HOUSTON SPINE INSTITUTE

Please check answers to questions that pertain to your problem. You may select more than one answer per questions. This information will help get an accurate appraisal of your problems, develop an appropriate plan of treatment, and will be included in your visit note. If you have any questions, please ask for assistance.

Referred By____________________________________. Is this a second opinion? ______________.

NAME: ____________________________________. DATE______________. Date of Birth__________

AGE_______SEX: ☐Male ☐Female ARE YOU: ☐Right Handed ☐Left Handed ☐Ambidextrous

CURRENT MEDICATIONS:

Name	Dose	for what problem?

ALLERGIES:

☐ No known Drug Allergies? Including iodine/contrast dye or shellfish

☐ Yes, Please List____

COMPLAINT: (What are you being seen for?)

☐ Neck Pain ☐ Upper Back Pain ☐ Midback Pain ☐ Buttock Pain ☐ Lower Back Pain

☐ Neck Pain with Headaches ☐ Scoliosis ☐ Sciatica ☐ Shoulder Pain

☐ Other ____

☐ Radiating Pain ☐ Left Leg Pain ☐ Right Leg pain ☐ Right Arm Pain ☐ Left Arm pain

☐ If one or more of the above is chosen, which is the most problematic? ____________________

PAIN LEVEL: _____/10 (Scale of 0 to 10)

Pain Describes As?

☐ Aching ☐ Shooting ☐Sharp ☐Burning ☐Tiring ☐Penetrating ☐Unbearable

☐ Throbbing ☐ Stabbing ☐ Stabbing ☐ tender

Describes Leg/Arm Pain?

☐ Tingling (Electricity like) ☐ Burning ☐ Aching ☐ Shooting ☐ Throbbing ☐ stabbing

Pain Moves: ☐Yes ☐ No

Pain Frequency: ☐ Always Present ☐Usually Present ☐ Often Present ☐ Occasionally Present

Pain Associated With: ☐ Numbness ☐Muscle spasms ☐Tingling ☐ Feelings of weakness ☐ Bladder issues ☐ Bowel Urgency

Pain Worse With: ☐ Sitting ☐ Physical Activity ☐ Cough ☐Sexual Activity ☐Lying ☐ Walking ☐ Standing

Pain Better With:☐Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Heating Application ☐Relaxation technique ☐ Physical Activity ☐ Drinking Alcohol

Self Assessment: ☐Felling Hopeless ☐ Felling Helpless

Pain began/How did the injury occur? ☐ Playing Sports ☐ Accident at work ☐ Work-Related event ☐ Home Accident ☐ Recent Surgery ☐Motor vehicle Accident ☐ None

Previous History of: ☐ Neck Pain ☐ Mid back Pain ☐ Lower Back Pain

Date of Injury/ When did this problem start? ______________________________

Please briefly explain the circumstances that led to your condition:

____

____

____

____

PREVOUS TREATMENTS: ☐ Epidural Steroid Injections ☐ Orthopedic Splinting ☐ EMG test ☐ MRI ☐ X-Ray ☐ Acupuncture ☐ Chiropractor ☐ Physical Therapy ☐ Muscle Injections ☐ Pain medication

PAST MEDICAL HISTORY: Do you have any of these medical conditions?

☐ Headache	☐ Abdominal pain	☐Anxiety	☐Kidney Disease	☐ Seizure	☐ Cataract
☐ Coronary Artery	☐ Hypertension	☐ Heart Disease	☐ Pneumonia	☐ Asthma	☐ COPD
☐ Emphysema	☐Esophageal Reflex	☐ Gastric Reflex	☐ Hemorrhoids	☐Liver Disease	☐Hyperlipidemia
☐ Obesity	☐Thyroid Disease	☐Osteoporosis	☐Diabetes	☐ Psoriasis	☐ Arthritis
☐ Gout	☐ SLE	☐ Stroke	☐ Depression	☐ Sleep Apnea	☐Tuberculosis
☐ Hematologic Disorder		☐ Anemia	☐ Cancer	☐Other ____________	

PAST SURGICAL HISTORY:

☐ Neck Surgery	☐ Appendectomy	☐ Cholecystectomy	☐ Hysterectomy	☐ C – Section
☐ Tonsillectomy	☐ Lumbar Spine Fusion	☐ Back Surgery	☐ Lumbar Disc surgery	☐ Shoulder Surgery
☐ Hip Surgery	☐ Knee Surgery	☐ Other Surgery ____________________		

SOCIAL AND FAMILY HISTORY

Do you smoke ☐No ☐ Current Smoker ☐ Previous Smoker

Alcohol ☐No ☐Yes ☐ Occasionally

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What is the highest level of education you have completed?

