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SPINE PATIENT HISTORY FORM

Please print all information. All blanks must be filled so that we may serve you more quickly and efficiently. Please use the back of the forms if you need more space. Thank you for your cooperation.

DATE: _____ DATE OF BIRTH: _____

PATIENT NAME: _____

ADDRESS: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____

HEIGHT: _____ WEIGHT: _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

REFERRING PHYSICIAN: _____

ADDRESS: _____

PHONE #: (_____) _____ FAX#: (_____) _____

Are there any other physicians that should need copies of your records?
 Please include name and address: _____

1. Where do you have pain? (Circle any area that applies to you)
- | | | | |
|----------------|-------------|---------------|------------|
| Neck | Low Back | Upper Back | Abdomen |
| Right Shoulder | Right Arm | Right Forearm | Right Hand |
| Left Shoulder | Left Arm | Left Forearm | Left Hand |
| Right Buttock | Right Thigh | Right Leg | Right Foot |
| Left Buttock | Left Thigh | Left Leg | Left Foot |
- Other: _____

2. How long have you had your pain? _____

3. Specific date when your pain started: _____

4. How did your pain begin? (If your complaints are the result of an injury, exactly what happened and where did this occur?)

5. Is this a worker's compensation case? Yes _____ No _____

6. Is legal action underway or contemplated? Yes _____ No _____
What is your lawyer's name and phone number?

7. Have you had any back or neck problems in the past? Please explain and describe the problems and treatments?

8. Is there a family history of back or neck problems? Please be specific

9. Have you had any previous spine surgery? If yes, please fill in below.
Procedure: _____
Name of Surgeon: _____
Date of Surgery: _____

10. For how long did you feel improvement following the surgery:

If no improvement, what complaints remained after the surgery?

CURRENT PAIN PROFILE

11. How would you describe your pain ratio? (Check one)

- 100% back/neck pain and 0% leg/arm pain
- 75% back/neck pain and 25% leg/arm pain
- 50% back/neck pain and 50% leg/arm pain
- 0% back/neck pain and 100% leg/arm pain

12. Please describe your pain in your own words.

13. Does the pain wake you up after falling asleep? Yes: _____ No: _____

14. Please answer the following questions using the following chart:

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

15. Which of the following activities change the nature of your pain:

	<u>Aggravates</u> <u>Pain</u>	<u>Relieves</u> <u>Pain</u>	<u>Neither</u>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaning forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOW, GO BACK AND CIRCLE THE BOX TO INDICATE THE MOST AGGRAVATING ACTIVITY AND THE MOST RELIEVING ACTIVITY.

TREATMENT ATTEMPTED FOR CURRENT PAIN

16. Using the following list of treatments, please indicate the effect of those which have been used in an attempt to heal your present injury.

	<u>HELPFUL</u>	<u>NOT HELPFUL</u>	<u>NOT USED</u>
Back School	<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"/>
TENS unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace/collar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epidural Block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facet blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

17. What doctors have you seen, when were you seen, and what were you told about your pain? What were you told could be done to help you?

18. If you have had any of the following tests, please note where the test was done and the approximate date of the test.

X-Rays	Date: _____	Location: _____
CAT Scan	Date: _____	Location: _____
EMG/NCV	Date: _____	Location: _____
MRI	Date: _____	Location: _____
Myelogram	Date: _____	Location: _____
Discogram	Date: _____	Location: _____
Other:	_____	

PAST MEDICAL HISTORY

19. Please circle and explain if you have had a disease involving the following:

Heart Problem	Angina	Stroke	Asthma
High Blood Pressure	Tuberculosis	Emphysema	Coughing
Breathing Problems	Gallbladder	Liver Problems	Ulcers
Colon Problems	Blood in Stool Diarrhea	Diarrhea	Kidney Stones
Kidney Problems	Painful Urination	Venereal Disease	Arthritis
Joint Problems	Thyroid Problems	Diabetes	Osteoporosis
Heavy Bleeding	Hemophilia	Anemia	Scarlet Fever
Cancer (any type)	Epilepsy	Seizures	Depression
Emotional Problems	Fatigue	Psoriasis	Infection
Other:	_____		

20. Have you ever been under the care of a psychiatrist or psychologist? _____
If yes, for what diagnosis were you treated? _____

21. List all previous surgeries (other than the back/neck surgeries):

MEDICATIONS

22. What medications (with dosages) are you currently taking?

PLEASE PUT A CHECK NEXT TO THE MEDICATION THAT WERE GIVEN TO RELIEVE THIS PROBLEM

ALLERGIES

23. Please list any allergies to any medication.

SOCIAL AND VOCATIONAL HISTORY

24. Are you a cigarette smoker? (check one) Yes No
If you answered "YES", how much do you smoke per day for and how long have you been smoking? _____
25. Do you drink alcoholic beverages? (check one)
- Never
 - Only on rare occasions
 - 1 to 2 per week
 - 1 to 2 per day
 - More than 5 drinks per day
26. Have you ever used drugs intravenously? Yes No
27. Please check your employment status
- Unemployed Employed Student Retired
 - Homemaker Other: _____
28. Please check the type of occupation below that applies to the majority of your work habits
- Heavy labor Light labor Professional Student
 - Unemployed Sedentary (Sitting or very little physical activity)
29. Please check the predominant activity of your work habits.
- Lifting Standing Twisting Driving
 - Sitting Anything else: _____

