



SPINE CENTER

NEW PATIENT INFORMATION FORM

Please print all information. All blanks must be filled to allow us to serve you quickly and efficiently. If you already completed this form in the last 3 months, please fill out just the first 2 pages and only items on other pages that have changed since your initial visit. Thank you for your cooperation.

Date: _____ Date of Birth: _____
Patient Name: _____
Address: _____
Phone: Home: () _____ Work: () _____

How were you referred to The Emory Spine Center: Physician Patient / Friend Health Connection
 Workers Comp Emory Reputation Insurance Radio / TV Advertisement Other:
Referring Physician or Referral Source: _____
Address: _____
City: _____
Phone: () _____ Fax: () _____
Do you want your medical records sent to this physician? Yes No

Primary Doctor: _____
Address: _____
City: _____
Phone: () _____ Fax: () _____
Do you want your medical records sent to this physician? Yes No

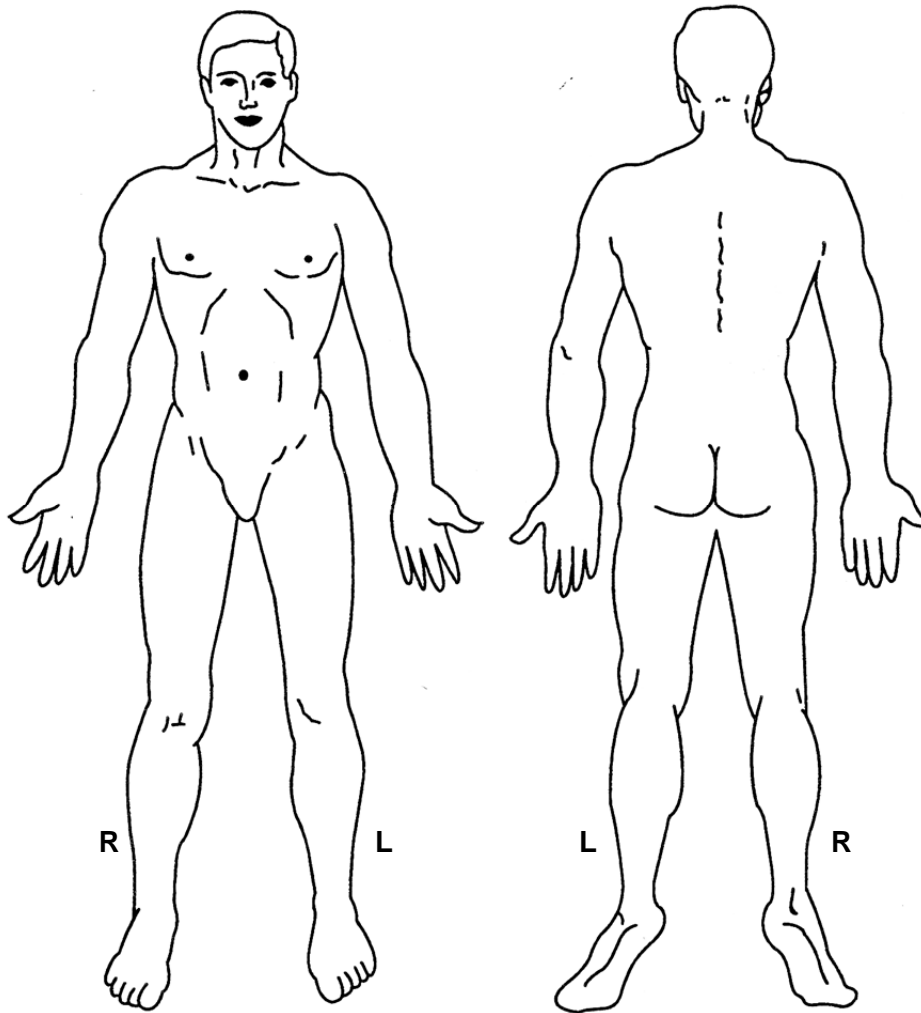
Are there any other physicians to whom you would like your medical records sent?
(Please include name and address)

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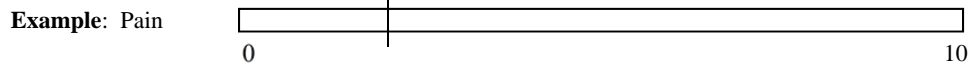
ORTHO PAIN CHART

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 =	==== ==== ====	Pin & Needles =	ooo ooo ooo	Burning =	xxx xxx xxx	Stabbing =	//// //// ////
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Please indicate your current pain level by placing a line below with "0" = no pain and "10" = worst pain imaginable.



Pain on Average

0 10

Pain at its Worst

0 10

Pain at its Best (lying down, resting)

0 10

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HISTORY OF PRESENT COMPLAINT

1. Age: _____ Male Female
2. Where is your problem located? Neck Upper Back Arm Lower Back Hip Leg
3. How long have you had this problem? _____ Since? _____ / _____ / _____
month day year
4. Briefly, please give the details of how this problem originally started:

5. Was this from a work-related injury? No Yes - Is it under workers compensation No Yes
 Have you missed any work because of this problem? No Yes, how much? _____
6. Please describe your present pain/problem now (what you feel, where, when, etc.):

