The Spine Center
Patient Information

DuPage Medical Group
WE CARE FOR YOU

Date:_____

LAST NAME	FIRST NAME	DATE OF BIRTH	CURRENT AGE

PRIMARY CARE PHYSICIAN _____ PHONE NUMBER _____

REFERRING PHYSICIAN OR OTHER REFERENCE _____ PHONE NUMBER _____

Reasons for Visit

☐ Work comp injury ☐ Automobile accident ☐ Other injury

PRIMARY REASON FOR THIS VISIT (describle location of pain)

_____

_____

_____

_____

Factors of Complaint

Explain how your pain or problem began and how it happenned ☐ Recent injury ☐ On-the-job

_____

_____

_____

_____

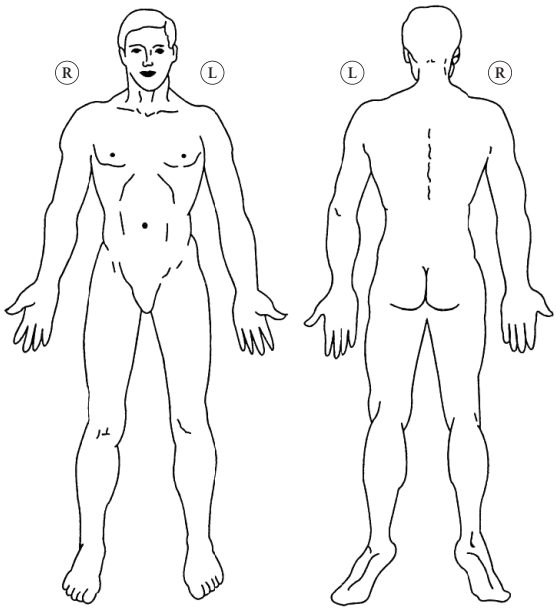
How long have you had this problem? _____

_____

Ortho Pain Chart

Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

numbness	= = =
pins & needles	o o o
burning/aching	x x x
stabbing	/ / /



FOR OFFICE USE ONLY

DX:

PLAN:

PATIENT INITIALS _____ DATE _____

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Current Pain Profile

WHICH OF THE FOLLOWING ACTIVITIES CHANGE THE NATURE OF YOUR PAIN

Sitting	☐ Aggravates pain	☐ Relieves pain	☐ Neither
Standing	☐ Aggravates pain	☐ Relieves pain	☐ Neither
Walking	☐ Aggravates pain	☐ Relieves pain	☐ Neither
Long car rides	☐ Aggravates pain	☐ Relieves pain	☐ Neither
Bending forward	☐ Aggravates pain	☐ Relieves pain	☐ Neither

LIST ANYTHING ELSE THAT DECREASES OR INCREASES YOUR PAIN (ex. temperature changes, laughing, using the restroom, etc.):

_____

_____

Functional History

PLEASE INDICATE THE ACTIVITIES THAT YOU REQUIRE ASSISTANCE PERFORMING:

☐ Driving
☐ Walking
☐ Standing
☐ Ambulating up or down stairs
☐ Lifting
☐ Cooking
☐ Bathing
☐ Using the washroom
☐ Dressing
☐ Shopping
☐ Writing
☐ Ambulating
☐ Household chores (laundry, dishes, vacuuming, etc.)
☐ Outdoor yard work (mowing lawns, trimming hedges, raking, gardening, etc.)
☐ Buttoning shirt
Do you frequently drop things? ☐ Yes ☐ No
☐ Dropping objects

PREVIOUS TREATMENTS FOR THIS CONDITION

Medications

Anti-inflammatories_____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Muscle relaxants _____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Pain medications _____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Other(s)_____	☐ Temporary relief	☐ Lasting relief	☐ No relief

Therapies

Chiropractic care _____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Physical therapy_____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Other(s)_____	☐ Temporary relief	☐ Lasting relief	☐ No relief

Injections

(i.e. epidural steroid injections, nerve-root blocks)

Date_____ Injection type_____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Date_____ Injection type_____	☐ Temporary relief	☐ Lasting relief	☐ No relief

Previous treating doctors _____

Specialty(s) *(i.e. surgeon)* _____

Spine Surgery _____

_____

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Family History

WHAT ILLNESSES RUN IN YOUR CLOSE FAMILY

☐ Scoliosis ☐ High blood pressure ☐ Mental illness
☐ Spine disease ☐ Diabetes ☐ Alcoholism
☐ Arthritis ☐ Cancer ☐ Kidney disease
☐ Heart disease ☐ Bleeding disorder ☐ Other

