

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex:  Male  Female HEIGHT: \_\_\_ FT. \_\_\_ IN. WEIGHT \_\_\_ LBS

- A.** 1. Referring doctor name and full address: \_\_\_\_\_  
\_\_\_\_\_
- If not referred, how did you choose this office?  Insurance list  Internet  Another patient  Other \_\_\_\_\_
2. Internist or family doctor name and address: \_\_\_\_\_  
\_\_\_\_\_
3. Chief complaint  Spinal Deformity (Scoliosis, Kyphosis, Flat Back Syndrome, etc.)  
(check all that apply):  Neck pain Arm:  Pain  Numbness  Weakness  
 Back pain Leg:  Pain  Numbness  Weakness
- Other: \_\_\_\_\_
4. How long has the pain (or your problem) been present? \_\_\_\_\_
5. Has your problem worsened recently?  No  Yes – How recently? \_\_\_\_\_
6. What started the pain (or problem)? \_\_\_\_\_

**B. For patients with NECK OR ARM pain, numbness or weakness:**

\*\*\*\*\* (If you have no neck or arm pain, go to “C”) \*\*\*\*\*

1. Are you:  Right handed  Left-handed  Ambidextrous
2. Please describe your Neck and Arm Pain:  No neck pain  No arm pain  Arm pain is as follows:
- |  |  |                                      |                                      |
|--|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Neck 0%, Arm 100% | <input type="checkbox"/> Right 0%, Left 100% | <b>Right</b>                         | <b>Left</b>                          |
| <input type="checkbox"/> Neck 10%, Arm 90% | <input type="checkbox"/> Right 10%, Left 90% | <input type="checkbox"/> Upper back  | <input type="checkbox"/> Upper back  |
| <input type="checkbox"/> Neck 25%, Arm 75% | <input type="checkbox"/> Right 25%, Left 75% | <input type="checkbox"/> Shoulder    | <input type="checkbox"/> Shoulder    |
| <input type="checkbox"/> Neck 40%, Arm 60% | <input type="checkbox"/> Right 40%, Left 60% | <input type="checkbox"/> Upper arm   | <input type="checkbox"/> Upper arm   |
| <input type="checkbox"/> Neck 50%, Arm 50% | <input type="checkbox"/> Right 50%, Left 50% | <input type="checkbox"/> Forearm     | <input type="checkbox"/> Forearm     |
| <input type="checkbox"/> Neck 60%, Arm 40% | <input type="checkbox"/> Right 60%, Left 40% | <input type="checkbox"/> Hand/finger | <input type="checkbox"/> Hand/finger |
| <input type="checkbox"/> Neck 75%, Arm 25% | <input type="checkbox"/> Right 75%, Left 25% |                                      |                                      |
| <input type="checkbox"/> Neck 90%, Arm 10% | <input type="checkbox"/> Right 90%, Left 10% |                                      |                                      |
| <input type="checkbox"/> Neck 100%, Arm 0% | <input type="checkbox"/> Right 100%, Left 0% |                                      |                                      |
3. Raising the arm:  Improves the pain  Worsens the pain  Does not affect the pain
4. Moving the neck:  Improves the pain  Worsens the pain  Does not affect the pain
5. There is:  No weakness of the arms and hands  Weakness of the (check the following):
- Right:**  Shoulder  Upper arm  Forearm  Hand/finger
- Left:**  Shoulder  Upper arm  Forearm  Hand/finger
6. There is:  No numbness of the arms and hands  Numbness of the (check the following):
- Right:**  Upper arm  Forearm  Thumb  Index finger  Long finger  Ring finger  Small finger
- Left:**  Upper arm  Forearm  Thumb  Index finger  Long finger  Ring finger  Small finger
7. There (  is  is no ) difficulty picking up small objects like coins or buttoning buttons.
8. There (  is a  is no ) problem with balance or tripping frequently.
9. There are: (  Frequent  Occasional  No ) headaches in the back of the head.

