CALIFORNIA ORTHOPEDICS & SPINE

# Spine Center
# New Patient Form
***Lisa Elvin, NP***

Name: _____ Age: _____ Date: _____

Occupation: _____ Dominant Hand: ___ Right ___ Left

Referred by: _____ Primary Care Doctor: _____

1. Area of Problem: _____

2. Please describe symptoms: _____

_____

3. When (roughly what date) did your present pain start? _____

Are you still working? ___ Yes ___ No Last day on job: _____

4. How did the pain start? (check appropriate responses)

| | | | |
|---|---|---|---|
| ___ Suddenly | ___ Twisting | ___ Pulling | ___ Hit from behind |
| ___ Gradually | ___ Fall | ___ Work injury | ___ Injured during sports |
| ___ Lifting | ___ Bending | ___ Automobile injury | ___ No apparent cause |

5. What activities make the pain worse?

| | | |
|---|---|---|
| ___ Exercise (during) | ___ Standing | ___ Bending backward |
| ___ Exercise (after) | ___ Walking | ___ Coughing |
| ___ Sitting | ___ Bending forward | ___ Sneezing |
| ___ Upon awakening in the AM | | |

6. Do you have night pain? ___ Yes ___ No

7. Do you have bowel and/or bladder problems? ___ Yes ___ No

8. What reduces the pain?

| | | | |
|---|---|---|---|
| ___ Lying down | ___ Walking | ___ Pain pills | ___ Muscle relaxants |
| ___ Sitting | ___ Manipulation | ___ Injection for pain | ___ Nothing |
| ___ Standing | ___ Physical Therapy | ___ Aspirin or anti-inflammatory medication | |
| ___ Other: _____ | | | |

9. How long have you had this pain? # ___ Years # ___ Months # ___ Weeks
How long have you had similar pain? # ___ Years # ___ Months # ___ Weeks

| 10. Have you had any of these diagnostic studies? | Yes | No | Date |
|---|---|---|---|
| Diagnostic x-rays of injured area | ___ | ___ | _____ |
| MRI (magnetic resonance imaging) | ___ | ___ | _____ |
| CT (computed tomography) scan | ___ | ___ | _____ |
| Myelogram (x-ray with dye injection) | ___ | ___ | _____ |
| Electromyogram (EMG) | ___ | ___ | _____ |
| Discogram | ___ | ___ | _____ |
| Arthrogram or sonogram | ___ | ___ | _____ |
| Injection | ___ | ___ | _____ |

11. Have you had epidural steroid injections? ___ Yes ___ No If so, when? _____

12. Have you been hospitalized for your pain problems? ___ Yes ___ No
    Number of times: _____ Dates: _____

13. Have you had surgery for this problem? ___ Yes ___ No
    Type:_____ Date: _____ Surgeon: _____
    Type:_____ Date: _____ Surgeon: _____

14. What other types of doctors or health care providers have you seen for this condition? _____
    _____

15. Have you been hospitalized for other medical problems? ___ Yes ___ No Number of times: _____
    Describe: _____

16. What medications are you currently taking? _____
    _____

17. Do you take antacids? ___ Yes ___ No

18. Do you have allergies? ___ Yes ___ No Please list: _____
    _____

19. Do you smoke? ___Yes ___No How much?: _____

20. Do you drink alcoholic beverages? ___Yes ___ No How much?: _____

21. Do you use recreational drugs? ___Yes ___ No Type?: _____
    How much?: _____

22. Living status of parents:
    Mother: ___ Living ___ Deceased Age ____ Cause of death_____
    Father : ___ Living ___ Deceased Age ____ Cause of death_____

23. Do you have any additional information that would be helpful in understanding your problem? _____
    _____

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

25. Do you plan to be at your regular job in 6 months? ___ Yes ___ No

26. **Medical History** – Have you been diagnosed with any of the following problems? (circle)

Ulcer or gastrointestinal bleeding
Diabetes mellitus – when diagnosed? _____ Insulin? _____
High Blood Pressure
Heart Disease/Prior Myocardial Infarction
Hepatitis – Which type? _____
HIV
Neurologic disease – including stroke, epilepsy, transient ischemic attacks
Chronic Lung Disease – including asthma, bronchitis or emphysema
Liver Disease
Kidney Disease
Thyroid
Migraines
Cancer – what type? _____
Rheumatoid Arthritis
Depression
Osteoporosis
Other? _____

