

Staff section
Date: _____
Acct #: _____

New Patient History Sheet



Patient Name: _____ Date of Birth: _____

Age: _____ Family physician: _____

May we send a copy of the clinic notes to your primary care doctor (family physician)? Yes No

Email address: _____ Are you pregnant? Yes / No

Who referred you to MOI Spine? _____

Reason for today's visit: _____

When and How did it start? _____

If it was an accident, how did the accident occur? _____

Is this a work-related injury? Y N If yes, did you file a Worker's Comp Claim? Y N

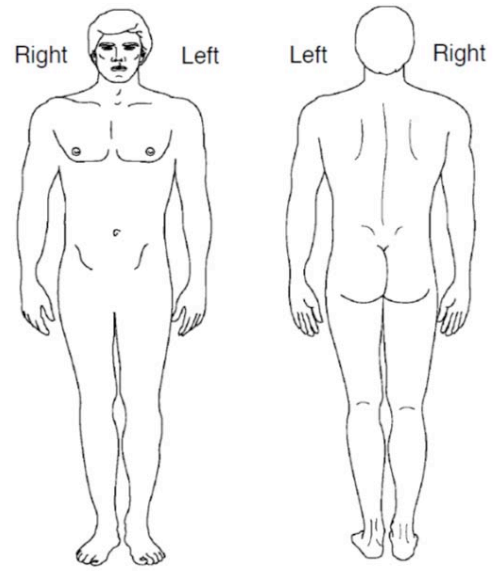
Did you notify your employer? Y N Are you still working? Y N If no, your last day of work: _____

PAIN DESCRIPTIONS:

Please mark the figure with the location of your symptoms.

Qualities of your pain: Aching / Dull /
Sharp / Burning / Numb / Tingling

Pain = P
Numbness = N
Tingling = T



Frequency of your pain: Constant / Comes & Goes

When is your pain at the worst...? Mornings / During day / Evenings

Associated symptoms (in the past 3 months):

Loss of bowel/bladder control? Depression? Difficulty sleeping?

Tripping/falling? Severe muscle weakness? Numbness between thighs/groin?

How does the pain affect your life? (What can you no longer do?) _____

Pain BETTER with: Sitting - Standing - Lying on back - Leaning forward - Arching back - Hot packs

Other: _____

Pain WORSE with: Sitting - Standing - Leaning forward - Arching back - Walking - Cough/sneeze

Other: _____

Pain scores for _____ **(name body part)** /10 today; /10 at worst; /10 at best; /10 on average

Pain scores for _____ **(name body part)** /10 today; /10 at worst; /10 at best; /10 on average

**** PLEASE COMPLETE OTHER SIDE ****

Have you had any of the following for this condition? MRI CT scan X-ray EMG/NCS

Have you had any of the following treatments for **THIS** pain? NSAIDS Oral steroids Narcotics Surgery
Injections Physical Therapy Chiropractor If yes, describe: _____

PAST MEDICAL HISTORY: CIRCLE if you have (or have had) these conditions or any others

Stroke _____ Osteoporosis _____ Hepatitis _____
Heart trouble _____ Seizures _____ Stomach ulcers / Reflux _____
High blood pressure _____ Depression _____ Easy bleeding _____
Diabetes _____ Anxiety _____ Blood clots _____
Cancer _____ Kidney problems _____
Other conditions _____

PAST SURGICAL HISTORY: Please list **all** surgeries and dates that you have had

SOCIAL HISTORY:

Occupation: _____ Duties at work: _____
Marital Status: S M W D Do you live alone or with family?: _____
Do you smoke? Y N Amount: _____ Did you quit smoking? Y N When _____
Do you use alcohol? Y N Amount: _____ How often: _____
Do you exercise? Y N How Often: _____
History of narcotic or prescription medication abuse? Y N What? _____
Activities or sports you're involved in: _____

FAMILY HISTORY:

Major medical problems or cause of death

Mother: Alive / Deceased
Father: Alive / Deceased
Sibling: Alive / Deceased
Sibling: Alive / Deceased

Do you have Allergies to Food or Drugs?

Y N

Please describe and include reactions:

MEDICATIONS: See attached list Pharmacy: _____ (city) _____

Please list **ALL** prescription, over-the-counter, and herbal medications you may be taking. Also, please list the dosage, frequency, and reason for each medication.

List ANY **blood thinners** use take? _____

<i>Name of Medication</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Reason</i>

REVIEW OF SYSTEMS:

CIRCLE if you have been troubled with any of the following symptoms **WITHIN THE LAST 4-6 WEEKS?**

- Unexplained weight loss / Fever / Chills
- Blurred vision
- Chest pain / Fainting
- Cough / Shortness of breath
- Loss of urine control / Blood in urine
- Joint pains / Joint swelling
- Rashes / Poor healing
- Heartburn / Constipation / Diarrhea / Blood stools
- Seizures / Unsteady gait
- Anxiety / Depression
- Easy bleeding / New bruising / Leg fatigue
- Excessive thirst / Heat intolerance
- Reactions to foods
- Headaches / Difficulty swallowing

*MOI Spine would like to **thank you** very much for taking the time to provide the necessary information regarding your symptoms and previous medical care.*

Patient's Signature: _____ Date: _____

Spine Tech Initials: _____ Doctor Initials _____

For Staff notes:

- PT:
- Injections:
- Antidepressants:
- Blood thinners:
- Renal dz:

BP:
HR:
Temp:
HT:
WT: