



CAROLINA SPINE & DISC CENTER

Name: _____ Today's Date: ____/____/____
First Middle Last

Age: _____ Gender: Male / Female Date of Birth: ____/____/____ SSN: ____-____-____

Address: _____
Street City State Zip

Home Phone _____ Cell _____ Work _____ Email: _____

How can we best contact you? (circle one): Home phone Work phone Cell phone Email

Marital Status: Single / Married / Widowed / Divorced / Domestic Partner Spouse's Name: _____

How did you hear about us: _____ Race: White/ Black / Asian / Native American / Other

Name of your Primary Care doctor: _____ Referring Physician (if applicable) _____

Emergency Contact: _____ Relationship: _____ Phone: _____

I allow voice messages to be left on my: Home phone Cell phone

I allow Email Notifications I allow SMS (Text Message) Notifications

I allow Carolina Spine & Disc Center to discuss my care with the following person(s): _____

PAST MEDICAL HISTORY: CIRCLE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

CNS

- Cerebral Aneurysm
- Stroke / Mini Stroke
- Brain Tumor
- Seizure Disorder
- Neuropathy

GASTROINTESTINAL

- Hiatal Hernia
- Ulcer
- Gastritis
- Reflux
- Intestinal Bleeding
- Other: _____

CANCER

- Type: _____
- Treatment: _____

CARDIOVASCULAR

- Hypertension
- Valve Disease
- Heart Blockage/Attack
- Heart Failure
- Aortic Aneurism
- Irregular Heartbeat
- Pacemaker

PSYCHIATRIC

- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia
- Post-Traumatic Stress Disorder
- Alcohol/Substance Abuse

RESPIRATORY

- Asthma
- Emphysema/COPD
- Sleep Apnea

BONE/MUSCLE

- Disc disease
- Arthritis
- Fibromyalgia
- Spondylolisthesis
- Osteoporosis
- Fractured Vertebra
- Sciatica
- Other: _____

METABOLIC

- Liver Disease
- Kidney Disease
- Diabetes, Type: ____
- Thyroid
- High Cholesterol
- Bleeding Disorder, Type: _____
- Taking Blood Thinners?

INFECTIOUS

- AIDS
- Meningitis
- Osteomyelitis (bone infection)
- Hepatitis, Type: ____
- Other: _____

SURGICAL HISTORY: LIST SURGERY TYPE & DATE

Name: _____

Occupation at time of injury or when symptoms started : _____ Unemployed / Retired

Current Occupation: _____ Unemployed / Retired / Disabled

Type of work: Office-Clerical / Light Labor / Moderate Labor / Heavy Labor Hours per week: _____

When did you last work? _____ Are you currently on work restrictions? Yes / No

If yes, what are they? _____

Why are you seeing the doctor today? (Where do you hurt?) _____

Onset of Symptoms: How long have you had this problem? _____

What caused your problem?: Injury / Motor Vehicle Accident / Work Accident / Unknown

Please Explain: _____

If Accident: Date of Accident ___/___/___ Is an attorney involved: Yes / No If yes, who: _____

Have you ever been treated for the same symptoms in the past? Yes / No If yes, when? _____

Did you fully recover? Yes / No

Are you presently being treated by a doctor for this problem? Yes / No

If yes, Name of Doctor or Clinic: _____ Date last seen: ___/___/___

What diagnosis have doctors given you for this problem? _____

PREVIOUS TREATMENT FOR THIS PAIN

Physical Therapy	Acupuncture	Back Brace
Chiropractic Treatment	Pain Clinic Medication	TENS Unit
Aquatic Therapy	Spine Injections	Referral to Neurologist
Massage Therapy	Spine Surgery	Referral to Spine Surgeon

TESTS PERFORMED TO DIAGNOSE THIS PAIN

Radiologic Studies	Part of Body	Date/When	Where	Results
X-Rays				
MRI				
CT Scan				
Nerve Conduction Study				

MEDICATIONS (include over the counter medicines): NONE LIST ATTACHED PRESENTLY TAKING THE FOLLOWING:

Name of Medication Dose Times Per Day Reason Last Dose Taken Pill/Injection/Other

ALLERGIES NONE IVP Dye Shellfish Aspirin Others: _____

WHAT TYPE OF REACTION? _____

Pharmacy Name: _____ **Pharmacy Address:** _____

FAMILY HISTORY HAVE ANY OF YOUR FAMILY HAD THE FOLLOWING:

- | | |
|--|---|
| <input type="checkbox"/> Osteoporosis. If yes, who _____ | <input type="checkbox"/> Heart Disease. If yes, who _____ |
| <input type="checkbox"/> Osteoarthritis. If yes, who _____ | <input type="checkbox"/> Alcoholism/Drug Abuse. If yes, who _____ |
| <input type="checkbox"/> Rheumatoid Arthritis. If yes, who _____ | <input type="checkbox"/> Suicide. If yes, who _____ |
| <input type="checkbox"/> Cancer. If yes, who _____ | <input type="checkbox"/> Psychiatric Disorders. If yes, who _____ |
| <input type="checkbox"/> Diabetes. If yes, who _____ | What Type _____ |

SOCIAL HISTORY

SMOKING: NEVER QUIT CURRENT PACKS PER DAY: _____ HOW MANY YEARS DID YOU SMOKE? _____

ALCOHOL: NEVER SOCIAL 1-2 DRINKS PER DAY 3-4 DRINKS PER DAY 5 OR MORE DRINKS PER DAY

DRUGS: NEVER OCCASIONALLY REGULARLY WHAT KIND? _____

PAST OR PRESENT INTRAVENOUS DRUG USE? Yes / No

REVIEW OF SYSTEMS: (Circle any symptoms you have)

