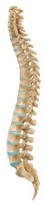
Nasa Spine Institute



LUMBAR SPINE BOOKLET

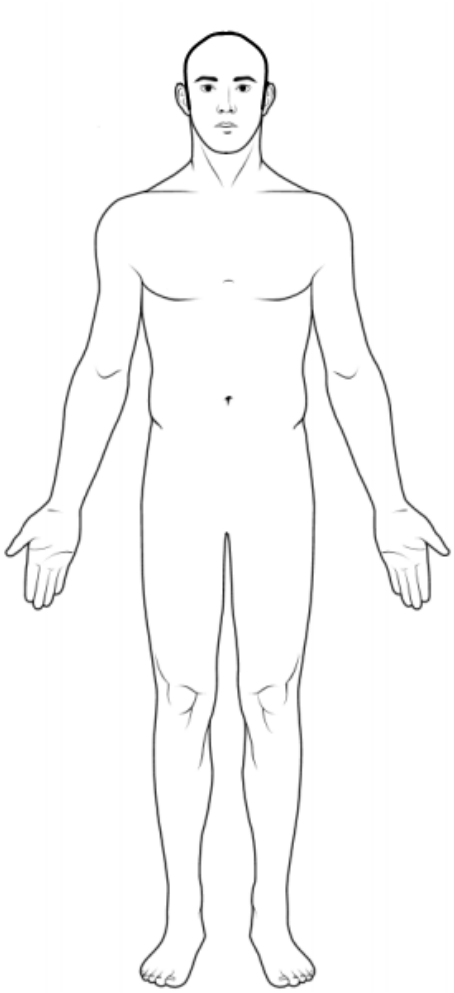
NAME: _____ DATE: _____

DOB: _____ FAMILY DOCTOR: _____

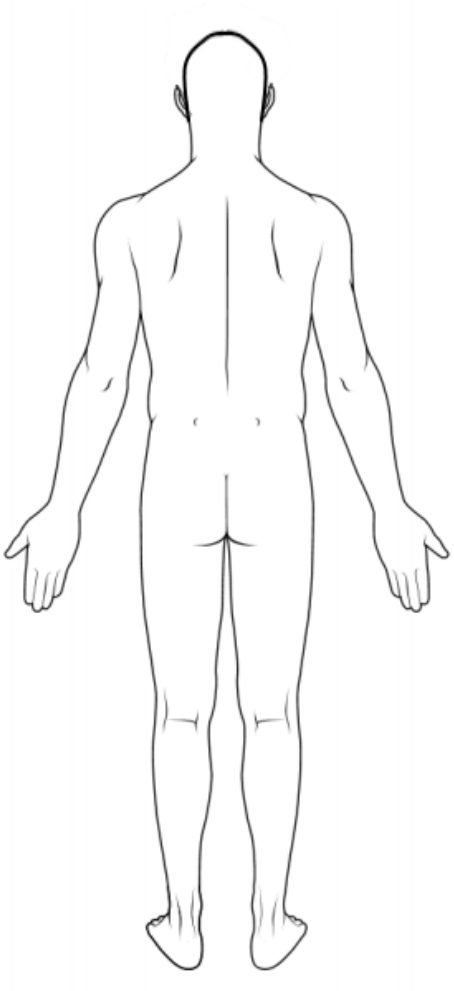
MARK THESE DRAWINGS USING THE SYMBOL THAT BEST DESCRIBES YOUR PAIN

Numbness: ========= Ache: UUUUUUUU Pins and Needles: 00000000

Stabbing: //////////// Burning: XXXXXXXX Cramping: ++++++++++



RIGHT LEFT



LEFT RIGHT

1. AGE: _____
2. Sex: ☐ Male ☐ Female

3. Who referred you to our office?

   _____

4. What hurts more your back or your legs? _____
   % Back Pain _____ % Leg Pain _____

5. Circle one number that best described your current pain level:
   (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

6. Are your current symptoms due to: Car accident? _____ Work injury? _____
   No injury or accident? _____ Date symptoms started? _____

7. Describe how your current symptoms began and if they're becoming better or worse and what makes them better or worse?

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

8. Have you ever had similar symptoms and who treated you for the symptoms and what was the treatment? When?

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

9. How long can you sit in a chair?
   Less than 5 minutes _____ 5-15 minutes _____ 15-30 minutes_____
   30-60 minutes _____ as long as I want _____

   How long can you stand?

