HANOWELL SPINE CLINIC
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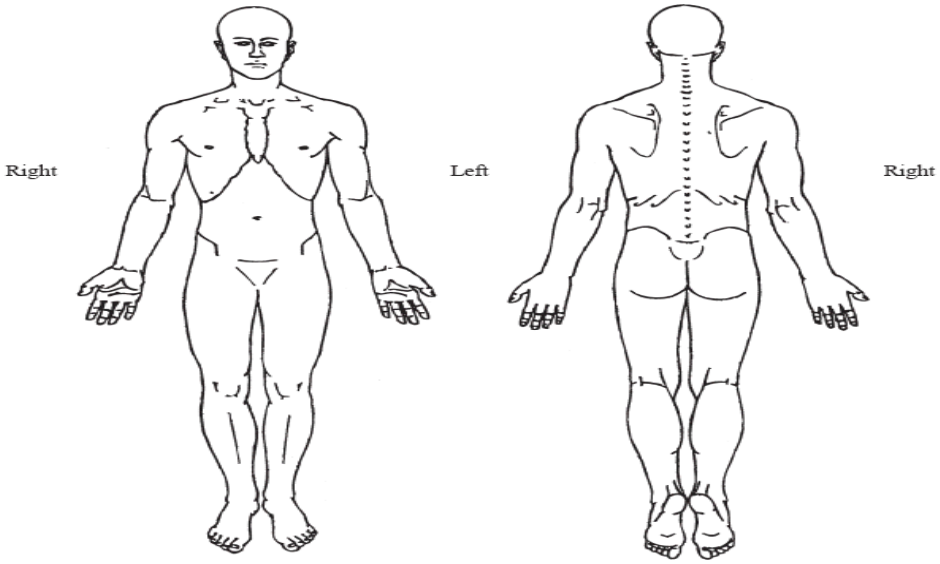
New Patient History & Physical

Name: _____ **Age:** _____

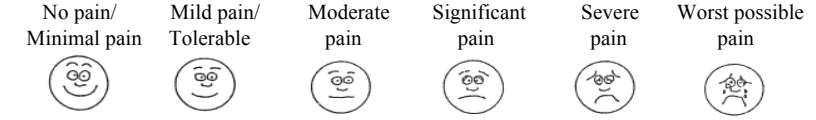
Referring Physician: _____ **Primary Care Physician**: _____

Other Physicians You See (what specialty?): _____



Please Draw In Your Areas of Pain

PAIN SCALE



Please Circle Your Current Level of Pain

1. **Which area hurts the most?** **(list worst pain first)**
   - ☐ _____
   - ☐ _____
   - ☐ _____
2. **What describes your pain?**
   ☐Dull ☐Aching ☐Stabbing ☐Spasm ☐Throbbing ☐Burning ☐Shooting
   ☐Electric bolt ☐Pins & Needles ☐Numbness ☐(Other) _____
3. **Overall, my pain is usually…**
   ☐Manageable ☐Fairly well controlled ☐Not well controlled
4. **Do you have any specific questions that you would like addressed during today's visit?**

   _____

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5. **When did your pain begin?** _____

6. **How did your pain begin?** ☐Gradually ☐Suddenly

7. **Under what circumstances did the pain begin?**
   ☐Pain just began, no reason ☐Accident at home ☐Following surgery ☐Following illness
   ☐Work related accident (date of injury) _____ (case #) _____
   (case manager's name) _____ (case manager's phone #) _____
   ☐Motor vehicle accident (date of injury) _____ (state where accident occurred) _____
   (insurance company) _____ (claim #) _____ (adjuster) _____ (phone #) _____
   ☐(Other) _____

8. **Have you pursued legal action for an injury?** ☐No ☐Yes
   (name of lawyer) _____ (lawyer's phone #)_____

9. **Is your pain...** ☐Constant ☐Always present with varying intensity ☐Comes and Goes

10. **Do you have any problems with any of the following? (When did they start)**
    ☐Weakness (since:_____) ☐Dropping things (since:_____)
    ☐Falling down (since:_____) ☐Bowel or bladder accidents (since:_____)
    ☐Skin sensitive to touch (Where? _____)
    ☐Skin sensitive to heat or cold (Where? _____)
    ☐Skin color or temperature change (Where? _____)

11. **What makes your pain worse?**
    ☐Sitting ☐Standing ☐Walking ☐Bending forward ☐Leaning back ☐Lifting
    ☐Lying flat ☐(Other) _____

12. **What makes your pain better?**
    ☐Sitting ☐Standing ☐Walking ☐Bending forward ☐Leaning back ☐Lifting
    ☐Lying flat ☐Ice ☐Heat ☐Massage ☐(Other) _____

13. **Does your pain affect your sleep?**
    ☐Sleep well ☐Awaken because of pain ☐Awaken because of _____
    ☐Difficulty falling asleep