General:	Unexplained Fever	Unintended Weight Loss	Bony Night Pain	Anal/Genital Numbness	Incontinence
OPHTHALMOLOGY:	Double Vision	Vision Change	Blurring of Vision		
ENT:	Ear Pain	Nasal Congestion	Sore Throat	Hoarseness	
CARDIOLOGY:	Chest Pain	Palpitations			
RESPIRATORY:	Cough	Shortness of Breath			
GASTROENTEROLOGY:	Abdominal Pain	Vomiting	Heartburn		
UROLOGY:	Urinary Loss of Control	Difficulty Urinating	Incomplete Emptying		
MUSCULOSKELETAL:	Muscle Aches	Swelling in the Extremities			
DERMATOLOGY:	Rash	Jaundice			
NEUROLOGY:	Headaches	Loss of Grip Strength	Worsening Handwriting	Frequent Falls	Frequent Stumbling
PSYCHOLOGY:	Depression	Moodiness			

- ◆ I ACKNOWLEDGE THAT THE HIPPA POLICY OF CAROLINA SPINE AND DISC CENTER IS AVAILABLE FOR ME TO REVIEW.
- ◆ ALL OF THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

NAME: _____

SIGNATURE: _____

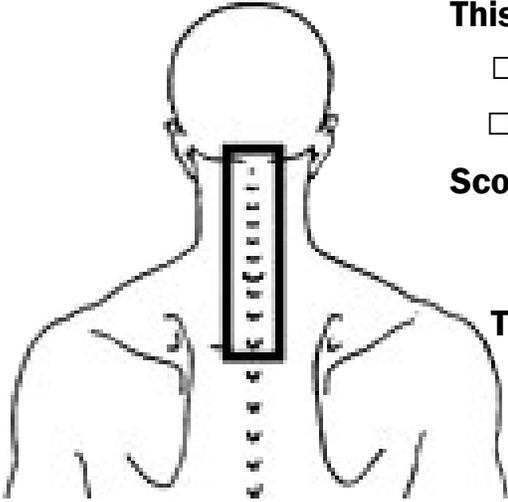
DATE: _____

Name: _____

DESCRIBE YOUR PAIN:

Part 1: Central Pain

If you have central pain (in the midline of your neck, *inside the black rectangle*), please draw 1 or more x's inside the black rectangle to indicate where your central pain is: (Do not draw x's outside of the black rectangle—that's for Part 2 below). If you don't have pain in this area, skip to Part 2.



This central pain:

- Is constant (always present, never *completely* goes away)
- Comes and goes, stays for: Seconds Minutes Hours Days

Score this central pain from 0 to 10 (*0 is no pain, 10 is the worst pain imaginable*):

Right now: _____ At its worst: _____

This central pain is best described as (select the 2-3 best choices):

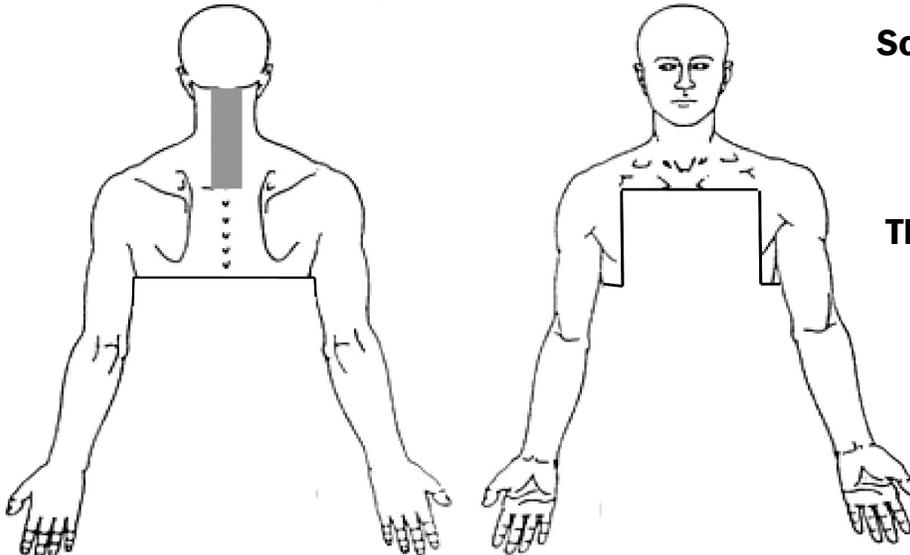
- Sharp Shooting Stabbing Aching Dull Sore
- Burning Pressure Pinching Squeezing Tightness
- Other _____

Part 2: Radiating Pain

If your pain radiates to the side or down the leg(s), draw arrow(s) to indicate where your pain radiates from and to.

This radiating pain:

- Is constant (always present, never *completely* goes away)
- Comes and goes, stays for: Seconds Minutes Hours Days



Score this radiating pain from 0 to 10 (*0 is no pain, 10 is the worst pain imaginable*):

Right now: _____ At its worst: _____

This radiating pain is best described as (select the 2-3 best choices):

- Sharp Shooting Stabbing Sore
- Aching Burning Pressure Dull
- Pinching Squeezing Tightness
- Other _____

Worsens: My pain is worse with:

- Lying Sitting Standing Walking
- Lifting Bending Sneeze or Cough
- Computer work Getting out of chair/bed/car
- Change in weather Other _____

Improves: My pain is improved with:

- Lying Sitting Standing Ice Heat
- Walking Stretching Meds: _____
- Other _____