\*\*\*\*\*IF YOU HAVE NO BACK PAIN OR SPINAL DEFORMITY – PLEASE GO TO “E”\*\*\*\*\*

**C. For patients with BACK OR LEG PAIN, numbness or weakness. \*\*\*\*\*(if none, go to D)\*\*\*\*\***

(If you are seeing the doctor for neck problems, please complete section "B")

1. Please describe your Back and Leg pain:  No back pain  No leg pain  Leg pain is as follows:

- |  |  |                                      |                                      |
|--|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Back 0%, Leg 100% | <input type="checkbox"/> Right 0%, Left 100% | <b>Right</b>                         | <b>Left</b>                          |
| <input type="checkbox"/> Back 10%, Leg 90% | <input type="checkbox"/> Right 10%, Left 90% | <input type="checkbox"/> Buttock     | <input type="checkbox"/> Buttock     |
| <input type="checkbox"/> Back 25%, Leg 75% | <input type="checkbox"/> Right 25%, Left 75% | <input type="checkbox"/> Thigh-front | <input type="checkbox"/> Thigh-front |
| <input type="checkbox"/> Back 40%, Leg 60% | <input type="checkbox"/> Right 40%, Left 60% | <input type="checkbox"/> Thigh-back  | <input type="checkbox"/> Thigh-back  |
| <input type="checkbox"/> Back 50%, Leg 50% | <input type="checkbox"/> Right 50%, Left 50% | <input type="checkbox"/> Calf        | <input type="checkbox"/> Calf        |
| <input type="checkbox"/> Back 60%, Leg 40% | <input type="checkbox"/> Right 60%, Left 40% | <input type="checkbox"/> Foot        | <input type="checkbox"/> Foot        |
| <input type="checkbox"/> Back 75%, Leg 25% | <input type="checkbox"/> Right 75%, Left 25% |                                      |                                      |
| <input type="checkbox"/> Back 90%, Leg 10% | <input type="checkbox"/> Right 90%, Left 10% |                                      |                                      |
| <input type="checkbox"/> Back 100%, Leg 0% | <input type="checkbox"/> Right 100%, Left 0% |                                      |                                      |

2. There is:  No weakness of the legs  Weakness of the (check the following):

- Right:**  Thigh  Calf  Ankle  Foot  Big toe  
**Left:**  Thigh  Calf  Ankle  Foot  Big toe

3. There is:  No numbness of the legs  Numbness of the (check the following):

- Right:**  Thigh  Calf  Foot  
**Left:**  Thigh  Calf  Foot

4. The worst position for the pain is:  Sitting  Standing  Walking

5. How many minutes can you stand in one place without pain?  0-10  15-30  30-60  60+

6. How many minutes can you walk without pain?  0-10  15-30  30-60  60+

7. Lying down:  Eases the pain  Does not ease the pain  Sometimes eases the pain

8. Bending forward:  Increases the pain  Decreases the pain  Doesn't affect the pain

**\*\*\*\*\*IF YOU HAVE NO SPINAL DEFORMITY, PLEASE GO TO "E"\*\*\*\*\***

**D. For patients with a SPINAL DEFORMITY/CURVATURE.**

- How was your spinal deformity discovered? \_\_\_\_\_
- Do you know your present curve measurement(s)? \_\_\_\_\_
- Reason(s) for seeking treatment at this time:  progressive deformity  pain  can't stand straight  
 I don't like the appearance of my back/waistline  Other: \_\_\_\_\_

**E. ★★★ ALL PATIENTS SHOULD ANSWER THE FOLLOWING ★★★**

- Coughing or sneezing  Increases  Sometimes increases  Does not increase the pain.
- There is:  No loss of bowel or bladder control  Loss of bowel or bladder control since \_\_\_\_\_
- I have:  Not missed any work because of this problem  Missed (how much?) \_\_\_\_\_ work
- Treatments have included:  No medicines, therapy, manipulations, injections, or braces

- |                          |   |                          |  |
|--------------------------|---|--------------------------|--|
| <b>Neck</b>              | <b>Back</b>   | <b>Neck</b>              | <b>Back</b>  |
| <input type="checkbox"/> | <input type="checkbox"/> Physical therapy, exercise | <input type="checkbox"/> | <input type="checkbox"/> Anti-inflammatory medications   |
| <input type="checkbox"/> | <input type="checkbox"/> Massage & ultrasound       | <input type="checkbox"/> | <input type="checkbox"/> Narcotic medication   |
| <input type="checkbox"/> | <input type="checkbox"/> Traction                   | <input type="checkbox"/> | <input type="checkbox"/> Epidural steroid injections _____ times which relieved the pain for (how long)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Manipulation               | <input type="checkbox"/> | <input type="checkbox"/> Trigger point injections _____ times which relieved the pain for (how long)? _____    |
| <input type="checkbox"/> | <input type="checkbox"/> Tens Unit                  | <input type="checkbox"/> | <input type="checkbox"/> Surgery (explain in section H)  |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder injections        |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Braces                     |                          |  |

