

Signature Health Services, Inc.
Dr. Sohn Dr. Lieb

Spine Center History Sheet
Date: _____

Name _____ Age _____

Primary Care Physician _____ Referring Physician _____

Dominant hand? Right Left Sex: Male Female Height _____ Weight _____

Reason for Visit/Chief Complaint _____

Date of Injury/Onset of Symptoms _____ Work Related? Yes No

Describe: _____

Treatment for Current Problem

Have you had any of the following for your current problem? (Circle all that apply)

X-Ray MRI Cat Scan Myelogram When and Where? _____

Have you had any Treatment for your problem? (Circle all that apply)

Physical Therapy Chiropractic Acupuncture Spine Injections Pain Clinic

What helped? _____ What did not help? _____

Past Medical History (Please check all that apply) NONE of the below

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Congestive Heart | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes-Insulin Y N |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pulmonary Embolus | <input type="checkbox"/> Reflux | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> DVT | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Enlarged Prostate |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Crohn's | <input type="checkbox"/> Frequent UTI's |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Psychiatric History |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Reaction to Anesthesia | <input type="checkbox"/> Sleep Apnea | |

Cancer: Type _____ Other: _____

Current Infection: Where? _____

Past Surgical History and Date _____

Past Spine Surgeries and Date _____

Current Medications

Name of Medication/Dosage

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Allergies (list name and type of reaction)

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Known Metal Allergy Yes No

Known LATEX Allergy Yes No

Family History (Check all that apply to your mother, father or siblings)

- Heart Disease High Blood Pressure Stroke Lung Disease
- Liver Disease Kidney Disease Diabetes Cancer
- Osteoporosis Osteoarthritis Rheumatoid Arthritis Psychiatric
- None of Above Unknown/Adopted Other _____

Social History

- Tobacco Use: No Yes _____ Packs per day for _____ years Stopped _____
- Alcohol Use: No Yes Type of alcohol/how often? _____
- Other substance abuse: _____
- Do you exercise? No Yes Describe _____

Occupational History

- Are you working: Yes No Disabled Retired
- Work Demands: Sedentary Light Moderate Heavy
- Current Employer: _____
- Have you lost time from your job due to the current problem? Yes No

Review of Systems (Please answer if negative or check symptoms)

- Constitutional:**
 Negative Weight Gain Weight Loss Fever Fatigue Night sweats
- Cardiovascular:**
 Negative Chest Pain Palpitations Short of breath on exertion Leg Edema
- Respiratory:**
 Negative Wheezing Frequent Cough Spitting up blood
- Gastrointestinal:**
 Negative Diarrhea Constipation Nausea Vomiting Bloody stool
- Genitourinary:**
 Negative Incontinence Bloody Urine Frequent urination Painful urination
- Musculoskeletal:**
 Negative Joint Pain Back Pain Weakness Difficulty walking
- Neurological:**
 Negative Headaches Paralysis Weakness Numbness/Tingling
- Skin:**
 Negative Itching Rash Varicose Veins Skin Ulcers Dry Skin
- Psychiatric:**
 Negative Memory loss Confusion Nervousness Insomnia Depression
- Hematologic/Lymphatic:**
 Negative Bruise easily Bleed easily Slow to heal after cuts Swollen lymph nodes

Physician Review _____

Date _____

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Spine Center Pain Questionnaire
Date: _____

Name _____ MRN _____

What describes your pain? (Circle all that apply)

- | | | | | | |
|-----------|-----------|-----------|---------|--------|--------|
| Throbbing | Shooting | Stabbing | Burning | Aching | Sharp |
| Cramping | Sickening | Splitting | Numbing | Heavy | Tender |

What makes your pain better? (Circle all that apply)

- | | | | | | |
|-----------|----------|---------|-------------|--------------|------------|
| Sitting | Standing | Walking | Bending | Coughing | Lying down |
| Straining | Ice | Heat | Medications | Other: _____ | |

What makes your pain worse? (Circle all that apply)

