THREE RIVERS SPINE & PAIN
Patient Form

******PLEASE COMPLETE FORM AND BRING TO YOUR APPOINTMENT*****

Name:_____

History of present illness

What is the major reason you are coming to see the doctor (chief complaint):

_____

Date of injury: ____/ ____/ ____

How long have you had this pain? _____

Onset: When did your pain start? (Please check one)

□sudden onset □gradually over time □while running □while walking
□while jumping □while getting down the stairs □while climbing
□while playing □when fell down □while lifting weight
□while bending while driving □when met with motor accident
□while standing up after prolonged standing

Frequency of pain: How often? (Please check one)

□constant □intermittent □infrequent □rare □seldom

Quality: Does your pain feel like it is... (Please check all that apply)

□throbbing □shooting □stabbing □sharp □cramping □hot-burning □aching
□tingling □numbness □dull □pins and needle □pressure like

Radiation: Does your pain spread to ... (Please circle all that apply)

Right upper extremity Left upper extremity Right lower extremity
Left lower extremity Right Head Right Shoulder Right Upper Arm
Right Forearm Right Hand Right Fingers Left Head Left Shoulder
Left Upper Arm Left Forearm Left Hand Left Fingers Bilaterally into the head
Bilateral lower extremity Right foot Right ankle Right leg Right knee Right thigh
Right sided hip Left foot Left ankle Left leg Left knee Left thigh Left sided hip
Back Flank

0 = No Pain and 10 = Most Excruciating

Worst Severity: When your pain is at its worst it is a (Please circle one)

0/10 1/10 2/10 3/10 4/10 5/10 6/10 7/10 8/10 9/10 10/10

Best Severity: When your pain is at its best it is a (Please circle one)

0/10 1/10 2/10 3/10 4/10 5/10 6/10 7/10 8/10 9/10 10/10

Average Severity: On average, what is your pain (Please circle one)

0/10 1/10 2/10 3/10 4/10 5/10 6/10 7/10 8/10 9/10 10/10

Worsening factors: What makes your pain worse? (Please circle all that apply)

nothing
bending coughing walking standing a long time lifting sneezing
sitting a long time defecation movement heat increased activity
going up stairs going down stairs laying flat

standing straight up turning to the right turning to the left turning side to side

Relieving factors: What makes your pain better? (Please circle all that apply)
nothing
medications heat cold massage rest exercise lying flat sitting
standing walking physical therapy manipulation
assistive devices injections changing position

Associated Symptoms: What problems do you have because of your pain? (Please circle all that apply)
unable to fall asleep unable to stay asleep wakes up due to pain at night
feeling blue all the time dependent on others for activities of daily living
restrictions on activities frustrated because of pain
difficulty staying asleep due to pain need for sleeping pills recent fevers
chills or sweats involuntary loss of bowel and bladder control non restful sleep restful sleep
increased pain with coughing and sneezing muscle cramps
tingling numbness

History of vertigo / dizziness: Yes No
History of falls: Yes No
History of fibromyalgia: Yes No

Use of supporting devices: None
Cane Crutches Walker Wheelchair

Treatment
How many times visited a professional caregiver:
0-5 6-10 Can't Remember Too many to count

Medicines taken prior to your arrival here today: (Please circle all that apply)
Tylenol/acetaminophen Non-steroidal anti inflammatory Mortin Ibuprofen Muscle relaxants
Flexaril Opioids Morphine Methadone Percocet
Darvocet Vicodin Lortab Steroids by mouth Medrol dose pack by mouth
Colchicine Tegretol Neurontin Topamax Trileptal
Amitriptyline Nortriptyline Imipramine Desipramiae

Medicines that have been tried in the past: (Please circle all that apply)
Tylenol/acetaminophen Non-steroidal anti inflammatory Mortin Ibuprofen Muscle relaxants
Flexaril Opioids Morphine Methadone Percocet
Darvocet Vicodin Lortab Steroids by mouth Medrol dose pack by mouth
Colchicine Tegretol Neurontin Topamax Trileptal
Amitriptyline Nortriptyline Imipramine Desipramiae

Have you had any injections to your back or epidural steroids? No Yes
If yes, how many times? 1 2 3 4 More

Have you had any of following to treat your pain?
Marijuana Heroin Cocaine Xanax Ativan Valium Prozac

Interventions done for your pain: (Please circle all that apply)
TENS Nerve Stimulator Ultrasound Heat Cold Cryotherapy
Diskography Facet injections Sacroiliac joints

If so how many times? 1 2 3 4 more

Have you had trigger point injections? No Yes

Have you ever had...
Discectomy done in_____
Laminectomy done in _____
Spinal fusion done in _____
Pump _____ **Stimulator** _____