14. **Does your pain cause you to feel...** ☐Depressed ☐Anxious

15. **What diagnostic tests have you had?**

□X-rays (date) _____ (where were they done) _____ (results) _____
□MRI (date) _____ (where were they done) _____ (results) _____
□Cat Scan (date) _____ (where were they done) _____ (results) _____
□Myelogram (date) _____ (where were they done) _____ (results) _____
□Bone Scan (date) _____ (where were they done) _____ (results) _____
□PET Scan (date) _____ (where were they done) _____ (results) _____
□EMG/Nerve Conduction Studies (date) _____ (where were they done) _____ (results) _____

16. **Who have you previously seen for your pain?**

□Pain Doctors (who and when) _____
□Other Doctors (who and when) _____
□Physical Therapist (who and when) _____
□Chiropractor (who and when) _____

17. **Have you had any of the following procedures for your pain:**

	WHEN	**WHAT Level(s)**	**RESULTS**
Nerve block	_____	_____	□ Good □ Moderate □ Minimal □ Short-lived □ None
Epidural steroid injection	_____	_____	□ Good □ Moderate □ Minimal □ Short-lived □ None
Radio frequency ablation	_____	_____	□ Good □ Moderate □ Minimal □ Short-lived □ None
Trigger point injection	_____	_____	□ Good □ Moderate □ Minimal □ Short-lived □ None
Joint injection	_____	_____	□ Good □ Moderate □ Minimal □ Short-lived □ None
Spinal cord Stimulation	_____	_____	□ Good □ Moderate □ Minimal □ Short-lived □ None
Back surgery	_____	_____	□ Good □ Moderate □ Minimal □ Short-lived □ None
Neck surgery	_____	_____	□ Good □ Moderate □ Minimal □ Short-lived □ None
Other procedure	_____	_____	□ Good □ Moderate □ Minimal □ Short-lived □ None

18. **Have you tried any of the following?** **How much pain relief?**

Treatment	**Yes**	**No**	**Good**	**Moderate**	**Minimal**	**Short-lived**	**None**
NSAIDS (Motrin, Alleve)							
Antidepressants							
Oral steroids (Medrol dose pack)							
Physical Therpay							
TENS unit (electrical stimulation)							
Massage therapy							
Chiropractor							
Ice or Heat							

MEDICATIONS:

***Current* PAIN medications** (give name, dose, frequency, and how long you have been taking each medicine)

_____ _____
_____ _____
_____ _____
_____ _____

***Current* OTHER medications**

_____ _____
_____ _____
_____ _____
_____ _____

***Current* Anticoagulants/Blood Thinners**

_____ _____

***Current* Herbal Medications**

_____ _____
_____ _____

List PAIN medications tried in the PAST, and why you are no longer on that medication.

_____
_____
_____
_____

DRUG ALLERGIES: (list medication and the type of reaction it caused)

_____ _____

Have you ever had a reaction to any **contrast dye** given for a special test? □ No □ Yes
If YES, what was the **test** and what kind of r**eaction** did you have? _____

MEDICAL HISTORY: Do you now, or have you ever had any of the following:

Heart problems	□ No	□ Yes	Details: _____
Lung / breathing problems	□ No	□ Yes	Details: _____
Kidney problems	□ No	□ Yes	Details: _____
High blood pressure	□ No	□ Yes	Details: _____
Diabetes/blood sugar problems	□ No	□ Yes	Details: _____
GI problems (ulcer, etc.)	□ No	□ Yes	Details: _____
Liver disease (hepatitis, etc.)	□ No	□ Yes	Details: _____
Bleeding problems/Easy bruising	□ No	□ Yes	Details: _____
Depression	□ No	□ Yes	Details: _____
Migraines	□ No	□ Yes	Details: _____
Seizures	□ No	□ Yes	Details: _____
Stroke	□ No	□ Yes	Details: _____
Cancer	□ No	□ Yes	Details: _____
HIV/AIDS	□ No	□ Yes	Details: _____
Hepatitis	□ No	□ Yes	Details: _____
Other	□ No	□ Yes	Details: _____

SURGICAL HISTORY: Please list all surgeries you have had and the year they were done:

_____

_____

FAMILY HISTORY: Has anyone in your immediate family (mother, father, brothers, sisters, children) had:

High blood pressure	□ No	□ Yes Details: _____
Heart Disease	□ No	□ Yes
Cancer	□ No	□ Yes
Diabetes	□ No	□ Yes
Asthma	□ No	□ Yes:
Seizures	□ No	□ Yes
Migraines	□ No	□ Yes
Tremor or Parkinsons	□ No	□ Yes
Depression	□ No	□ Yes
Other Psychiatric illness	□ No	□ Yes

Other (please list): _____

SOCIAL HISTORY:

