EMORY HEALTHCARE

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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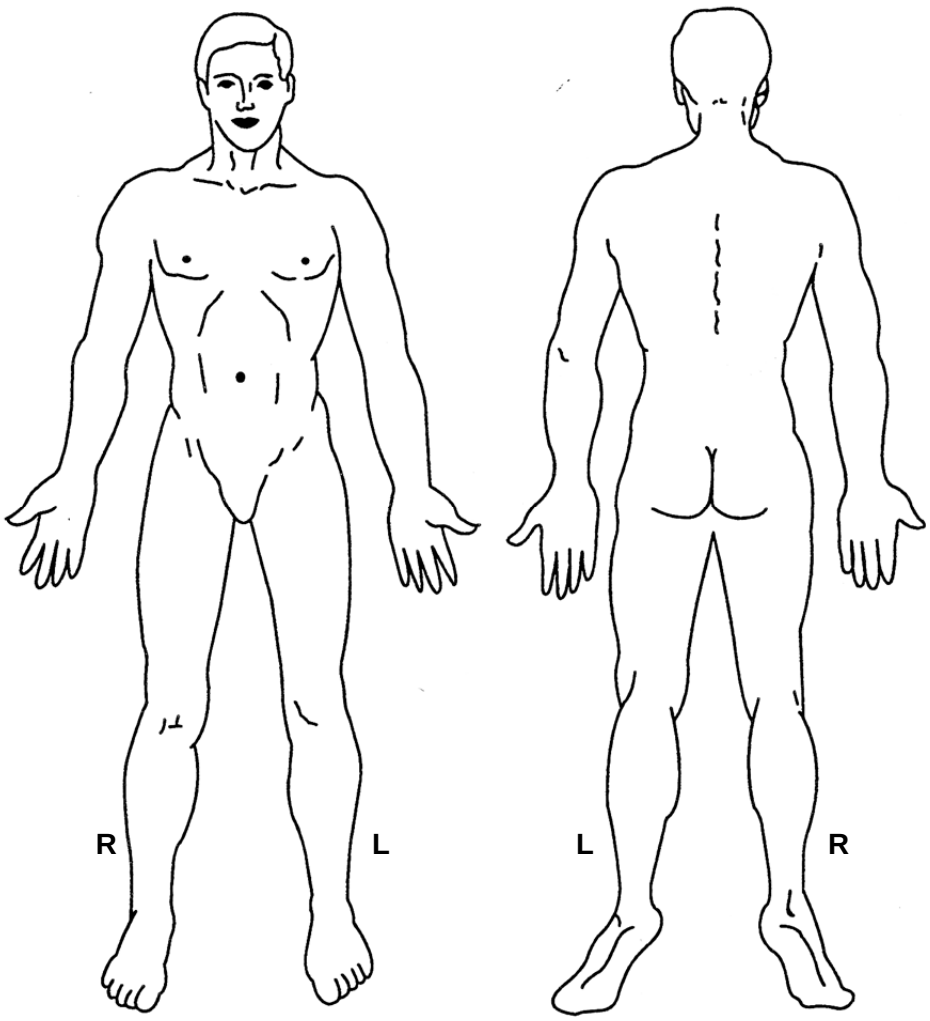
ORTHO PAIN CHART

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 =	o o o o o o o o o	Burning Aching =	x x x x x x x x x	Stabbing =	/ / / / / / / / / / / /



Please indicate your current pain level by placing a line below with "0" = no pain and "10" = worst pain imaginable.

Example: Pain

0 10

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
B. 75% back pain and 25% leg pain
C. 50% back pain and 50% leg pain
D. 25% back pain and 75% leg pain
E. 0% back pain and 100% leg pain

A. 100% neck pain and 0% arm pain
B. 75% neck pain and 25% arm pain
C. 50% neck pain and 50% arm pain
D. 25% neck pain and 75% arm 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)

Leg Symptoms

A. 100% left leg and 0% right leg
B. 75% left leg and 25% right leg
C. 50% left leg and 50% right leg
D. 75% right leg and 25% left leg
E. 100% right leg and 0% left leg

Arm Symptoms

A. 100% left arm and 0% right arm
C. 75% left arm and 25% right arm
D. 50% left arm and 50% right arm
E. 75% right arm and 25% left arm
G. 100% right arm and 0% left arm

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CURRENT PAIN PROFILE

10. Please choose letters A – F (in first column) to answer the questions in column two.

A. Unable to tolerate	How long can you sit? _____
B. About 15 minutes only	
C. About 30 minutes only	How long can you stand? _____
D. About 45 minutes	
E. About 1 hour	How long can you walk? _____
F. Indefinitely	

11. Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Leaning forward (brushing teeth)	❑	❑	❑
Bending forward	❑	❑	❑
Lying in your side	❑	❑	❑
Lying on your back	❑	❑	❑
Lying on your stomach	❑	❑	❑
Rising from sitting	❑	❑	❑
Changing positions	❑	❑	❑
Coughing / Sneezing	❑	❑	❑
Driving	❑	❑	❑

Now go back and CIRCLE the box to indicate **the most aggravating activity** and the **most relieving activity.**

12. If the symptoms of your present pain have changed, please indicate the most appropriate statement: (Circle one)
    A. My symptoms have remained the same since the time of onset.
    B. My symptoms are more severe since the time of onset
    C. My symptoms are less severe since the time of onset.

13. How have the symptoms of your present pain changed: (Circle one)
    A. no change in symptoms
    B. increased aggravation in one arm or leg
    C. increased aggravation in both arms or legs
    D. increased aggravation in the back or neck
    E. increased aggravation in both arms/legs and back/neck

For Office Use Only

BB:	Myl:
NP:	

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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)

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

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	❑	❑		Myelogram	❑	❑	
CT Scan of spine	❑	❑		Discogram	❑	❑	
EMG	❑	❑		MRI of spine	❑	❑	
Bone Scan	❑	❑					

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

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

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

_____

_____

_____

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.

_____

_____

_____

_____

(Continued on next page)

FAMILY HISTORY

What illnesses run in your close family?

- ❑ Scoliosis
- ❑ Spine disease
- ❑ Arthritis
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Cancer
- ❑ Bleeding disorder
- ❑ Mental illness
- ❑ Alcoholism
- ❑ Kidney disease
- ❑ Other: _____
- _____
- _____
- _____

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