Have you undergone any of the following: (Please circle all that apply)
Bed rest Lumbar traction Exercises Physical therapy Manipulations
Mobilization Medications Prolotherapy Therapeutic inj. of any kind
Acupuncture Hypnosis Counseling Education Loss of work

What is your ethnicity? (Please circle one)
Caucasian African American Hispanic Latino Asian
Pacific Islander American Indian Eastern Indian Other

Treatment History
Caregivers you have visited: (Please circle all that apply)
Pain Medicine Physician Family physician Spine Surgeon Internist
Physical Therapist General practitioner Neurologist Rheumatologist Chiropractor
Orthopedist General Surgeon Gynecologist Sports Medicine Anesthesiologist
Occupational Medicine Rehabilitation Medicine Osteopathic Physician Acupuncturist
Alternative Medicine Podiatrist Neurosurgeons Nurse practitioner
Psychiatrist Urologist Endocrinologist

What tests have you undergone in the past: (Please circle all that apply)
X-Rays CAT Scan EMG Test Discogram Neural Block
Myelogram CT Myelogram Flexion/extension films Bone scan
Nerve conduction EEG CBC PT PTT INR Rheumatologic panel
Neuropathy panel Electrolytes Lumbar puncture EKG Chest x-ray
Hepatic profile MRI Scan

Please list any Allergies:
1._____ 2._____
3._____ 4._____

Please list your Current Medications and include dosage and how often:
1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Past Medical History:

1._____ 2._____
3._____ 4._____
5._____ 6._____

Surgical History:

1._____ 2._____
3._____ 4._____
5._____ 6._____

Family History:

Ailment	**Relation**
1._____	_____
2._____	_____
3._____	_____

Social History

Do you drink alcoholic beverages? Yes No
If yes, how often do you drink? (Please circle one)
1 drink / day 2-3 drinks / day 3-4 drinks / day 4-5 drinks / day
More than 6 drinks / day
How many years? _____

Are you a smoker: Yes No
If yes, how much and how often: (PPD = Packs Per Day)
1/4 PPD 1/2 PPD 1 PPD
1 and 1/4 PPD 1 and 1/2 PPD 2 PPD More than 2 PPD
If no, have you ever smoked in the past? Yes No
How many years have/did you smoke? _____

Have you ever....
Non prescription drug use? Yes No
Drug or substance abuse? Yes No
Participation to detoxification or rehabilitation: Yes No

Family:
Marital Status Single Married Divorced Widowed
# of children_____

Employment: Are you...
Currently working? Yes No
Current Occupation _____
If not, when did you work last?_____
Applying for disability? Yes No
Currently on disability or workman's comp? Yes No
Exposed to toxins/poisonous substances at work? Yes No

General: (Please circle the highest level completed)
Education Grade School High School College Post-Graduate Vocational Training

Involved in any legal proceedings or lawsuits? Yes No

Are you or is there a chance you could be pregnant? Yes No

Review of Systems
Have you, or are you currently experiencing problems with any of the following?
****Please circle all that apply****

CONSTITUTIONAL SYMPTOMS:
Fever Weight loss Night sweats

HEAD/NECK/EYES:
Blurred vision Double vision Frequent headache Loss of vision Neck pain
Loss of strength Pain in eyes Neck lumps

NEUROLOGICAL:
Fainting spells Seizures Tremors Poor coordination

EARS:
Discharge from ears Dizziness Earaches

PSYCHIATRIC:
Anxiety Depression Mood swings Nervousness Sleeping difficulty

NOSE/THROAT:
Frequent head colds Frequent nose bleeds Hoarseness Problems with teeth Sore throat
Smell difficulty Taste difficulty Sinus problems Difficulty Swallowing

ENDOCRINE:
Excessive urination Heat or cold intolerance Thyroid problem Excessive Thirst

RESPIRATORY:
Wheezing Asthma

HEMATOLOGIC:
Easy bruising Blood transfusions Anemia

CARDIOVASCULAR:
Chest pain High blood pressure Feet swelling Thumping in the chest
Ankle swelling Poor circulation Irregular heart beat

SKIN:
Rashes Itching Boils

Muscular:

Arthritis Swollen Joints Muscular Pain

URINARY:

Blood in urine Difficulty in urination Inability to control urine Kidney stones

GASTROINSTENTINAL:

Heart burn Indigestion Stomach ulcer Nausea/vomiting
Abdominal pain Frequent constipation Frequent diarrhea Hemorrhoids/piles
Painful bowel movement Blood in stool Jaundice