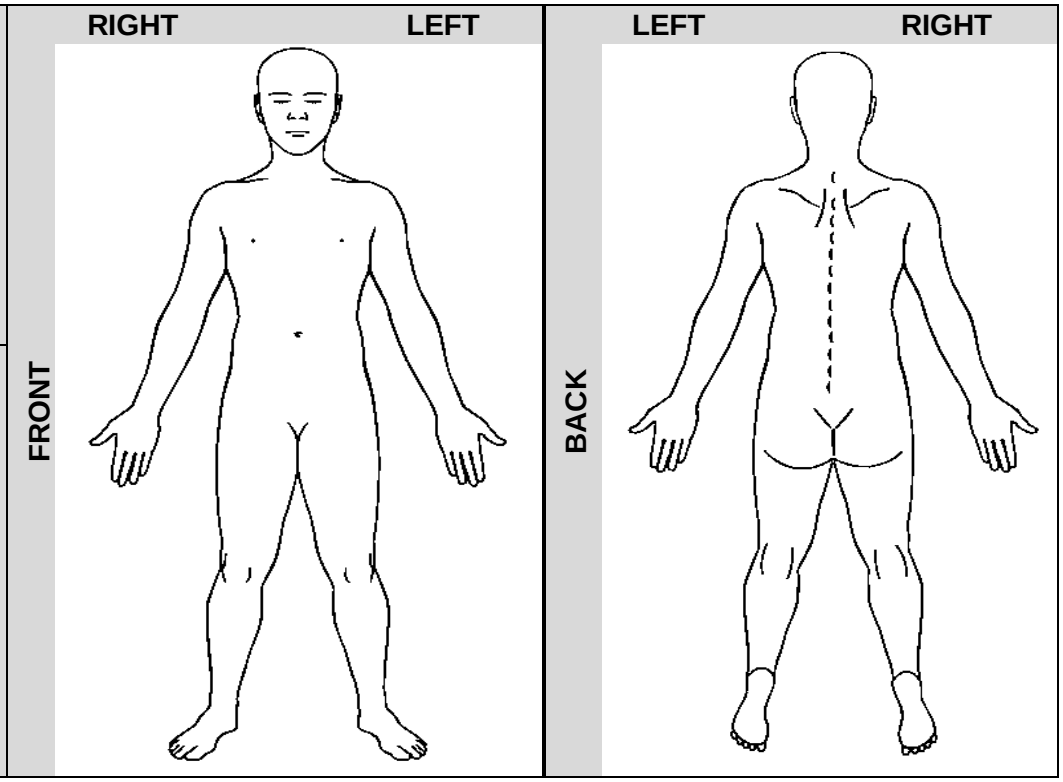
Type of Sensation:

Stabbing/Burning: ^

Aching: X

Pins and Needles: –

Numbness: O



✓ **Do you have:**	No	Yes	Explain where
Numbness in the arms/hands or legs/feet?			
Weakness in the arms/hands or legs/feet?			

✓	Morning	Afternoon	Evening	Night	Lying flat	Sitting	Standing	Walking	Bending Back	Coughing/ Sneezing
Pain worse with										
Pain better with										

List the daily activities, sports, or hobbies you are having difficulty performing due to your pain

_____

_____

✓ **Do you have:**	No	Yes
Loss of bowel control? (difficulty controlling/initiating bowel movements or incontinence)		
Loss of bladder control? (difficulty controlling/initiating urination or incontinence)		
Night pain for which you change position or get out of bed?		
Balance problems from leg weakness?		
Balance problems not from weakness but from lack of coordination?		
Problems handling small objects such as coins or problems buttoning your shirts?		

