DATE_____

PATIENT HISTORY – SPINAL PROBLEMS

Name: _____ Age: _____Date of Birth_____

Occupation: _____Years at current job _____

Who referred you to this office? _____

When did this pain begin? _____ (Accident/injury date, or slow or delayed onset)

Please complete this form front and back, if for any reason you need help in order to complete this form, please call us at 904-391-6862 ext. 10 and we'll arrange for the medical assistant will help you when you arrive for your appointment.

Please Check all that apply to your current condition, and answer each question

1. **Where is your pain?** Neck Pain____ Thoracic Spine Pain____ Low Back Pain___
   Sacroiliac Joint Pain___(Right / Left / Both) Leg Pain ___ (Right / Left / Both) Arm Pain___(Right / Left / Both)

(Please check all that apply to your pain symptoms and then circle the one that causes you the most pain or distress)

Have you ever had these symptoms before? ❑ Yes ❑ No if so, When? _____
Have you ever had treatment for these symptoms before? ❑ Yes ❑ No
Did you miss time from work? ❑ Yes ❑ No

2. Are the current symptoms Work Related? ❑ Yes ❑ No
   Is this a worker's compensation claim? ❑ Yes ❑ No
   Have you had a prior WC claim? ❑ Yes ❑ No If so, When?_____
   Were you in a Motor Vehicle Accident? ❑ Yes ❑ No
   Have you had a prior MVA? ❑ Yes ❑ No If so, When? _____

3. What caused the pain to begin (check all that apply):
   - ❑ Unknown
   - ❑ Lifting
   - ❑ Twisting
   - ❑ Fall
   - ❑ Other _____
   - ❑ Bending forward
   - ❑ Bending backward
   - ❑ Pulling
   - ❑ Hit in back
   - ❑ Auto Accident ___Rear ended ____Side swiped ___ Head on ____ Roll over

4. Did you seek medical help at once? ❑ Yes ❑ No If yes, where and what did they do?_____
_____
How long afterwards did you get medical help? _____

5. What treatment(s) have you had? __ None __Medication __Rest __Physical Therapy __ Bracing
   __ Chiropractic __ Massage Therapy __ Acupuncture __ Exercise Program __ Surgery __ Other _____

6. Has any treatment helped, if so, which ones? _____

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7. Have you had any diagnostic imaging or injections? ❑ Yes ❑ No If yes, please complete this list
   - ❑ Plain x-rays Performed where_____ Date_____
   - ❑ MRI Performed where_____ Date_____
   - ❑ CT Scan Performed where_____ Date_____
   - ❑ Myelogram Performed where_____ Date_____
   - ❑ Discogram Performed where_____ Date_____
   - ❑ Facet Blocks Performed where_____ Date_____
   - ❑ Epidural Steroid Performed where_____ Date_____
   - ❑ Sacroiliac Injections Performed where_____ Date_____
   - ❑ Nerve Injections Performed where_____ Date_____

   Did you have an adverse experience with any of these? ❑ Yes ❑ No if yes, please explain _____
   _____

CURRENT STATUS

1. Do you have bowel or bladder problems? ❑ Yes ❑ No

   If yes, please explain the symptoms? _____

2. Do you have any numbness or tingling? ❑ Yes ❑ No Where? _____

3. Do you have any weakness? ❑ Yes ❑ No Do you stumble or do your legs give way? ❑ Yes ❑ No

4. Is your sleep affected? ❑ Yes ❑ No How?_____

   How many hours do you sleep at night? ____ Do you take naps during the day? ❑ Yes ❑ No

5. Can you walk through the grocery store or supermarket to shop? ❑ Yes ❑ No

6. Can you sit through dinner with your family or friends? ❑ Yes ❑ No

7. What activities make the pain worse? (check all that apply)

❑ Walking	❑ Bending forward	❑ Exercise
❑ Sitting	❑ Bending backward	❑ Rolling over in bed
❑ Standing	❑ Coughing	❑ Sneezing/Coughing

8. What reduces your pain? (check all that apply)

❑ Lying down
❑ Sitting
❑ Walking
❑ Manipulation/Chiropractic
❑ Massage Therapy
❑ Trigger Point Injections
❑ Physical therapy
❑ Medicine:
  ❑ Pain pills ❑ Muscle relaxants ❑ Other _____
  ❑ Tylenol ❑ Ibuprofen (advil/nuprin/motrin)
❑ Moist Heat ❑ Ice Packs
❑ Other _____

