❑ Dr. Su

❑ Dr. Sponzilli

❑ Lisa Elvin, NP

Spine Center

New Patient Form

Last Name	First Name	Middle Name	MRN

This form is used to gather information so that my doctor can maximize the time used to examine me and answer my questions about my condition and treatment options. I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

____
Patient Signature (Date)

Carefully read the following definitions	*Definitions*	
	Pain Levels	The level of pain you have had on average since your problem began
	Neck Pain	"Neck" includes middle of neck, upper shoulders, between shoulder blades
	Arm Pain	"Arm" includes shoulder, arm, or hand
	Back Pain	"Back" includes pain above the belt line across the lower back
	Leg Pain	"Leg" includes areas below the belt line including the buttock, legs, or feet

Age	✓ Hand Dominance		✓ Gender		What is the main complaint you wish to discuss?
		Right		Male	
		Left		Female	

What was the approximate date your problem started?				
✓ Which best describes the onset of the problem		Gradual Onset		Sudden Onset
If sudden onset, what were you doing when it started? *i.e. fell off ladder, golfing, lifting groceries*				
Did your problem begin with a car accident?		No		Yes
If yes:	Were you the driver? ❑No ❑Yes	Were you wearing a seatbelt? ❑No ❑Yes		Did you pass out? ❑No ❑Yes

✓ **When did you first seek medical attention?**	Less than 1 month ago	1-3 months ago	3-6 months ago	6 months to 1 year ago	1 -2 years ago	More than 2 years ago

For a total of 100%, what % is back pain and what % is leg? (i.e. 30% low back pain with 70% leg pain)	% Low Back Pain		% Leg Pain	
		+		=100%

For a total of 100%, what % is neck pain and what % is arm? (i.e. 20% neck pain with 80% arm pain)	% Neck Pain		% Arm Pain	
		+		=100%

✓ **Your level of pain from 0 to 10**	0	1	2	3	4	5	6	7	8	9	10
	←Less Pain						Worse Pain →				
Neck Pain											
Right Arm Pain											
Left Arm Pain											
Low Back Pain											
Right Leg Pain											
Left Leg Pain											

Using the symbols, mark the location and type of pain on the diagrams

If you have pain into the lower leg, feet, or hands, make sure you note it

<u>Type of Sensation:</u>

Stabbing/Burning: **Λ**

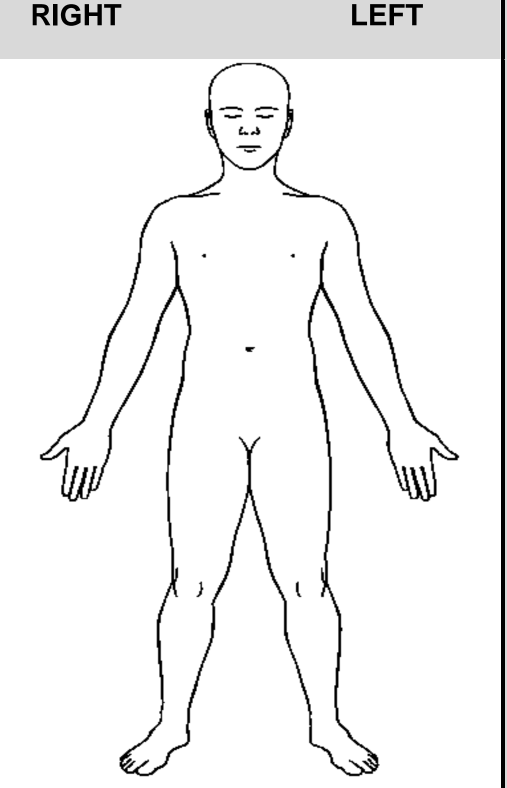
Aching: X

Pins and Needles: **-**

Numbness: O

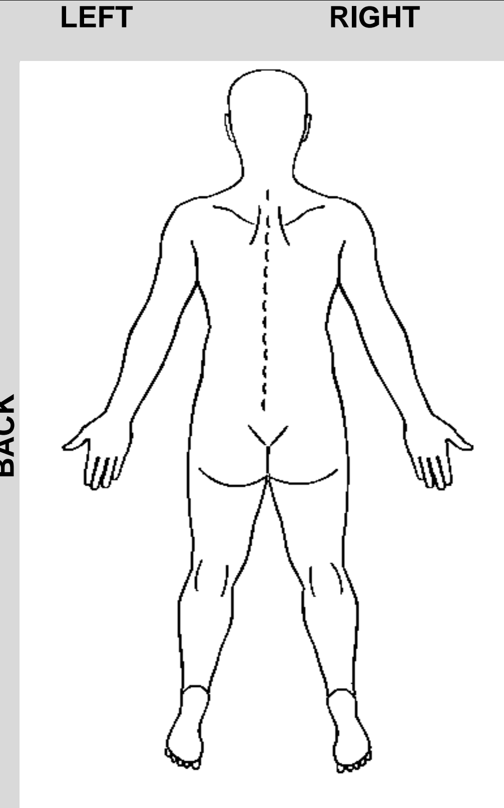
RIGHT LEFT

FRONT



LEFT RIGHT

BACK



✓ **Do you have:**	No	Yes	Explain where
Numbness in the arms/hands or legs/feet?			
Weakness in the arms/hands or legs/feet?			

