

**RESURGENS SPINE CENTER**  
**Initial Patient Assessment and History**

Visit Date: \_\_\_\_\_

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Name: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Sex: **Male / Female**                      Handedness: **Left / Right**

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

**SYMPTOMS: (Please circle all that apply)**

**Back Pain    Neck Pain    Arm Pain    Leg Pain**

The pain has been present for . . .

- |                     |                      |
|---------------------|----------------------|
| <b>0 - 1 week</b>   | <b>3 - 6 months</b>  |
| <b>1 - 3 weeks</b>  | <b>6 - 12 months</b> |
| <b>3 - 6 weeks</b>  | <b>1 - 2 years</b>   |
| <b>6 - 8 weeks</b>  | <b>2 - 3 years</b>   |
| <b>8 - 12 weeks</b> | <b>3+ years</b>      |

Does the pain radiate to.....**an arm?**                      **Right / Left**  
*or*                      **a leg?**                      **Right / Left**

Do you have weakness in.....**an arm?**                      **Right / Left**  
*or*                      **a leg?**                      **Right / Left**

Do you have numbness in.....**an arm?**                      **Right / Left**  
*or*                      **a leg?**                      **Right / Left**

Did you have an injury?                      **Yes / No**                      *If so, was it:*  
At work?    **Yes / No**  
In a motor vehicle collision?                      **Yes / No**  
Other type of injury: \_\_\_\_\_  
Date of injury: \_\_\_\_\_  
Litigation pending?    **Yes / No**

Any difficulty controlling your bladder or bowels?    **Yes / No**

Does your pain wake you up at night?    **Yes / No**

Do you have fever, chills or sweats?    **Yes / No**

What makes your pain better?  
**lying down    sitting    walking    bending**  
**Other:** \_\_\_\_\_

What makes your pain worse?  
**lying down    sitting    walking    bending**  
**Other:** \_\_\_\_\_

**TREATMENT HISTORY: (Did you have any of the following treatments for your pain?)**

Medications?	<b>Yes/No</b>	Improvement? <b>Yes/No</b>
<i>If yes, which ones?</i> _____		
Physical Therapy?	<b>Yes/No</b>	Improvement? <b>Yes/No</b>
<i>If yes, what type?</i> _____		
Injections?	<b>Yes/No</b>	Improvement? <b>Yes/No</b>
<i>If yes, what kind?</i> _____		
Massage?	<b>Yes/No</b>	Improvement? <b>Yes/No</b>
Chiropractic?	<b>Yes/No</b>	Improvement? <b>Yes/No</b>
Names of doctors that have treated you before for this problem: _____		

**PREVIOUS INJURIES:**

Have you ever had Back or Neck Pain **before** this episode?    **Yes / No**  
*If yes, when?* \_\_\_\_\_  
Have you had back or neck surgery?    **Yes / No**  
*If yes, what type?* \_\_\_\_\_  
What diagnostic tests have you had?  

<b>X-rays</b>	<b>Bone Scan</b>	<b>Myelogram</b>
<b>MRI</b>	<b>Dexa Scan</b>	<b>Discogram</b>
<b>CT Scan</b>	<b>EMG/NCS</b>	

**OCCUPATIONAL HISTORY:**

Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
How long have you worked there? \_\_\_\_\_ months / years  
Which of the following best describes you currently:  

<b>Working regular duty</b>	<b>Working restricted duty</b>
<b>Homemaker</b>	<b>Unemployed</b>
<b>Disabled</b>	<b>Retired</b>
<b>Not working due to back/neck problems</b>	
<b>Not working due to another health problem</b>	

  
Time Lost from Work? \_\_\_\_\_ Days/Weeks/Months/Years

**CURRENT MEDICATIONS: (Please list all the medications that you are currently taking, including both prescription and over-the-counter)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES: (to medications, food & environment)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Visit Date: \_\_\_\_\_

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**REVIEW OF SYSTEMS: (Do you currently have any of the following medical symptoms)**