9. Has your pain improved? ❑ Yes ❑ No Has your pain gotten worse? ❑ Yes ❑ No

10. When is your pain the worst? _____

11. Is your pain worse during the night? ❑ Yes ❑ No

12. Rate your typical pain on a scale of 1-10: _____ (One being mild – Ten being extreme and unbearable)

13. Are you still working? ❑ Yes ❑ No If yes, do you have restrictions?_____

    Have you taken any time off of work? ❑ Yes ❑ No If yes, when? _____

14. How does your pain affect your home life? _____

15. Has your weight changed in the last year? ❑ Yes ❑ No
    If yes, how much have you Gained _____LBS Lost _____LBS

FAMILY HISTORY

Please list family illnesses or serious health problems:

Mother _____ Living ____ Age___ Deceased___
Father _____ Living ____ Age___ Deceased___
Brother(s)_____ Living ____ Age___ Deceased___
Sister(s)_____ Living ____ Age___ Deceased___
Children_____ Living ____ Age___ Deceased___
Has anyone in your family had back trouble, ongoing pain or surgery? ❑ Yes ❑ No
If yes, please explain_____

How many people live in your home? _____ What relation are they to you? _____

MEDICAL HISTORY

Do you or have you had any of these medical conditions? (Check all that Apply)

❑ Diabetes	❑ Liver Disease	❑ Stomach Ulcers
❑ Heart Disease	❑ Hepatitis	❑ Irritable Bowel
❑ Circulatory Problems	❑ Kidney Disease	❑ Auto Immune Disease
❑ Hypertension/High blood pressure	❑ Frequent Bladder Infections	❑ Arthritis
❑ Anemia	❑ Shortness of Breath	❑ Any type of Cancer
❑ Hypo/Hyper Thyroid	❑ Asthma or Lung Problems	❑ Clinical Depression
❑ Fibromyalgia	❑ Anxiety or Panic Disorder	❑ Epilepsy (seizures)
❑ Rheumatic Fever	❑ _____	❑ _____

MEDICATIONS

Do you take any medications regularly for **any** medical conditions you checked above? ❑ Yes ❑ No If so, please list

① _____ ② _____ ③ _____

④ _____ ⑤ _____ ⑥ _____

Medications for pain:

Narcotics _____ How long? _____ Muscle relaxers_____

Anti-Inflammatories _____ Others _____

ALLERGIES

Do you have medical allergies? ❑ Yes ❑ No **if so, please list the allergy and the reaction you have experienced**

① _____ ② _____

③ _____ ④ _____

⑤ _____ ⑥ _____

PAST SURGICAL HISTORY

Have you ever had any kind of spinal surgery? ❑ Yes ❑ No If yes, please explain _____

_____

Have you ever had any other kind of surgery? ❑ Yes ❑ No If yes, please list and include the year or date

① _____ ② _____

③ _____ ④ _____

⑤ _____ ⑥ _____

SOCIAL HISTORY

Are you the primary financial contributor in your household? ❑ Yes ❑ No

Has your medical condition caused financial hardship for you and or your family? ❑ Yes ❑ No

Has your pain interfered with your ability to handle your household chores or responsibilities? ❑ Yes ❑ No
If yes, please explain _____

Do you smoke now? ❑ Yes ❑ No If so, How much?_____
Have you ever smoked? ❑ Yes ❑ No If so, when and for how long?_____
Do you use any other Tobacco products? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No if yes, How frequently _____
❑ Beer ❑ Wine ❑ Liquor ❑ Mixed Drinks
Have you used any recreational drugs now or in the past 5 years? ❑ Yes ❑ No

EDUCATION

Did you graduate from High School? ❑ Yes ❑ No if no, last year completed_____
Did you go to College? ❑ Yes ❑ No if yes, how many years _____
Do you have a College Degree? ❑ Yes ❑ No
Are you in school now? ❑ Yes ❑ No if yes, pursuing _____
Do you want to go back to school? ❑ Yes ❑ No
Do you have vocational training? ❑ Yes ❑ No

MEDICO-LEGAL STATUS

Do you have a lawyer representing you for your current injury? ❑ Yes ❑ No
If yes, please provide the following:
Firm_____ Attorney_____ Phone Number: _____
Address _____
_____

Have you ever been involved in any other lawsuits? ❑ Yes ❑ No
If so, please explain the situation: _____
_____

Is there anything else that you would like us to know about your current problem or the prior care that you have received?
_____
_____

Do you have any specific questions that you want to remember to ask Dr. Graham Smith? If so please list here

① _____

② _____

③ _____

④ _____

⑤ _____

⑥ _____

PHYSICIAN NOTES:
_____
_____
_____
_____
_____
_____
_____