✓	Rest	Laying flat	Sitting	Walking on flat surfaces	Walking up stairs	Walking down stairs	Bending / twisting	Other (Describe)
Pain worse with								
Pain better with								

✓ **Do you have:**	No	Yes
Loss of bowel control? (difficulty controlling/initiating bowel movements or incontinence)		
Loss of bladder control? (difficulty controlling/initiating urination or incontinence)		
Balance problems from leg weakness?		
Balance problems not from weakness but from lack of coordination?		
Problems handling small objects such as coins or problems buttoning your shirts?		

✓**Treatment history**	No	Yes	Details (If Yes)	✓ Made my pain:		
				Better	No Change	Worse
Anti Inflammatory pain medicine (ie Motrin, Aleve)			Medication:			
Narcotics (ie Vicodin, Percocet)			Medication:			
Epidurals or Selective Nerve Root injections			How many: Date of last injection:			
Physical Therapy			How long:			
Physiatrist (Pain Specialist)			Name:			
Acupuncture			Name:			
Chiropractor			Name:			

Medical history (ie: High blood pressure, asthma, high cholesterol, etc)	❑ I have no medical problems	

✓Do you have history of cancer?	No	Yes	Details (If Yes)
			Type: Prior treatment:

Surgical history (i.e.:Tonsillectomy, hip replacement, heart surgery, etc)	❑ I have not had surgery in the past
Date of Surgery	Surgery (Specify Right or Left side if relevant)

List ALL medications, vitamins, and supplements you are currently taking. (May attach list of medications)	❑ I currently take no medications		

Allergic reactions including medicines, iodine, intravenous dye, latex, shellfish, etc	❑ I have no allergies
Medication/Substance	Allergic Reaction

Occupational/Social history			❑ I am currently retired	
What is your occupation?				
✓	No	Yes	Details (If Yes)	
Are you out of work due to your spinal condition?			How long have you been out of work?	
Do you have a workman's compensation claim?			Date of work injury:	
Do you smoke cigarettes?			How many packs per day? For how many years?	
Do you smoke a pipe or cigars?			How often?	
Do you dip snuff or chew tobacco?			How often?	
Do drink alcohol?			How many drinks per week?	
Do you use any street drugs?			Which drugs and how often?	
Who do you live with?				

Family history of disease		❑ I have no family history of disease	
Relationship	Disease	Relationship	Disease

Review of systems

✓	*General*	✓	*Eye,Ear Nose,Throat*	✓	*Musculoskeletal*	✓	*Psychiatric*
	Fever or Chills		Difficulty swallowing		Joint pains		Anxiety
	Dizziness		Hearing loss		Muscle aches		Depression
	Fainting spells		Hoarseness		Ankylosing spondylitis		Psychiatric hospitalization
	Fatigue		Nose bleeds		Weak bones		Panic attacks
	Frequent headaches		Ringing in ears		Rheumatoid arthritis		Suicidal thoughts
	Insomnia		Sinus problems		Osteoarthritis		Psychiatric drugs
	Sweats		Blurry vision		Bone cancer		Memory loss
	Weight changes		Poor vision		Bone infections	Other:	
Other:		Other:		Other:			

✓	*Cardiovascular*	✓	*Gastrointestinal*	✓	*Genitourinary*	✓	*MEN only*
	Ankle swelling		Poor appetite		Bladder control		Breast lumps
	Chest pains		Bowel changes		Blood in urine		Enlarged prostate
	Enlarged heart		Constipation		Frequent urination		Erectile dysfunction
	Heart attack		Diarrhea		Kidney stones		Penis discharge
	Heart murmur		Excessive thirst		Painful urination		Prostate cancer
						Other:	
	Heart palpitations		Heartburn		Urgent urination	✓	*WOMEN only*
	High blood pressure		Nausea		Weak stream		Abnormal pap smear
	Shortness of breath		Rectal bleeding	Other:			Breast lumps
	Irregular heartbeat		Stomach pain	✓	*Neurological*		Vaginal discharge
	Prolonged bleeding		Ulcers		Loss of motor control		Severe menstrual pain
	History of blood clots		Vomiting		Weakness		Hot flashes
Other:		Other:			Paralysis	All other ROS Negative	

✓	*Endocrine*	✓	*Skin*		
					Poor balance
	Blood sugar problem		Bruise easily		Seizures
	Use of steroids		Foot ulcers		Speech difficulties
	Over active thyroid		Rashes		Tremors
	Under active thyroid		Sores that won't heal		Muscle wasting
Other:		Other:		Other:	

Office Use Only	Height		Weight		BP	/	Pulse	