Abnormal Bleeding:	Yes / No
Abnormal Menstrual Cycle:	Yes / No
Balance Problems:	Yes / No
Chest Pain:	Yes / No
Cold Hands / Feet:	Yes / No
Constipation:	Yes / No
Cough:	Yes / No
Depression:	Yes / No
Ear Pain:	Yes / No
Fainting:	Yes / No
Fever:	Yes / No
Growth Disturbance:	Yes / No
Impotence:	Yes / No
Incontinence of Bowel:	Yes / No
Incontinence of Urine:	Yes / No
Loss of Appetite:	Yes / No
Mania:	Yes / No
Muscle Weakness:	Yes / No
Nausea:	Yes / No
Numbness of Hands:	Yes / No
Numbness of Feet:	Yes / No
Runny Nose:	Yes / No
Seizures:	Yes / No
Shortness of Breath:	Yes / No
Skin Rash:	Yes / No
Skin Ulcer:	Yes / No
Sleep Disturbance:	Yes / No
Sore Throat:	Yes / No
Sputum Production:	Yes / No
Stomach Pain:	Yes / No
Swelling in Legs:	Yes / No
Visual Disturbance:	Yes / No
Vomiting:	Yes / No
Weight Gain:	Yes / No
Unexplained Weight Loss:	Yes / No
Wheezing:	Yes / No

Other: \_\_\_\_\_

Are you independent in normal daily activities?

Yes / No

Has this changed recently? Yes / No

**Thank you for taking the time to complete this Health History and Medical Assessment.**

**Form Reviewed on:**

**By:**

**PAST MEDICAL HISTORY:**

*(Do you have any of the following medical problems)*

AIDS/ HIV:	Yes / No	Anemia:	Yes / No
Arthritis:	Yes / No	Bleeding Probs.:	Yes / No
Cancer:	Yes / No	Diabetes:	Yes / No
Depression:	Yes / No	Emphysema:	Yes / No
Epilepsy:	Yes / No	Fibromyalgia:	Yes / No
Gout:	Yes / No	Headaches:	Yes / No
Heart Probs.:	Yes / No	Hepatitis:	Yes / No
Hypertension:	Yes / No	Kidney Problems:	Yes / No
Migraines:	Yes / No	Muscle Diseases:	Yes / No
Nerve Probs.:	Yes / No	Osteoporosis:	Yes / No
Pneumonia:	Yes / No	Polio:	Yes / No
Psych. Disorders:	Yes / No	Stomach Probs.:	Yes / No
Stroke:	Yes / No	Thyroid Probs.:	Yes / No

Other: \_\_\_\_\_

**PAST SURGICAL HISTORY: (Please list any previous surgeries and the dates)**

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY: (Does any member of your family have a history of)**

AIDS/ HIV:	Yes / No	Anemia:	Yes / No
Arthritis:	Yes / No	Bleeding Probs.:	Yes / No
Cancer:	Yes / No	Depression:	Yes / No
Diabetes:	Yes / No	Emphysema:	Yes / No
Epilepsy:	Yes / No	Fibromyalgia:	Yes / No
Gout:	Yes / No	Heart Probs.:	Yes / No
Hepatitis:	Yes / No	Hypertension:	Yes / No
Migraines:	Yes / No	Headaches:	Yes / No
Kidney Probs.:	Yes / No	Muscle Diseases:	Yes / No
Nerve Probs.:	Yes / No	Osteoporosis:	Yes / No
Pneumonia:	Yes / No	Psych. Disorders:	Yes / No
Stomach Probs.:	Yes / No	Stroke:	Yes / No

Other: \_\_\_\_\_

**SOCIAL HISTORY:**

Marital Status: Single / Married / Divorced / Widowed

Do you smoke? Yes / No

*If yes, Amount: \_\_\_\_\_ per day / week*

Do you drink alcohol? Yes / No

*If yes, Amount: \_\_\_\_\_ per day / week*

Do you or have you used recreational drugs?

