PLEASE FILL OUT COMPLETELY
SPINE HISTORY

Occupation	**Date back / neck pain started**	**Current episode started**
Did pain start? ❑ gradually ❑ suddenly	**How did it start?** ❑ Auto Accident ❑ Fall ❑ Lifting ❑ Bending ❑ Pulling ❑ Twisting ❑ Hit in Back ❑ Other	
Do you have arm pain ❑ Yes ❑ No	**Do you have leg pain?** ❑ Yes ❑ No	**When did arm / leg pain start**
Do you have numbness in arm? ❑ Yes ❑ No	**Do you have numbness in leg?** ❑ Yes ❑ No	**Do you have muscle weakness?** ❑ Yes ❑ No

List doctors you have consulted about your back/neck pain

1. _____ **3.** _____

2. _____ **4.** _____

Have you had any of the following for your back / neck?

	# of times	**Dates**	**Doctor/Facility**
Hospitalization	_____	_____	_____
MRI	_____	_____	_____
X-Rays	_____	_____	_____
CT Scan	_____	_____	_____
Myelogram	_____	_____	_____
EMG	_____	_____	_____
Bone Scan	_____	_____	_____
Discogram	_____	_____	_____

Have you returned to work ❑ Yes ❑ No | **If not presently working, date last worked**

Have you taken medication for this pain? ❑ Motrin ❑ Celebrex ❑ Naprosyn ❑ Clinoril ❑ Indocin ❑ Voltaren ❑ Cortisone (Steroids: Prednisone, Decadron or Medrol) ❑ Other _____

❑ Hydrocodone ❑ Other Narcotics _____

Duration medication attempted _____ **Did medication improve symptoms?** ❑ Yes ❑ No ❑ Temporarily

Have you taken any of these muscle relaxants? ❑ Flexeril ❑ Norflex ❑ Parafon Forte ❑ Robaxin ❑ Soma ❑ Valium ❑ Zanaflex ❑ Other _____

Have you had?

		Dates	**Facility**
Physical Therapy	❑ Yes ❑ No ❑ Better ❑ Worse ❑ No Change	_____	
Chiropractic	❑ Yes ❑ No ❑ Better ❑ Worse ❑ No Change	_____	
Home Exercise Program	❑ Yes ❑ No ❑ Better ❑ Worse ❑ No Change	_____	
Corset or Brace	❑ Yes ❑ No ❑ Better ❑ Worse ❑ No Change	_____	
Cortisone Injection	❑ Yes ❑ No ❑ Better ❑ Worse ❑ No Change	_____	
Back / Neck Surgery	❑ Yes ❑ No ❑ Better ❑ Worse ❑ No Change	_____	

Please check one

❑ Back pain is worse than leg pain ❑ Back pain equals leg pain ❑ Leg pain is worse than back pain

Please check the appropriate boxes. **My pain is:**

With cough or sneeze	❑ Better	❑ Worse	❑ No Different
With straining	❑ Better	❑ Worse	❑ No Different
Sitting	❑ Better	❑ Worse	❑ No Different
Bending forward to brush teeth	❑ Better	❑ Worse	❑ No Different
Walking up stairs	❑ Better	❑ Worse	❑ No Different
Walking down stairs	❑ Better	❑ Worse	❑ No Different
Lying flat on stomach	❑ Better	❑ Worse	❑ No Different
Lying on side with knees bent	❑ Better	❑ Worse	❑ No Different
Lying on back	❑ Better	❑ Worse	❑ No Different
Bending	❑ Better	❑ Worse	❑ No Different
Lifting	❑ Better	❑ Worse	❑ No Different
Standing	❑ Better	❑ Worse	❑ No Different

Which best describes the amount of pain you have daily

❑ No Pain ❑ Little Pain ❑ Moderate Pain ❑ Quite Bad Pain ❑ Very Bad Pain ❑ Unbearable Pain

PLEASE FILL OUT COMPLETELY

MEDICAL HISTORY

PLEASE COMPLETE THIS MEDICAL HISTORY FORM AS THROUGHLY AND ACCURATELY AS POSSIBLE. IF THE QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE N/A IN THAT BLANK. IF YOU DO NOT UNDERSTAND A QUESTION, PLEASE ASK FOR ASSISTANCE. TURN OVER AND COMPLETE SIDE 2.

Name	Age	Height	Weight	Dominant Hand	Marital Status	# of Children
				❑ Right ❑ Left	❑ Married ❑ Single ❑ Divorced ❑ Widowed	

Major Illnesses ❑ None ❑ High Blood Pressure ❑ Diabetes ❑ Heart Disease ❑ Lung ❑ Cancer ❑ Other (specify)

Current Medications ❑ None ❑ Blood Thinners

Preferred Pharmacy Name Address Phone

Previous Surgeries (Type and Date) ❑ None

Allergies ❑ None ❑ Penicillin ❑ Sulfa ❑ Latex ❑ Other (specify)

Occupation	Tobacco Type / Tobacco Amount	Alcohol Amount / Alcohol Frequency
	❑ None	❑ None

Family Medical History	High Blood Pressure	Heart Disease	Diabetes	Cancer
	❑ Mother ❑ Father ❑ Sibling	❑ Mother ❑ Father ❑ Sibling	❑ Mother ❑ Father ❑ Sibling	❑ Mother ❑ Father ❑ Sibling

Review of Systems

AIDS/HIV	❑ Yes ❑ No	Hernia	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No
Anxiety/Depression	❑ Yes ❑ No	Hypertension	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Bleeding Disorder	❑ Yes ❑ No	Migraines	❑ Yes ❑ No
Blood Clot	❑ Yes ❑ No	Orthotics	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
COPD	❑ Yes ❑ No	Pace Maker	❑ Yes ❑ No
Cancer (type) _____	❑ Yes ❑ No	Peripheral Vascular Disease	❑ Yes ❑ No
Coronary Artery Disease	❑ Yes ❑ No	Pulmonary Embolism	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Rheumatoid Arthritis	❑ Yes ❑ No
Gout	❑ Yes ❑ No	Seizures/Epilepsy	❑ Yes ❑ No
Heart Attack	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Heart Problems	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Heart Stents	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Hepatitis	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No

Please detail any other problems or concerns that you feel your doctor needs to be aware of

Patient Signature _____ **Date** _____

Physician Signature _____

Please turn over and complete Spine History