Marital Status:
□ Married □ Divorced
□ Separated □ Widowed
□ Single

Do you or have you used: How much:
□ Alcohol _____
□ Drugs _____
□ Tobacco _____

Are you interested in quitting smoking? □ Yes □ No

Are you currently working? □ No □ Yes What type of work did/do you do? _____

If NOT working: When did you stop work? _____ Why? _____

If working: Full or part time? _____ With or without restrictions? _____

Describe restrictions? _____

Who issued the restrictions? _____

HANOWELL SPINE CLINIC

REVIEW OF SYSTEMS:

How would you describe your current health status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check any of the following symptoms you have experienced in the past **MONTH**:

GENERAL
_____ WEAKNESS
_____ TIREDNESS
_____ LACK OF APPETITE
_____ WEIGHT LOSS
_____ WEIGHT GAIN
_____ FEVER
_____ DIFFICULTY SLEEPING

EYES, EARS, NOSE, THROAT
_____ BLURRED VISION
_____ EYE PAIN
_____ RINGING IN YOUR EARS
_____ HOARSENESS

CARDIOVASCULAR
_____ CHEST PAIN, TIGHTNESS OR SQUEEZING
_____ SHORTNESS OF BREATH LYING DOWN
_____ NEED TO SIT UP TO BREATHE
_____ HEART RACING
_____ IRREGULAR HEART BEAT (PALPITATIONS)
_____ HEART MURMUR
_____ SWELLING OF THE LEGS
_____ LEG PAIN AT REST
_____ LEG PAIN WITH EXERTION
_____ DISCOLORATION OF HANDS OR FEET

RESPIRATORY
_____ COUGH
_____ WHEEZING
_____ SHORTNESS OF BREATH AT REST
_____ CHEST PAIN WITH COUGH, SNEEZE, MOVEMENT

GASTROINTESTINAL
_____ NAUSEA
_____ VOMITING
_____ DIARRHEA
_____ CONSTIPATION
_____ HEARTBURN
_____ ABDOMINAL PAIN
_____ BRIGHT RED BLOOD IN STOOLS
_____ BLACK STOOLS
_____ CHANGE IN BOWEL HABITS
_____ NEED FOR ANTACIDS

ENDOCRINE
_____ HEAT INTOLERANCE
_____ COLD INTOLERANCE
_____ HAND TREMBLING
_____ CHANGE IN PITCH OF VOICE

FEMALE GENITO-REPRODUCTIVE
_____ WHAT WAS THE DATE OF YOUR LAST PERIOD?
_____ HISTORY OF SEXUALLY TRANSMITTED DISEASE
_____ HOT FLASHES

MALE GENITO-REPRODUCTIVE
_____ HISTORY OF SEXUALLY TRANSMITTED DISEASE
_____ TESTICULAR PAIN
_____ LUMPS IN TESTICLES OR SCROTUM
_____ DECREASE IN TESTICULAR SIZE
_____ DECREASED SEXUAL DESIRE
_____ DECREASED ABILITY TO ACHIEVE ERECTION

URINARY
_____ URINARY TRACT INFECTIONS
_____ PAIN OR BURNING ON URINATION
_____ FREQUENT URINATION DURING THE NIGHT
_____ STRESS INCONTINENCE OF URINE
_____ URGENCY INCONTINENCE OF URINE
_____ INABILITY TO CONTROL URINATION

MUSCULOSKELETAL
_____ MUSCLE PAIN
_____ NECK OR BACK PAIN
_____ SHOULDER OR ARM PAIN ___RIGHT ___LEFT
_____ PAIN DOWN YOUR LEGS ___RIGHT ___LEFT
_____ JOINT PAIN
_____ JOINT SWELLING
_____ JOINT REDNESS
_____ JOINT STIFFNESS
_____ JOINT OR EXTREMITY DEFORMITY

SKIN
_____ ITCHING
_____ RASH
_____ CHANGE IN SKIN COLOR
_____ CHANGE IN SKIN TEMPERATURE
_____ FALLING OUT OF HAIR
_____ NAIL CHANGES
_____ SKIN ULCERS

NEUROLOGIC
_____ SEIZURES
_____ HEADACHES
_____ BLACKOUTS
_____ DIZZINESS
_____ PARALYSIS OR WEAKNESS OF LIMB(S)
_____ LOSS OF SENSATION
_____ LOSS OF BALANCE
_____ LOSS OF COORDINATION
_____ SPEECH PROBLEMS

PSYCHIATRIC
_____ NERVOUSNESS
_____ DEPRESSION
_____ SLEEPING PROBLEMS
_____ EARLY MORNING AWAKENING
_____ PROBLEMS WITH MEMORY OF PAST EVENTS
_____ PROBLEMS WITH MEMORY OF RECENT EVENTS
_____ DIFFICULTY THINKING WITH PROBLEM SOLVING