Yes / No

*If yes, Type: \_\_\_\_\_*

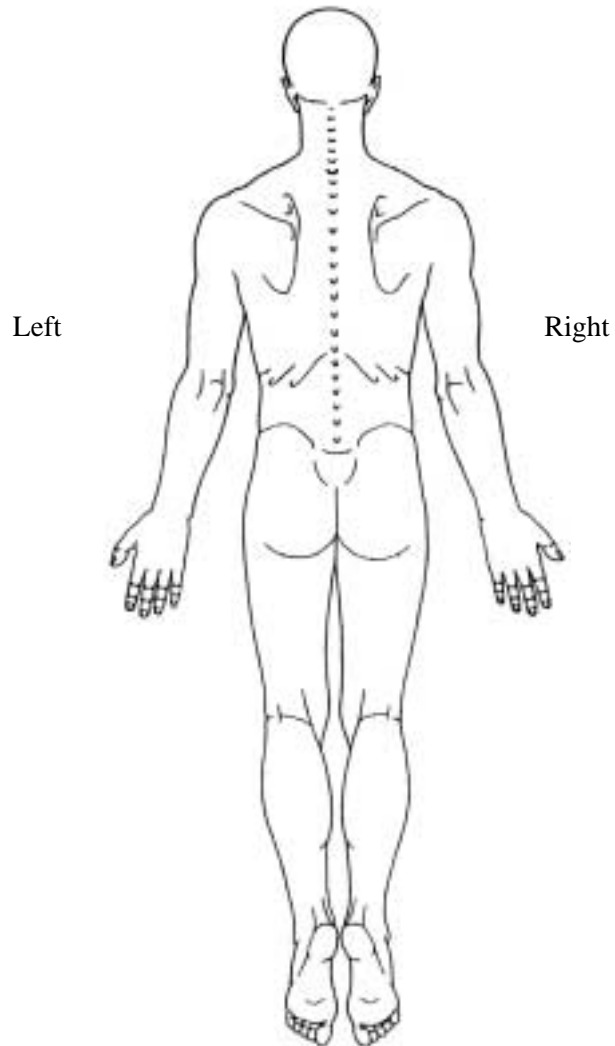
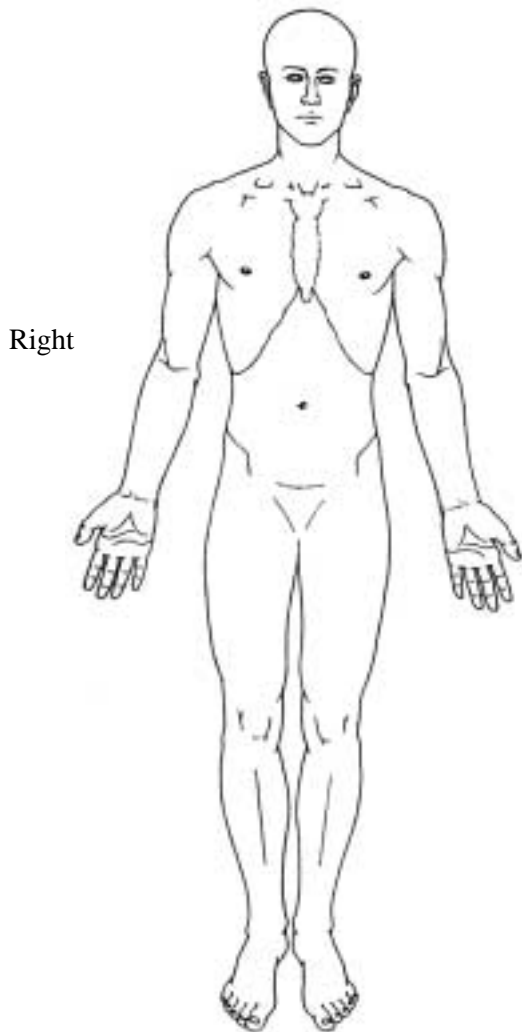
# RESURGENS SPINE CENER

## PAIN DRAWING

### Instructions:

Mark these drawings according to where you hurt (i.e., if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

**Key:** Stabbing /// Burning XXX Pins & Needles 000 Numbness === Aching +++



**Pain Level:** 0 1 2 3 4 5 6 7 8 9 10  
(Check the worst & best it's been and circle your current pain level)

- Key:**
- 0 No Pain.
  - 1 Mild pain; you are aware of it, but it doesn't bother you.
  - 2 Moderate pain that you can tolerate without medication.
  - 3 Moderate pain that requires medication to tolerate.
  - 4-5 More severe pain; you begin to feel antisocial.
  - 6 Severe pain.
  - 7-9 Intensely severe pain.
  - 10 Most severe pain.