CALIFORNIA ORTHOPEDICS & SPINE

Spine Center
New Patient Form
Dr. Ernest Sponzilli

Name: _____

Date: _____

Referring MD: _____

Describe your condition: In your own words, note the following: 1) What happened to you; 2) What you feel; 3) When it began; 4) What caused it; 5) How it changed over time.

_____

_____

_____

_____

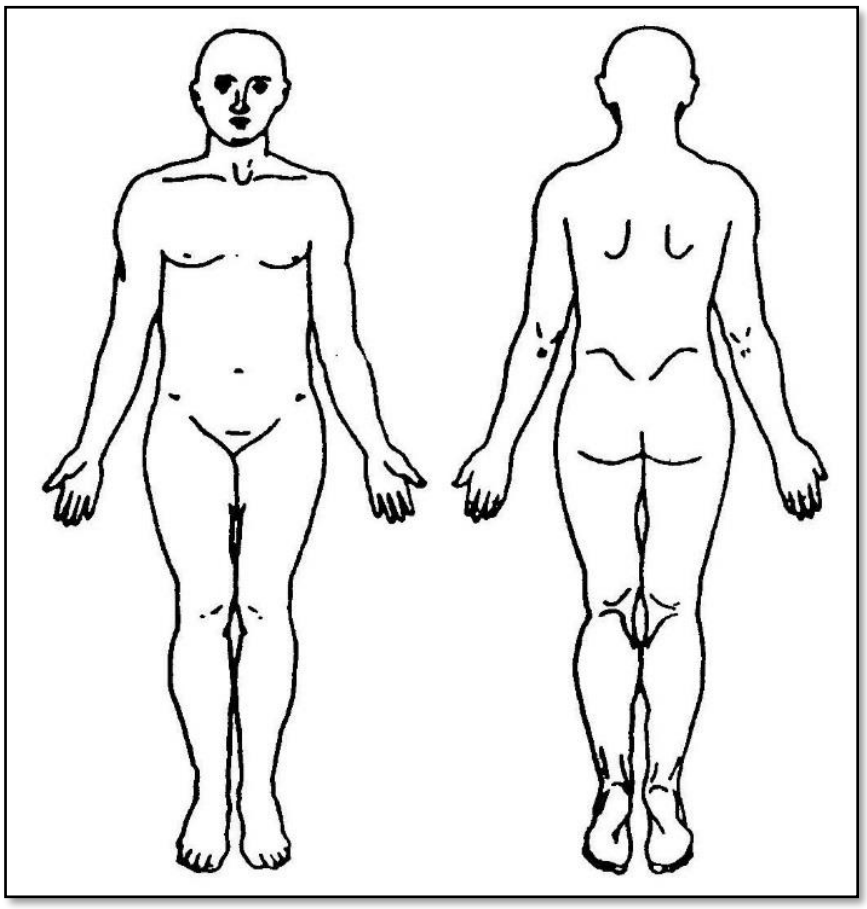
_____

_____

_____

_____

Where is your pain? Please indicate on the diagram below, the following areas on you affected by pain.



Use the following key:

SSS	Stabbing
BBB	Burning
XXX	Numbness
AAA	Aching
PPP	Pins and Needles
OOO	Other

Describe the quality and severity of your pain. To what degree do the following terms apply to your pain?
Use the following key: 0) Not at all 1) Mildly so 2) Moderate 3) Severe

throbbing:	0 1 2 3	gnawing:	0 1 2 3	splitting:	0 1 2 3
shooting:	0 1 2 3	hot-burning:	0 1 2 3	tiring/exhausting:	0 1 2 3
stabbing:	0 1 2 3	aching:	0 1 2 3	sickening:	0 1 2 3
sharp:	0 1 2 3	heavy:	0 1 2 3	fearful:	0 1 2 3
cramping:	0 1 2 3	tender:	0 1 2 3	punishing-cruel:	0 1 2 3

Place a mark on the line showing how bad your pain has been over the past 2 weeks:

No Pain ---------- Worst pain

How does your pain change with time?