☐Some high School ☐High School ☐Trade School ☐College ☐Professional School

Current Employment Status:

☐ Regular ☐part time ☐retired ☐Unemployed ☐ Student ☐other ____________

OCCUPATION: ______________________

FAMILY HISTORY: Do you have any family history of any of these diseases? (Check all that are appropriate)

☐None ☐ Heart Disease ☐ Family History of bleeding ☐ Coronary Artery disease ☐Hypertension

☐ Asthma ☐ COPD ☐ Renal Disease ☐ Hyperlipidemia ☐ Thyroid Disease ☐ Osteoporosis

☐ Diabetes Mellitus ☐ Stroke ☐ Hematologic Disorder ☐ Cancer

REVIEW OF SYSTEMS (check all that appropriate)

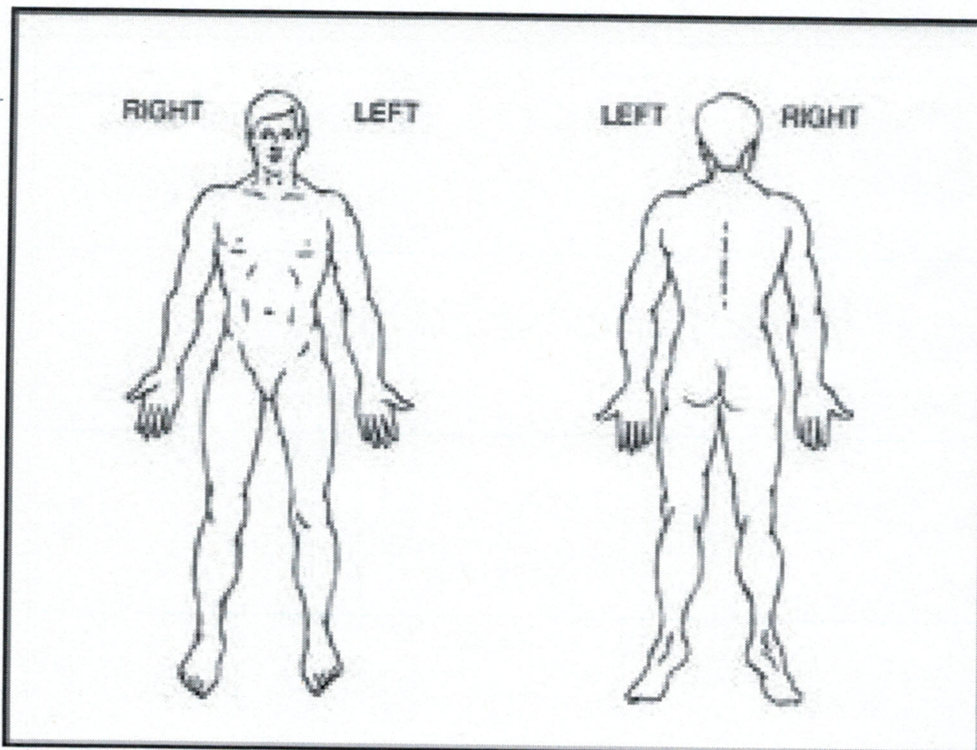
SYSTEMIC:	☐ Feeling fatigued	☐ Fever	☐ Chills	☐ Recent Weight loss	☐ Recent Weight gain
HEAD	☐ Headache	☐ Sinus Pain			
EYES:	☐ Worsening vision	☐Floaters	☐ Blurry Vision		
ENT:	☐ Hearing loss	☐ Earache	☐ Otorrhea	☐ Tinnitus	☐ Sore Throat
HEART:	☐ Chest pain	☐Palpitations	☐ Slow Heart rate	☐ Tachycardia (fast Heart rate)	
RESPIRATORY:	☐ Difficulty Breathing	☐Shortness of breath	☐ Coughing	☐ Wheezing	
GI:	☐ Decreased Appetite	☐ Heartburn	☐ Nausea	☐ Vomiting	☐ Diarrhea
GU:	☐ Frequent urination	☐Urinary urgency	☐ Urinary incontinence		
ENDOCRINE:	☐Heat Intolerance	☐ cold intolerance	☐ Feelings of weakness		
MUSCLE:	☐ Neck pain	☐ Back Pain	☐ Muscle Aches	☐ Joint Pain	☐ Muscle cramps
	☐ Joint pain	☐ Joint Swelling	☐ Joint Stiffness		
NEUROLOGY	☐ Dizziness	☐ Vertigo	☐ Fainting	☐ weakness	☐ Tingling ☐ Numbness
PSCH:	☐ Anxiety	☐Depression	☐ Memory loss		
SKIN:	☐ Dry Skin	☐ itching	☐ peeling of skin	☐ Skin Discoloration	☐ Rash

PAIN ASSESMENT FORM

Draw the location of your pain on the figures below.

For Symptoms of pain, fill in the affected area with the following pattern: xxxxxxxxxx

For symptoms of numbness and or tingling, fill in the affected area with the following pattern: ooooooooooo



I attest that the information provided above is true to my knowledge.

Patient/Authorized Signature______________________________ Date____________

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