5. List **pain** medications and dose taken for your spine problem:  None

Medication	Dose

6. Previous doctors seen about this problem:  None

Doctor	Specialty	City (If not NYC)	Treatments

7. Tests done to evaluate your problem, the dates and the location they were done:  None

	Neck	Back	#1 DATE	WHERE	#2 DATE	WHERE	#3 DATE	WHERE
Plain x-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
EMGs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____

**F. REVIEW OF SYSTEMS:** Check all that apply.

- Reading glasses
  - Change of vision
  - Loss of hearing
  - Ear pain
  - Hoarseness
  - Nosebleeds
  - Difficulty swallowing
  - Morning cough
  - Shortness of breath
  - Fever or chills
  - Heart or chest pain
  - Abnormal heartbeat
  - Swollen ankles
  - Calf cramps w/ walking
  - Poor appetite
  - Toothache
  - Gum trouble
  - Nausea or vomiting
  - Stomach pain
  - Ulcers
  - Frequent belching
  - Frequent diarrhea
  - None apply
  - Frequent Constipation
  - Hemorrhoids
  - Frequent urination
  - Burning on urination
  - Difficulty starting urination
  - Get up more than once every night to urinate
  - Frequent headaches
  - Blackouts
  - Seizures
  - Frequent rash
  - Hot or cold spells
  - Recent weight change
  - Nervous exhaustion
- Women only:**
- Irregular periods
  - Vaginal discharge
  - Frequent spotting
  - Other \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_

**G. MEDICAL HISTORY:** Check all that apply.

- Heart attack
- Heart failure
- High blood pressure
- Osteoarthritis
- Rheumatoid arthritis
- Ankylosing spondylitis
- Gout
- Osteoporosis
- Diabetes
- Stroke
- Seizures
- Mental illness
- Kidney stones
- Kidney failure
- Cancer
- Alcoholism
- None apply
- Lung disease
- HIV
- AIDS
- Tuberculosis
- Asthma
- Blood clot in leg
- Blood clot in lung
- Stomach ulcers
- Liver trouble
- Hepatitis
- Thyroid trouble
- Bleeding disorders
- Anemia
- Serious injuries (explain) \_\_\_\_\_
- Other: \_\_\_\_\_

**H. SURGICAL HISTORY:** Previous surgeries - List procedures, surgeon and date.  None

OPERATION	SURGEON	DATE

**I. FAMILY HISTORY:** Check all that apply.  None apply

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Mental illness           | <input type="checkbox"/> Alcoholism   |
| <input type="checkbox"/> Heart trouble       | <input type="checkbox"/> Gout           | <input type="checkbox"/> Kidney trouble or stones | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Cancer                   | _____                                 |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Spine problems | <input type="checkbox"/> Bleeding disorders       | _____                                 |

**J. MEDICATIONS YOU TAKE:**  None


**K. ALLERGIES TO MEDICATIONS:**  No known drug allergies

MEDICATION	Rash	Swelling Wheezing or Shock	Upset Stomach	Unknown Reaction	Other
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

