patient information

The Spine Center
OF DUPAGE MEDICAL GROUP

Date: _____

LAST NAME | FIRST NAME | DATE OF BIRTH | CURRENT AGE

PRIMARY CARE PHYSICIAN | PHONE NUMBER

REFERRING PHYSICIAN | PHONE NUMBER

reasons for visit

☐ Work comp injury ☐ Automobile accident ☐ Other injury

PRIMARY REASON FOR THIS VISIT (describe location of pain)

factors of complaint

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

How long have you had this problem? _____

FOR OFFICE USE ONLY

DX:

PLAN:

PRIOR SURGERY(S)

☐ Yes ☐ No Prior surgery for this problem

Number of surgeries _____

TIME OFF FROM WORK

☐ Yes ☐ No Off work due to this recent problem

How long _____

PREVIOUS OCCURRENCES

☐ Yes ☐ No Have you had any previous occurrences?

PATIENT INITIALS | DATE

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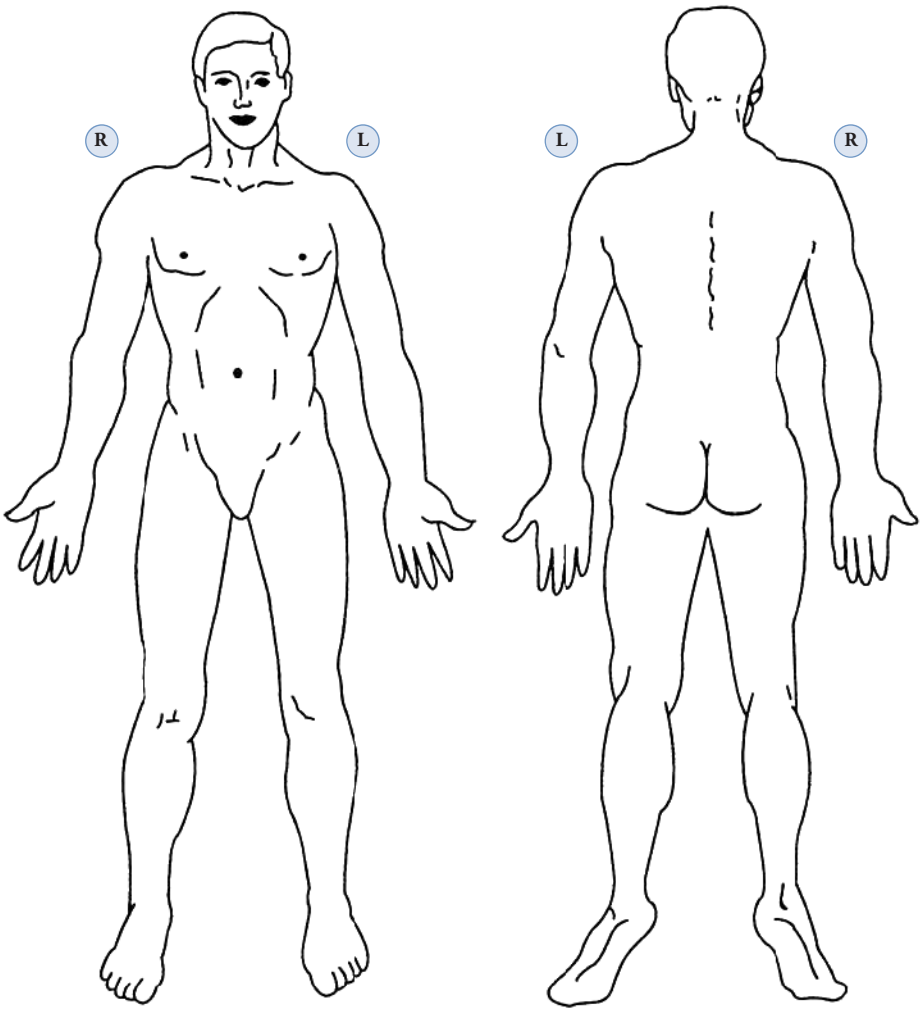
ortho pain chart

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	/ / /



PATIENT INITIALS DATE

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current pain levels

Please indicate your current pain level by placing an x on the line
"0" = no pain & "10" = worst pain imaginable

Example 0 — X — 10

How bad is your **low back** pain now?

Pain on average	0	10
Pain at its worst	0	10
Pain at its best (Lying down, resting)	0	10

How bad is your **leg pain/numbness** now?