Medical History

PLEASE CHOOSE ALL CURRENT & PAST MEDICAL CONDITIONS

☐ No medical problem
☐ High blood pressure
☐ Heart attack
☐ Heart failure
☐ Abnormal heart rhythm
☐ Lung disease
☐ Cancer *where?* _____
☐ Asthma
☐ Bronchitis
☐ Elevated cholesterol
☐ Emphysema
☐ Liver disease
☐ Hepatitis
☐ Diabetes
☐ Thyroid disease
☐ Stomach ulcers
☐ Irritable bowel
☐ Stroke
☐ Seizures
☐ Parkinsons
☐ Fibromyalgia
☐ Tuberculosis
☐ Kidney failure
☐ Kidney stones
☐ Osteoporosis
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Bleeding disorders
☐ Blood clots in leg/lung
☐ Endometriosis
☐ Multiple sclerosis
☐ Chronic Pain
☐ Ovarian cysts
☐ Anxiety
☐ Depression
☐ Schizophrenia
☐ Anorexia/bulimia
☐ Alcoholism
☐ Seen a psychiatrist
☐ HIV
☐ Sleep apnea ☐ Use CPAP
☐ RSD
☐ Chronic Fatigue

Are you under a doctor's care for any other medical condition ☐ Yes ☐ No

If yes, please explain _____

_____

Surgical History

PLEASE CHOOSE ALL SPINAL SURGERIES YOU HAVE HAD

☐ Other _____ Type of surgery _____ Date(s) _____
☐ Back _____ Type of surgery _____ Date(s) _____
Type of surgery _____ Date(s) _____

_____

Social History

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widow/Widower
Number of children_____ ☐ At home ☐ Away Other dependents_____

☐ Yes ☐ No I live with my children or other relatives *(Explain)*_____

Do you drink? ☐ Yes ☐ No
I drink ☐ Beer ☐ Wine ☐ "Hard" drinks
Frequency ☐ Rarely ☐ Socially ☐ Daily

Do you smoke? ☐ Yes ☐ No
I smoke ☐ Cigarettes ☐ Cigar/pipe ☐ Smokeless/leaf
Frequency Per day_____ Years_____
I quit When_____ _____

Review of Systems

PLEASE CHECK OFF ANY CURRENT OR RECENT PROBLEMS YOU HAVE

General
- ☐ Unexplained weight loss
- ☐ Appetite change
- ☐ Fevers or chills
- ☐ Night sweats
- ☐ Marked fatigue
- ☐ Difficulty sleeping

Cardiovascular
- ☐ Heart or chest pain
- ☐ Abnormal heartbeat
- ☐ Poor heart function

Musculoskeletal
- ☐ Joint pain/swelling
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle aches

Digestive
- ☐ Nausea or vomiting
- ☐ Stomach pain or ulcers
- ☐ Heartburn/acid stomach
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Uncontrolled loss of stool
- ☐ Blood in stool

Skin
- ☐ Easy bruising
- ☐ Swollen ankles

Lung
- ☐ Morning cough
- ☐ Shortness of breath
- ☐ Productive cough or sputum

Neurological
- ☐ Seizures
- ☐ Blackouts/fainting
- ☐ Tremor
- ☐ Headaches/migraines
- ☐ Loss of balance
- ☐ Increased clumsiness

Genitourinary
- ☐ Burning on urination
- ☐ Difficulty starting urination
- ☐ Incontinence (stress)
- ☐ Pelvic pain
- ☐ Urinate at night more than once
- ☐ Unable to completely empty bladder

Psychiatric
- ☐ Depression
- ☐ Nervous exhaustion
- ☐ Anxiety
- ☐ Paranoia
- ☐ Obsessive/compulsive behavior
- ☐ History of sexual abuse
- ☐ History of physical abuse

Other:_____

_____

_____

Work History

Employment status: ☐ Full time ☐ Part time ☐ Self employed ☐ Disabled ☐ Retired ☐ Unemployed

Last date of employment:_____

I work as a _____ Previous occupations(s)_____

Describe job duties: _____

☐ Yes ☐ No Do you have any lawsuits pending?

☐ Yes ☐ No Are you considering filing a lawsuit regarding this problem?

☐ Yes ☐ No Do you have any workman's compensation claims pending?

☐ Yes ☐ No Have you ever had any past workman's compensation claims?