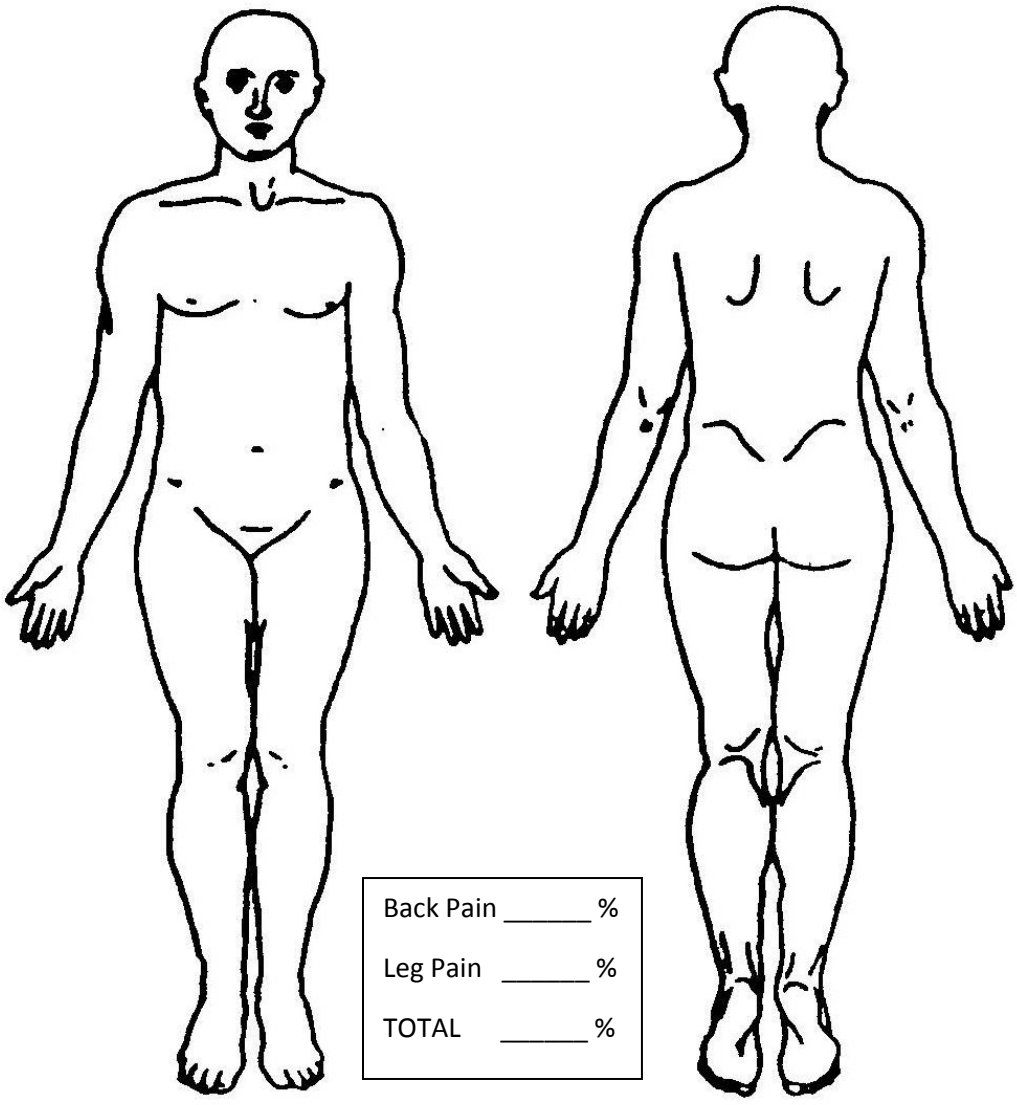
27. What surgeries have you had in your life?

| Surgery: | Year: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## Where is your pain now?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ^ ^ ^ | | o o o | | ■ ■ ■ | | x x x | | / / / |
| ACHE- | ^ ^ ^ | NUMBNESS- | o o o | PINS & NEEDLES- | ■ ■ ■ | BURNING- | x x x | STABBING- | / / / |
| | ^ ^ ^ | | o o o | | ■ ■ ■ | | x x x | | / / / |



| | |
|---|---|
| Back Pain | _____ % |
| Leg Pain | _____ % |
| TOTAL | _____ % |

**Please mark on the line** – How bad is your pain now?

▲ no pain

▲ worst pain

CALIFORNIA ORTHOPEDICS & SPINE

# New Patient Form
## *(Review of Systems)*

Circle any of the following symptoms you've previously experienced and/or are currently having. If you have none of the symptoms, circle "None"

| | |
|---|---|
| **1. General:** Fever, chills, sweats, non-intentional weight loss, recent injections? | None |
| **2. Cardiovascular:** Any chest pain, palpations, irregular heartbeat, high blood pressure, exercise intolerance? | None |
| **3. Endocrine:** Any excessive thirst or hunger, hyper/hypoactivity, sweating, fatigue? | None |
| **4. GI:** Any weight loss, indigestion, abdominal pain, diarrhea, constipation, loss of appetite, hernias, ulcers, jaundice, bloody stool? | None |
| **5.Head and Neck:** Any headaches, vision problems, double visions, eye pain, glaucoma, cataracts, hearing loss, ringing in ears, dizziness, sinusitis, hoarseness, voice change, goiter? | None |
| **6.Hematological/Lymphatic:** Any bleeding tendency, lymph node pain/enlargement, anemia, transfusion, easy bruising, unusual fatigue? | None |
| **7. Musculoskeletal:** Any loss of strength, muscle wasting, joint pain/stiffness, osteoporosis, gout? | None |
| **8. Neurological:** Any headaches, loss of consciousness, seizures, loss of balance, loss of bowel/bladder control, loss of memory, stroke? | None |
| **9. Psychological:** Any depression, mood swings, sleep disturbances, hallucinations? | None |
| **10.Reproductive Tract:** Any history of STDs, fertility problems, abnormal pap tests? | None |
| **11.Respitory:** Any shortness of breath, asthma, coughs, wheezing? | None |
| **12. Skin:** Any rashes, itching, scars, lesions, masses, discoloration? | None |
| **13. Urinary Tract:** Any painful urination, incontinence, urinary infections, flank pain, kidney stones, blood on urination? | None |

Are you being treated for any of the above you circled? ___ Yes ___ No

In NO, we recommend you discuss with your primary care doctor.