Pain on average	0	10
Pain at its worst	0	10
Pain at its best (Lying down, resting)	0	10

How bad is your **middle back** pain now?

Pain on average	0	10
Pain at its worst	0	10
Pain at its best (Lying down, resting)	0	10

How bad is your **neck or upper back** pain now?

Pain on average	0	10
Pain at its worst	0	10
Pain at its best (Lying down, resting)	0	10

How bad is your **arm pain/numbness** now?

Pain on average	0	10
Pain at its worst	0	10
Pain at its best (Lying down, resting)	0	10

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

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sleep history

What time do you go to bed? _____ # hours to fall asleep: _____

# of times you wake up at night: _____ # hours you sleep per night: _____ How many hours do you require? _____

Have you taken any sleep medications or natural supplements to help you fall asleep? ☐ Yes ☐ No

Please list: _____

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 _____

tests & treatment

☐ Yes ☐ No

Any previous tests (examinations) or treatments for your current condition
(If yes, please complete the following, if no, please skip to "past back history" section)

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 imaging history

PLEASE INDICATE WHETHER YOU HAVE HAD ANY OF THE FOLLOWING STUDIES AND WRITE WHEN & WHERE THE MOST RECENT WAS

☐ Yes ☐ No	Regular x-ray of spine	When _____	Where _____
☐ Yes ☐ No	CT scan of spine	When _____	Where _____
☐ Yes ☐ No	EMG	When _____	Where _____
☐ Yes ☐ No	Bone scan	When _____	Where _____
☐ Yes ☐ No	Myelogram	When _____	Where _____
☐ Yes ☐ No	Discogram	When _____	Where _____
☐ Yes ☐ No	MRI of spine	When _____	Where _____

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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
- ☐ Emphysema
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Stomach ulcers
- ☐ Irritable bowel
- ☐ Stroke
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Bleeding disorders
- ☐ Blood clots in leg/lung
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Anxiety
- ☐ Depression
- ☐ Schizophrenia
- ☐ Anorexia/bulimia
- ☐ Alcoholism
- ☐ Seen a psychiatrist
- ☐ HIV
- ☐ Sleep apnea ☐ Use CPAP

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

- ☐ Spine-neck — Type of surgery _____ Date(s) _____
- ☐ Spine-lower back — Type of surgery _____ Date(s) _____
- ☐ Other _____ — Type of surgery _____ Date(s) _____

current medications *(may attach a list)*

NAME	DOSE	# PER DAY

allergies *(may attach a list)*

☐ No known medical allergies

SUBSTANCE	REACTION

PATIENT INITIALS _____ DATE _____

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
- ☐ Chronic pain syndrome
- ☐ Fibromyalgia
- ☐ Chronic fatigue syndrome
- ☐ Reflex sympathetic dystrophy
- ☐ Loss of balance
- ☐ Increased clumsiness
- ☐ Difficulty buttoning shirt
- ☐ Dropping things

genitourinary
- ☐ Burning on urination
- ☐ Difficulty starting urination
- ☐ Incontinence
- ☐ 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: _____

_____

_____

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)* _____

Highest educational level attained ☐ Grammar ☐ High school ☐ College ☐ Post graduate

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 _____ _____

work history

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

Last date of employment: _____

I work as a _____ Previous occupation(s) _____

Describe job duties: _____

How many hours/day do you work: _____ How many days/week do you work: _____

How many hours do you spend: Standing _____ *hours* Sitting _____ *hours* Walking _____ *hours*

Bending _____ *hours* Computer work _____ *hours* Lifting _____ *hours*

How much weight do you lift? _____ *hours* How many repetitions per day? _____ *reps/day*

☐ 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

effect of your injury or complaint on lifestyle

☐ Yes ☐ No I describe my home setting as supportive of me during this time

☐ Yes ☐ No I describe my work setting as supportive of me during this time

☐ Yes ☐ No My pain has affected my interaction with my family and friends

☐ Yes ☐ No My pain has affected my ability to do my job or get a job

☐ Yes ☐ No The changes in my lifestyle due to my problem have been difficult for me

☐ Yes ☐ No Do you like your job situation

Ability to enjoy life

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

what do you want to happen as a result of this visit

☐ Discuss surgical options

☐ Discuss non-surgical options

☐ Other: _____

☐ Yes ☐ No Is there anything we have failed to ask you that you believe is important

Explain _____

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FOR OFFICE USE ONLY:

Height: _____ Weight: _____

Vitals: _____ Blood pressure: _____ Pulse: _____

physical exam

imaging studies

assessment/plan