How severe is your pain?	**Right now:**	**At its worst:**	**At its least:**
	0 No Pain	0	0
	1 Mild	1	1
	2 Discomforting	2	2
	3 Distressing	3	3
	4 Horrible	4	4
	5 Escruciating	5	5

Choose the word or words you would use to describe the pattern of your pain:

1.	2.	3.
Continuous	Rhythmic	Brief
Steady	Periodic	Momentary
Constant	Intermittent	Transient

Pain Modifiers: What kind of things relieve you pain: _____

_____

What kind of things increase your pain (e.g. sitting, lying, walking, stress, etc.) _____

_____

Treatment Summary

1. Have you visited the emergency room for your pain? __No __Yes Number of times:_____
2. Have you been hospitalized for your pain? __No __Yes Number of times:_____
3. Have you had any surgical operations for your pain? __No __Yes Names & dates of operations

_____

4.) Have you had any of the following for relief of pain?

__ Nerve Blocks (injections)	__ Biofeedback	__ Massage therapy
__ TENS (electrical stimulation)	__ Acupuncture	__ Manipulation
__ Bed rest	__ Heat therapy	__ Traction
__ Exercise	__ Ultrasound	__ Hypnosis
__ Psychotherapy/psychiatric care	__ Other: _____	

5.) Please list all PAIN medications you are currently taking (name, doseage, number of tablets/day): _____

_____

6.) How long do the pain medications provide relief?

__ Less than one hour	__ 2-4 hours	__ More than 6 hours
__ 1-2 hours	__ 4-6 hours	__ I do not take pain medication

Diagnosis/Tests/Work Up: List any tests you have had (x-ray, MRI, EMG, etc.) _____

_____

General Medical History

Please list any illnesses, surgeries, and hospitalizations you have had: _____

_____

Please list any non-pain medications you take: _____

_____

Any allergies to medicines: _____

Any family history of cancer, heart disease, diabetes, hypertension, anemia, high cholesterol, tuberculosis, kidney disease, arthritis: _____

General survey of body systems: Circle any of the following symptoms you are having.

Skin: Any rashes, itching, discoloration, temperature change, dryness/sweatiness, dry hair, or brittle nails? **Y N**

Blood: Any swollen nodes, transfusions, easy bruising, bleeding gums, nosebleeds, or unusual fatigue? **Y N**

Head & Neck: Any headache, vision problems, double vision, eye pain, redness, glaucoma, cataracts, hearing loss, ringing in the ear, vertigo, drainage, congestion, sinus pain, sore throat, voice changes, or goiter? **Y N**

Respiratory: Any fever, cough, stridor, weight loss, sputum production, chest pain, night sweats, pain on inspiration, history of tuberculosis/pneumonia/asthma/bronchitis, shortness of breath, or wheezing? **Y N**

Cardiovascular: Any hypertension, chest pain, trouble breathing at night, having to sleep sitting up, palpitations, history of rheumatic fever, leg pain, varicose veins, phlebitis, exercise intolerance, bluish skin, painful finger in cold weather, or swelling? **Y N**

GI: Any weight loss, loss in appetite, indigestion, swallowing problems, distention, nausea, vomiting, hernias, abdominal pain, change in bowel habits, constipation, diarrhea, bloody stool, rectal pain, hemorrhoids, hepatitis, pancreatitis, ulcer disease, or jaundice? **Y N**

Urinary Tract: Any painful urination, excessive/inadequate urine production, frequent urination, night time urination, bloody urine, urinary infections, flank pain, history of sexually transmitted disease, difficulty initiating flow, dribbling, kidney stones, night sweats, or chills? **Y N**

Reproductive Tract: Any painful menstrual bleeding, fertility problems, loss of libido, pelvic infections, or abnormal Pap smears? **Y N**