7. Have you had spinal surgery in the past: (Check one) Yes No How many times? _____
 What type of surgery(s) was/were performed? Discectomy Laminectomy Fusion IDET
 Unknown Other _____ What spinal level? _____
 What was the date of your most recent spine surgery? _____
 Did you improve from your spine surgery procedure(s)? Yes No
8. Which of the following best describes your ratio for neck & arm or back & leg discomfort (if appropriate)
- | | |
|-----------------------------------|-----------------------------------|
| A. 100% back pain and 0% leg pain | A. 100% neck pain and 0% arm pain |
| B. 75% back pain and 25% leg pain | B. 75% neck pain and 25% arm pain |
| C. 50% back pain and 50% leg pain | C. 50% neck pain and 50% arm pain |
| D. 25% back pain and 75% leg pain | D. 25% neck pain and 75% arm pain |
| E. 0% back pain and 100% leg pain | E. 0% neck pain and 100% arm pain |
9. For any pain/numbness in your arm(s) or leg(s), which side is worse? (Choose one if appropriate)
- | <u>Leg Symptoms</u> | <u>Arm Symptoms</u> |
|-----------------------------------|-----------------------------------|
| A. 100% left leg and 0% right leg | A. 100% left arm and 0% right arm |
| B. 75% left leg and 25% right leg | C. 75% left arm and 25% right arm |
| C. 50% left leg and 50% right leg | D. 50% left arm and 50% right arm |
| D. 75% right leg and 25% left leg | E. 75% right arm and 25% left arm |
| E. 100% right leg and 0% left leg | G. 100% right arm and 0% left arm |

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PAST BACK HISTORY

14. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury: (Check one of each)

	<u>Which type</u>	Helpful	No Help	Not Used
Antiinflammatory	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Relaxants	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotic Pain Medications	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Packs	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit / Muscle Stim (Circle)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy Treatment	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Exercises	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractor	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epidural Block/Injection	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facet Block/Injection	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SI Joint Block/Injection	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trigger Point Injection	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traction / VAX-D (Circle)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Please indicate whether you have had any of the following studies and write when/where the most recent was:

	YES	NO	WHEN/WHERE		YES	NO	WHEN/WHERE
Regular X-ray of Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____	Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT Scan of spine	<input type="checkbox"/>	<input type="checkbox"/>	_____	Discogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMG	<input type="checkbox"/>	<input type="checkbox"/>	_____	MRI of spine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____				

16. Have you had any past episodes of similar pain or injury? Yes No (please describe)

17. List all other physicians with whom you have consulted in the past year for this problem.

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MEDICAL/SURGICAL HISTORY

Please choose all current and past medical conditions

- | | | |
|--|--|---|
| <input type="checkbox"/> No medical problem | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Blood clots in legs/lung |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer – where? _____ | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Anorexia/bulemia |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Seen a psychiatrist |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> HIV |

Are you under a doctor's care for any other medical condition? Yes No If yes, please explain

Please choose all surgeries you have had

- | | | |
|---|--|--|
| <input type="checkbox"/> Spine-Neck | <input type="checkbox"/> Appendix / <input type="checkbox"/> Intestine | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Spine-Lower back | <input type="checkbox"/> Hernia / <input type="checkbox"/> Colon / <input type="checkbox"/> Rectum | <input type="checkbox"/> Ears |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Hysterectomy / <input type="checkbox"/> C-section / <input type="checkbox"/> Female | <input type="checkbox"/> Nose |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Kidneys / <input type="checkbox"/> Bladder / <input type="checkbox"/> Urinary | <input type="checkbox"/> Throat / <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Angioplasty / <input type="checkbox"/> Stent | <input type="checkbox"/> Prostate | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Shoulders / <input type="checkbox"/> Arms / <input type="checkbox"/> Hands | _____ |
| <input type="checkbox"/> Gallbladder / <input type="checkbox"/> Stomach | <input type="checkbox"/> Hips / <input type="checkbox"/> Knees / <input type="checkbox"/> Legs / <input type="checkbox"/> Feet | _____ |
| | | _____ |

Allergies	
Substance	Reaction

Current Medications	
Name	Dose

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SOCIAL HISTORY

18. Current work status: Working full duty Working restricted duty (Since _____) Retired
 Disabled (Since _____) Student Homemaker Unemployed

Company: _____ Occupation: _____ Title: _____

How long have you worked for this company? _____

19. Marital status Single Married Divorced Widowed

20. Number of Children: _____

21. I live: Alone With: _____

22. I live in a: House Apartment Assisted living Nursing home

23. Are you a cigarette smoker? Yes, now Never Quit - How long ago did you quit? _____

If you answered "yes" or "quit", how much do or did you smoke per day?

Less than ½ pack ½ pack ¾ pack 1 pack More (How many?) _____

How old were you when you started smoking? _____

24. Do you drink any alcoholic beverages? (Check one) None

0 to 3 drinks per month 1 to 2 drinks per week 1 to 2 drinks per day 3 to 5 drinks per day

More than 5 drinks per day. How many? _____ Alcoholic in past? Yes No

25. Have you ever had a problem with drug dependence? Yes No

26. Are there any law suits pending or contemplated related to your problem? Yes No

If yes, please give your attorney's name and phone number:

27. Please write any additional information that you feel is important for us to know.

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FAMILY HISTORY

What illnesses run in your close family?

- | | | |
|--|--|---|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Spine disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding disorder | _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental illness | _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Alcoholism | _____ |

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

EAR, NOSE, THROAT

- Difficulty swallowing
- Hoarseness
- Loss of hearing
- Ear pain
- Nosebleeds
- Gum trouble

EYES

- Glasses
- Change of vision

CARDIOVASCULAR

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

LUNG

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

DIGESTIVE

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

SKIN

- Frequent rashes
- Frequent itchiness
- Easy bruising
- Swollen ankles

NEUROLOGICAL

- Seizures
- Blackouts/fainting
- Tremor
- Headaches/migraines

MUSCULOSKELETAL

- Joint Pains / Swelling
- Back Pain
- Neck Pain
- Muscle Aches

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