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:**

☐ Osteoporosis. If yes, who_____

☐ Osteoarthritis. If yes, who_____

☐ Rheumatoid Arthritis. If yes, who_____

☐ Cancer. If yes, who_____

☐ Diabetes. If yes, who_____

☐ Heart Disease. If yes, who_____

☐ Alcoholism/Drug Abuse. If yes, who_____

☐ Suicide. If yes, who_____

☐ Psychiatric Disorders. 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

GASTROGENTEROLOGY: 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.

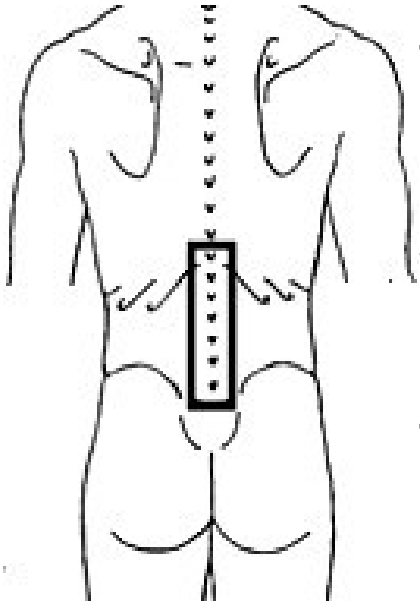
NAME: _____

SIGNATURE:_____ DATE:_____

Name:_____ DESCRIBE YOUR PAIN:

Part 1: Central Pain

If you have central pain (in the midline of your back, 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:____

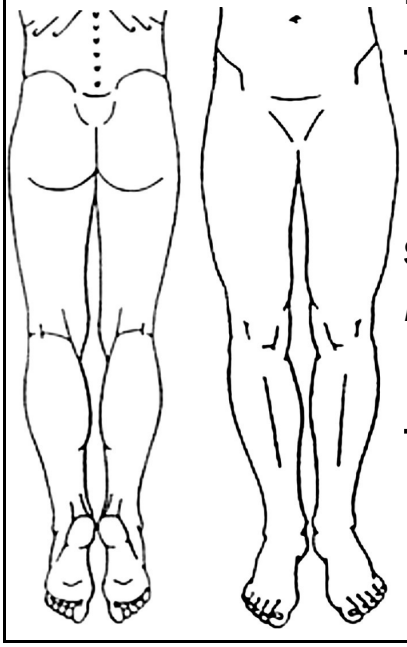
This central pain is best described as (choose no more than 2):

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Aching ☐ Dull ☐ Sore ☐ Burning

☐ Pressure ☐ Pinching ☐ Squeezing ☐ Tightness ☐ _____

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 (choose no more than 2):

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Aching ☐ Dull ☐ Sore ☐ Burning

☐ Pressure ☐ Pinching ☐ Squeezing ☐ Tightness ☐ _____

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 ☐_____

Improves: My pain is improved with:

☐ Lying ☐ Sitting ☐ Standing ☐ Walking

☐ Stretching ☐ Ice ☐ Heat

☐Meds:_____ ☐_____