Endocrine: Any weight change, insensitivity to cold or hot, fatigue, sweating, excessive thirst or hunger, tremor, or changes in facial features? **Y N**

Musculoskeletal: Any loss of strength, unusual sensations, muscle wasting, loss of coordination, joint pain/stiffness, osteoporosis, or gout? **Y N**

Neurologic: Any changes in sleep patterns, headache, loss of consciousness, seizures, dizziness, loss of balance, trouble walking, loss of bowel or bladder control, loss of memory, or personality change? **Y N**

Disability Questionnaire

1. Pain Intensity	6. Standing
☐ I tolerate the pain I have without having to use painkillers. ☐ The pain is bad but I manage without taking pain killers. ☐ Pain killers give complete relief from pain. ☐ Pain killers give moderate relief from pain. ☐ Pain killers give very little relief from pain. ☐ Pain killers have no effect and I do not use them.	☐ I stand as long as I want without extra pain. ☐ I stand as long as I want but it gives me extra pain. ☐ Pain prevents me from standing for more than 1 hour ☐ Pain prevents me from standing for more than 30 min. ☐ Pain prevents me from standing more than 10 min. ☐ Pain prevents me from standing at all.
2. Personal Care (Washing, dressing, etc.)	**7. Sleeping**
☐ I can look after myself normally without extra pain. ☐ I can look after myself normally but it causes extra pain. ☐ It is painful to look after myself so I am slow and careful. ☐ I need some help but manage most of my personal care. ☐ I need help every day in most aspects of self-care. ☐ I do not get dressed, washed and stay in bed.	☐ Pain does not prevent me from sleeping. ☐ I can sleep well only by using tablets. ☐ Even with tablets I have less than six hours sleep. ☐ Even with tablets I have less than four hours sleep. ☐ Even with tablets I have less than two hours sleep. ☐ Pain prevents me from sleeping at all.
3. Lifting	**8. Sex**
☐ I can lift heavy weights without extra pain. ☐ I can lift heavy weights but it gives me extra pain. ☐ Pain prevents my lifting heavy weights off the floor but ☐ I am able if conveniently positioned, e.g. on a table. ☐ Pain prevents me from lifting heavy weights but I can lift light to medium weights if conveniently positioned. ☐ I can lift only very light weights. ☐ I cannot lift or carry anything at all.	☐ My sex life is normal and causes no extra pain. ☐ My sex life is normal but causes some extra pain. ☐ My sex life is nearly normal but is very painful. ☐ My sex life is severely restricted by pain. ☐ My sex life is nearly absent because of pain. ☐ Pain prevents any sex life at all.
4. Walking	**9. Social Life**
☐ Pain does not prevent me from walking any distance. ☐ Pain prevents me walking more than 1 mile. ☐ Pain prevents me walking more than ½ mile. ☐ Pain prevents me walking more than ¼ mile. ☐ I can only walk using a stick or crutches. ☐ I am in bed most of the time and have to crawl to the toilet.	☐ My social life is normal and gives me no extra pain. ☐ My social life is normal but increases my pain. ☐ Pain has no significant effect on my social life except for limiting energetic interests e.g. dancing, etc. ☐ Pain has restricted my social life so I don't go out as often. ☐ Pain has restricted my social life to my home. ☐ I have no social life because of pain.
5. Siting	**10. Travelling**
☐ I can sit in any chair as long as I like. ☐ I can sit as long as I like only in my favorite chair. ☐ Pain prevents me from sitting more than 1 hour. ☐ Pain prevents me from sitting more than ½ hour. ☐ Pain prevents me from sitting more than 10 min. ☐ Pain prevents me from sitting at all.	☐ I can travel anywhere without extra pain ☐ I can travel anywhere but it gives me extra pain ☐ Pain is bad but I manage journeys over two hours. ☐ Pain restricts me to journeys of less than one hour. ☐ Pain restricts me to short necessary journeys under 30 min. ☐ Pain prevents me from travelling except to the doctor or hospital.