SpineTeam Spokane

1 Patient Information

Chart #

Today's Date (M/D/Y) | Referring Doctor

Last Name | First Name | MI

Date of Birth (M/D/Y) | Age | Sex (M/F)

Height | Weight | Marital Status (S/M/D/W)

2 Your Symptoms

What are your symptoms?

Is this pain mostly in back, neck, or elsewhere?

How long ago did these symptoms begin?

How did they begin?

Is the pain constant, or does it come and go?

How do these symptoms limit you?

What things makes the pain better? (rest, ice, heat, pills?)

What makes the pain worse?

☐ Yes ☐ No
Do you have pain that radiates into the arm or leg? (If yes, describe)

☐ Yes ☐ No
Have you lost any control over bowel or bladder functions? (If yes, describe)

☐ Yes ☐ No
Do you have any weakness or numbness in an arm or leg? (If yes, describe)

How long can you... Sit | Stand | Walk

☐ Fall ☐ Auto accident ☐ Other (list)
Is your pain the result of a...

3 Current Status

Which of the following describes you currently?
- ☐ Working
- ☐ Not working because of back or neck problem
- ☐ Not working because of another health problem
- ☐ Homemaker, retired or unemployed

How long have you been at that job? | ☐ Yes ☐ No Is there a law suit pending on problem?

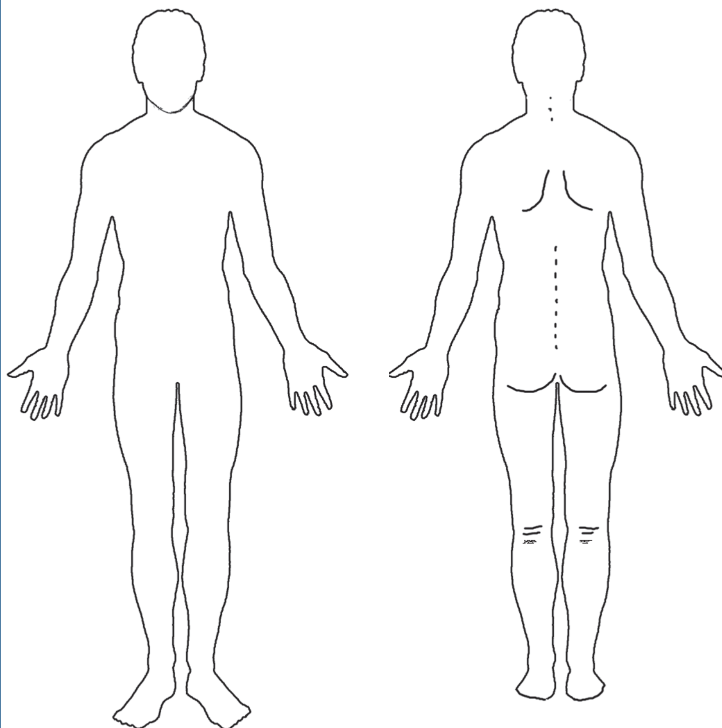
Does your job require lifting, standing, sitting?

Employer at time of injury

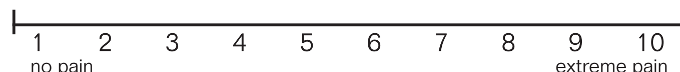
4 Your Pain

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

Stabbing pain **/////** Burning pain **OOO** Aching pain **XXX**
Pins & needles **VVV** Numbness **===**



Circle your pain level on a scale of 1 to 10, with 10 being unbearable, or worst imaginable, pain.



Reviewed by | Date

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5 Previous Treatments & Tests

List the name of the doctor that treated you first for this problem — City

What treatments did you have then?

☐ CT scan ☐ MRI ☐ X-ray ☐ EMG ☐ Other (list)

What tests have you had?

☐ Yes ☐ No

Did you have any injections for your problem? (If yes, describe)

☐ Yes ☐ No

Did these injections help? (If yes, describe)

☐ Yes ☐ No

Did you have previous back or neck surgery? (If yes, describe)

List any PREVIOUS SURGERIES you had, and dates:

☐ Yes ☐ No

Did you have physical therapy before for your problem? (If yes, describe)

☐ Yes ☐ No

Did this therapy help? (If yes, describe)

☐ Yes ☐ No

Do you do any special exercises for your back or neck? (If yes, describe)

What do you hope we can accomplish today?

List any medications you are taking:

What other medications have you tried?

What other concerns do you have?

Reviewed by — Date

6 Your Health

List any ALLERGIES you have to medications, foods, etc.

☐ Yes ☐ No

Do you smoke? (If yes, how many packs a day?)

☐ Yes ☐ No

Do you drink alcohol? (If yes, how many days a week?)

Do you have any of the following medical problems:

AIDS/HIV	☐ Yes	☐ No	Nerve problems	☐ Yes	☐ No
Arthritis or joint pain	☐ Yes	☐ No	Psychiatric problems	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No	Stomach	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No			
Epilepsy	☐ Yes	☐ No	Recently, have you had...		
Heart problems	☐ Yes	☐ No	Fever or chills	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Weight loss	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Chest pain	☐ Yes	☐ No
Migraines/headaches	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Muscle diseases	☐ Yes	☐ No	Worse pain at night	☐ Yes	☐ No

Other problems?

7 Your Family History

Do any family members have a history of:

Back or neck problems	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Arthritis or joint pain	☐ Yes	☐ No	Migraines/headaches	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No	Muscle diseases	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Nerve problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric problems	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Stomach	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No

Other problems?

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