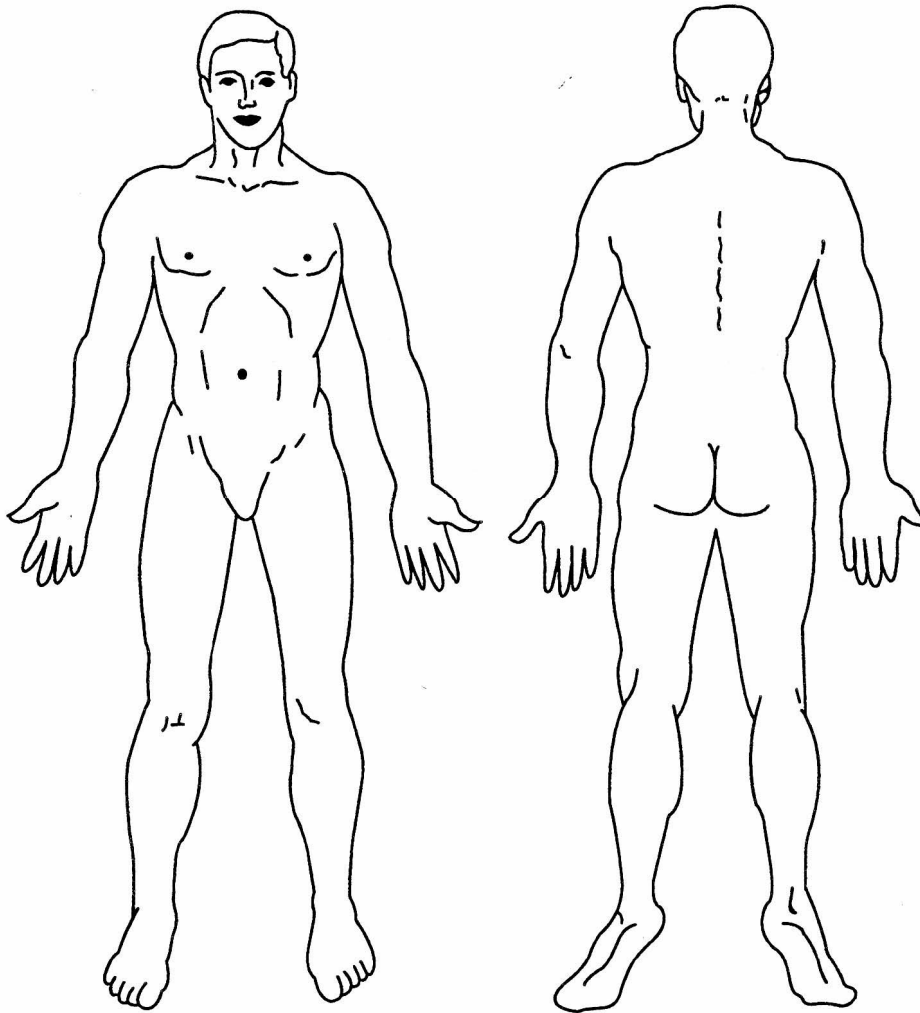
**L. SOCIAL HISTORY:**

- Work status:  Homemaker  Retired  Disabled  On leave  Unemployed  
 Working: \_\_Full time \_\_ Part time  
Occupation: \_\_\_\_\_
- Marital status:  Married  Single  Co-habiting  Widowed  Divorced
- Number of living children:  1  2  3  4  5  6  7  8  9  10
- I live:  Alone  With: \_\_\_\_\_
- Tobacco use:  Never (skip to #6)  
 Cigar  Chew  Pipe  Cigarettes \_\_\_\_\_ packs per day for \_\_\_\_\_ years.  
 Quit – When? \_\_\_\_\_ after smoking \_\_\_\_\_ packs per day for \_\_\_\_\_ years (total)
- Alcohol:  Never or rare  Social  Frequently intoxicated (more than twice a week)  
 Alcoholic  Recovering alcoholic
- Drug overuse/abuse:  Never  Currently  In the past
- Because of this spine problem, I have filed or plan to file:  
 A lawsuit  A Worker’s Compensation claim  Neither a lawsuit or Worker’s Compensation claim

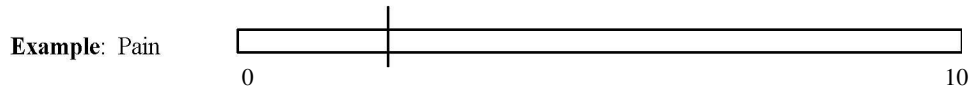
# PAIN CHART

Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

Numbness =	=== === ===	Pin & Needles =	ooo ooo ooo	Burning =	xxx xxx xxx	Stabbing =	//// //// ////
------------	-------------------	-----------------	-------------------	-----------	-------------------	------------	----------------------



Please indicate your current pain level by placing a line below with "0" = no pain and "10" = worst pain imaginable.



Pain at its Worst   
0 10

Pain at its Best  
(lying down, resting)   
0 10

Pain on Average   
0 10

\*\*\*\*\*

**Please take time to review the questionnaire for completeness.**

**Your complete medical information is very important to us!**

**Thank you!**

---

Patient Signature

---

Date

---

Physician Signature

---

Date