SPINE WORKS INSTITUTE
Please complete at each visit

Today's Date: _____

ARE YOU ON BLOOD THINNERS YES NO
DR. THAT PRESCRIBED _____

Name: _____ **Date of Birth:** _____
Height: _____ **Weight:** _____

1. What brings you to the clinic today? _____

2. Where is your pain located? Neck Mid Back Low Back Other: _____
   Arm(s) Leg(s): Right Left Bilateral

3. When did your pain begin? _____

4. Pain is a result of an: accident injury fall other: _____

5. Pain has: improved worsened remains unchanged
   Since: onset injection surgery last appointment

6. Pain level at this time: _____ Average over the past week: _____
   On a scale of 1 to 10 with 10 being the worst

7. Pain is: aching burning dull gnawing itching jabbing sharp sore stiff throbbing shooting cramping (circle all that apply)

8. Are you experiencing any numbness or tingling or weakness? Yes No
   If yes, where? _____

9. What makes your pain worse? bending coughing straining extension lifting sitting sleeping standing weather changes working walking physical activity

10. What makes your pain better? bending heat ice lifting sitting sleeping standing working medications rest exercise stretching nothing

11. Are you experiencing any problems with urination or having bowel movements? Yes No

12. Previous Treatments: (Please circle all treatments you have tried)

    X-Ray MRI CT Scan Physical Therapy Chiropractic Care Accupuncture

    Massage Traction Trigger Point Injection Epidural Injection Facet Injection

    Rhizotomy Home Exercise NSAIDS Pain Medication Other Medications Surgery

Patient Name: _____ DOB: _____

Have there been any changes to your medications since your last visit (new medications or medications you are no longer taking? Y N WHAT DR. PRESCRIBED NEW MEDS _____

If yes please list medication: _____

Have you had any surgical procedures or been admitted to the hospital since your last visit? Y N

If yes please list date and surgery type or reason for hospital admission: _____

_____

List All Drug Allergies: _____

HAVE YOU TRAVELED OUTSIDE THE UNITED STATES WITHIN THE PAST 30 DAYS? Y N

REVIEW OF SYSTEMS

Have you experienced any of the following in the past month? (circle all that apply)

General: chills fever weight gain weight loss

Allergies: hives rash seasonal allergies

Eyes: vision changes blurred vision

ENT: difficulty swallowing nosebleed ringing in ears sore throat

Cardiovascular: chest pain/angina swelling irregular heartbeat heart murmur

Respiratory: cough blood in sputum shortness of breath wheezing

Gastrointestinal: abdominal pain constipation diarrhea nausea vomiting

Genitourinary: difficulty urinating painful urination frequent urination painful urination

Musculoskeletal: leg cramps muscle aches painful joints swollen joints weakness

Skin: hives itching rash frequent infections

Neurologic: fainting headache seizure tremors numbness tingling

Hematology: easy bruising prolonged bleeding recent transfusions clotting disorders