30. Are you presently working? Yes No

If not, is it because of this problem? Yes No

What was the last date that you worked? _____

Which physician recommended that you not work? _____

31. Please check the level of education you have completed.

Grade school

High school

Some college

College grad

32. Please check our marital status.

Single

Married

Divorced

Separated

Widowed

33. Number of children, if any: _____

REVIEW OF SYSTEMS

34. Please check any of the following problems which you have had within the past six months:

Night Pain

Weight Loss

Appetite Change

Marked Fatigue

Night Fever

Night Sweats

Difficulty Sleeping

Psychological Difficulties

Uncontrolled Loss of Stool

Blood in Stool

Constipation

Back or leg pain with Bowel Movement

Difficulty with Urination

Loss of Bladder Control

Impotence/Reduced Sexual Function

Joint Pain

Joint Stiffness

Joint Redness

Joint Swelling

35. Is there any thing else that you wish to say or that we should know?

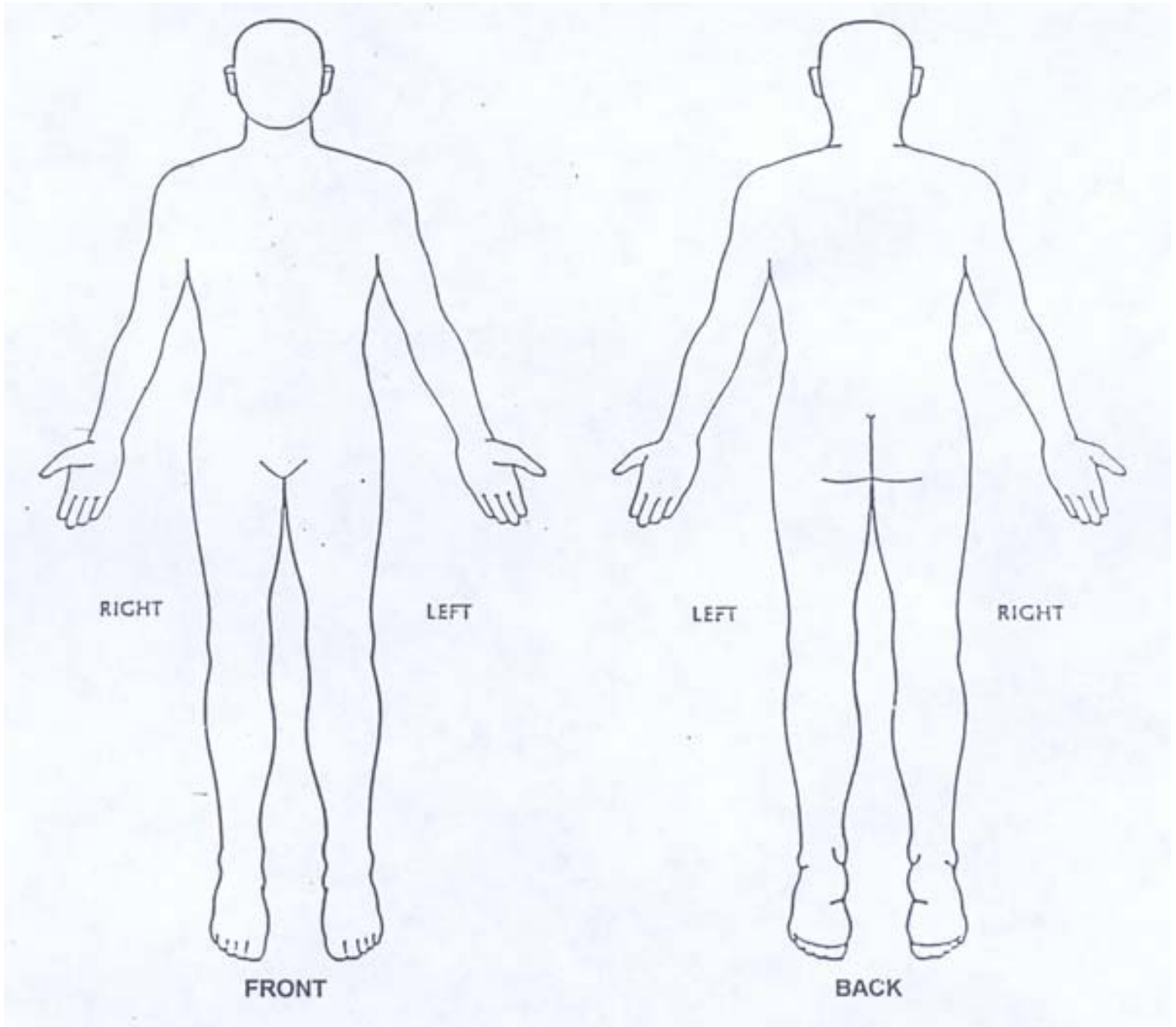
Please complete the Pain Diagram as instructed. This is the last page.

We thank you for your cooperation and assistance.

PAIN DIAGRAM

Please mark the areas on your body where you feel the described sensations. Please include all affected areas and use the appropriate symbols as below:

ACHE ^ ^ ^ ^ NUMBNESS 0000 PINS & NEEDLES = = = = =
BURNING X X X X STABBING / / / /



Please rate your pain on a scale of 1 through 10; 0=no pain; 10=intolerable
Pain at its best: _____ Pain at its worst: _____