✓**Treatment history**	No	Yes	Details (If Yes)	✓ Made my pain:		
				Better	No Change	Worse
Acetaminophen (Tylenol)			Medication:			
Non Steroidal Anti-inflammatory Drugs (NSAIDS) or COX-inhibitors (e.g. Advil)			Medication:			
Opiods (ie Vicodin, Percocet, Morphine)			Medication:			
Neuropathic pain meds (Gabapentin, Lyrica)			Medication:			
Interventional pain procedures (Epidurals, nerve or joint injections, implants)			How many: Date of last injection:			
Physical Therapy			How long:			
Acupuncture			Name:			
Chiropractor			Name:			
Physiatrist or Pain Specialist			Name:			
Pain Psychologist			Name:			
Other Pain Physician			Name:			

Medical history (ie: High blood pressure, asthma, high cholesterol, heart problems, diabetes, etc)	❑ I have no medical problems	

✓Do you have history of cancer?	No	Yes	Details (If Yes)
			Type: Prior treatment:

Surgical history (i.e.:Tonsillectomy, hip replacement, heart surgery, etc)	❑ I have not had surgery in the past
Date of Surgery	Surgery (Specify Right or Left side if relevant)

Mental Health History		❑ I have not seen a mental health expert in the past		
	No	Yes	Name	Practice Location
Psychiatrist				
Psychologist				

List ALL medications, vitamins, and supplements you are currently taking. (May attach list of medications)		❑ I currently take no medications	

Allergic reactions including medicines, iodine, intravenous dye, latex, shellfish, etc.	❑ I have no allergies
Medication/Substance	Allergic Reaction

Occupational/Social history			❑ I am currently retired
What is your occupation?			
✓	No	Yes	Details (If Yes)
Are you out of work due to your spinal condition?			How long have you been out of work?
Do you have a workman's compensation claim?			Date of work injury:
Do you smoke cigarettes?			How many packs per day? For how many years?
Do you smoke a pipe or cigars?			How often?
Do you dip snuff or chew tobacco?			How often?
Do drink caffeine?			How many cups per day?
Do drink alcohol?			How many drinks per week?
Do you use any street drugs?			Which drugs and how often?
Have you been diagnosed with a substance abuse problem			Which substance?
Who do you live with?			

Family history of disease		❑ I have no family history of disease	
Relationship	Disease	Relationship	Disease

Review of systems							
✓	*General*	✓	*Eye,Ear Nose,Throat*	✓	*Musculoskeletal*	✓	*Psychiatric*
	Fever or Chills		Difficulty swallowing		Joint pains		Anxiety
	Dizziness		Hearing loss		Muscle aches		Depression
	Fainting spells		Hoarseness		Ankylosing spondylitis		Psychiatric hospitalization
	Fatigue		Nose bleeds		Weak bones		Panic attacks
	Frequent headaches		Ringing in ears		Rheumatoid arthritis		Suicidal thoughts
	Insomnia		Sinus problems		Osteoarthritis		Psychiatric drugs
	Sweats		Blurry vision		Bone cancer		Memory loss
	Weight changes		Poor vision		Bone infections	Other:	
Other:		Other:		Other:		✓	*MEN only*
✓	*Cardiovascular*	✓	*Gastrointestinal*	✓	*Genitourinary*		Breast lumps
	Ankle swelling		Poor appetite		Bladder control		Enlarged prostate
	Chest pains		Bowel changes		Blood in urine		Erectile dysfunction
	Enlarged heart		Constipation		Frequent urination		Penis discharge
	Heart attack		Diarrhea		Kidney stones		Prostate cancer
	Heart murmur		Excessive thirst		Painful urination	Other:	
	Heart palpitations		Heartburn		Urgent urination	✓	*WOMEN only*
	High blood pressure		Nausea		Weak stream		Abnormal pap smear
	Shortness of breath		Rectal bleeding	Other:			Breast lumps
	Irregular heartbeat		Stomach pain	✓	*Neurological*		Vaginal discharge
	Prolonged bleeding		Ulcers		Loss of motor control		Severe menstrual pain
	History of blood clots		Vomiting		Weakness		Hot flashes
Other:		Other:			Paralysis	Other:	
✓	*Endocrine*	✓	*Skin*		Poor balance	Date of last period:	
	Blood sugar problem		Bruise easily		Seizures	Age periods began:	
	Use of steroids		Foot ulcers		Speech difficulties	Age of menopause:	
	Over active thyroid		Rashes		Tremors	Are you pregnant?	
	Under active thyroid		Sores that won't heal		Muscle wasting	# of pregnancies?	
Other:		Other:		Other:		# of live births?	

This form is used to gather information so that my doctor can maximize the time used to examine me and answer my questions about my condition and treatment options. I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

Patient Signature (Date)

Physician Signature (Date)

Office Use Only	Height		Weight		BP	/	Pulse	