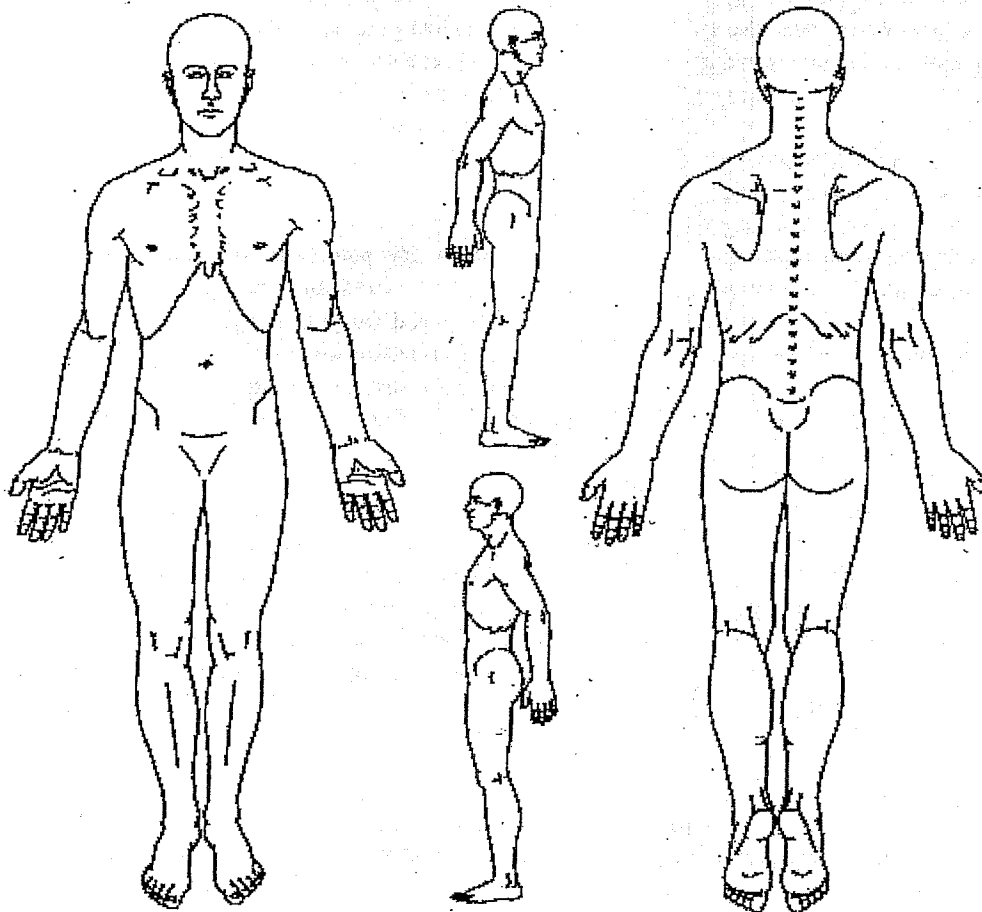
- | | | | | | |
|-----------|----------|---------|-------------|--------------|------------|
| Sitting | Standing | Walking | Bending | Coughing | Lying down |
| Straining | Ice | Heat | Medications | Other: _____ | |

On a scale from 1 to 10 where 1 equals no pain and 10 equals severe pain:

- What is your pain at its worse? _____
- What is your pain at its best? _____
- What is pain most commonly? _____
- What is your pain right now? _____

How long have you had back pain? _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now.



A = ACHE	B = BURNING	N = NUMBNESS
P = PINS & NEEDLES	S = STABBING	O = OTHER

This questionnaire provides information as to how your pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the box that best describes your condition.

During the past 4 weeks.....

1. Pain Intensity:

- I can tolerate the pain I have without having to use pain medication.
- The pain is bad, but I can manage without having to take pain medication.
- Pain medication provides me with complete relief of pain.
- Pain medication provides me with moderate relief of pain.
- Pain medication provides me with little relief of pain.
- Pain medication has no effect on my pain.

2. Personal Care:

- I can take care of myself normally without causing increased pain.
- I can take care of myself normally, but it increases my pain.
- It is painful to take care of myself, and I am slow and careful.
- I need help, but I am able to manage most of my personal care.
- I need help every day in most aspects of my care.
- I do not get dressed; I wash with difficulty, and stay in bed.

3. Lifting:

- I can lift heavy weights without increased pain.
- I can lift heavy weights, but it causes increased pain.
- Pain prevents me from lifting weights off the floor, but I can manage if the weights are conveniently positioned. (e.g., on a table)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

4. Walking:

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can walk only with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

5. Sitting:

- I can sit in a chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ an hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

6. Sleeping:

- My sleep is never disturbed by pain.
- I can only sleep well only using pain medication.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

7. Standing:

- I can stand as long as I want without increased pain.
- I can stand as long as I want but it increases my pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than ½ hour.
- Pain prevents me from standing more than 10 min.
- Pain prevents me from standing at all.

8. Social Life:

- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (sports, dancing).
- Pain prevents me from going out very often.
- Pain has restricted my social life to home.
- I have hardly any social life because of my pain.

9. Traveling:

- I can travel anywhere without increased pain.
- I can travel anywhere, but it increases my pain.
- My pain restricts my travel over 2 hours.
- My pain restricts travel over 1 hour.
- My pain restricts my travel to short necessary journeys under ½ hour.
- My pain prevents all travel except for visits to the Physician, therapist or hospital.

10. Changing Degree of Pain:

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

DISABILITY INDEX SCORE _____ %