   _____

   How long or how far can you walk?

   _____

   Do you use a cane, walker or wheelchair?

   _____

10. Do your symptoms affect your sleep? ☐ YES ☐ NO
    How long do you sleep before your symptoms wake you? _____
    Do you take medication to help you sleep? ☐ YES ☐ NO
    Medication used to sleep? _____

11. Due to your symptoms do you need help with activities of daily living? ☐ YES ☐ NO
    Explain:_____

    _____

12. Have you missed any work due to spinal problems? ☐ YES ☐ NO
    How much work have you missed? _____
    Date you last worked? _____
    Do your symptoms affect your work? ☐ YES ☐ NO
    Explain:_____

    _____

    Do you take medication for your symptoms while at work? ☐ YES ☐ NO
    What medications? _____

    _____

13. Have you had an MRI of your back? When? _____ Where? _____

    CT Scan? _____ Myelogram? _____

    X-rays? _____ EMG/Nerve conduction studies? _____

MEDICAL HISTORY:

MEDICAL PROBLEMS FOR WHICH YOU TAKE MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

MEDICAL PROBLEMS FOR WHICH YOU DO NOT TAKE MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

DO YOU TAKE ASPIRIN OR PRODUCTS CONTAINING ASPIRIN? ☐ YES ☐ NO

DO YOU TAKE OVER THE COUNTER NSAID (MOTRIN, ADVIL, ALEVE, ETC? ☐ YES ☐ NO
HAVE YOU EVER HAD BLOOD CLOTS? ☐ YES ☐ NO

ALLERGIES TO MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

If you are not allergic to any medications, please check ☐ NONE

SURGERIES:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

DO YOU BLEED EXCESSIVELY WITH DENTAL WORK OR WITH SURGERY OR WITH MINOR INJURIES? ☐ YES ☐ NO

HAVE YOU EVER BEEN ON CHRONIC PAIN MEDICATIONS? ☐ YES ☐ NO
WHAT PAIN MEDICINE HAS WORKED WELL FOR YOU IN THE PAST?

1. _____
2. _____
3. _____
4. _____

LIST ALL MEDICATIONS AND VITAMINS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____
26. _____
27. _____
28. _____
29. _____
30. _____

Social History:

Do you drink alcoholic beverages? ☐ Yes ☐ No

How much per day/week?_____

Do you drink alcohol to control your pain? ☐ Yes ☐ No How much? _____

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

What form and how much per day?_____

Are you currently working? ☐ Full-time ☐ Part-time ☐Not working

What type of work do you do?_____

Are you experiencing financial difficulties due to your spine-related problems? ☐ Yes ☐ No

Retired? (What age)_____

Disabled? (What age and year and the reason)_____

_____

Marital status? ☐ Married ☐ Single ☐ Divorced ☐ Widow

Living arrangement? ☐ Alone ☐ With family ☐ With friends ☐ Other

Does your pain affect your social and recreational life? ☐ Yes ☐ No

How and what activities?_____

Has your pain affected your sex life? ☐ Unchanged ☐ Extra pain ☐ Very painful

☐ Severely restricted ☐ Nearly absent ☐ Prevents any sex at all

Family History: Mother Father Brothers Sisters Children

Heart Disease: _____
Hypertension: _____
Stroke: _____
Cancer: _____
Diabetes: _____
Glaucoma: _____
Epilepsy: _____
Bleeding Disorders: _____
Kidney Disease: _____
Thyroid Disease: _____
Mental Illness: _____
Osteoporosis: _____
Back Problems: _____
Living: _____
Deceased: _____

PLEASE CIRCLE THE ONES THAT APPLY

Review of Systems:

Weight: _____

Height: _____

General state of health ☐ Good ☐ Fair ☐ Poor

Ability to conduct usual activities ☐ Yes ☐ No

Exercise tolerance ☐ Good ☐ Fair ☐ Poor

Comments: _____

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.

Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.

Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.

Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.

Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.

Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.

Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.

Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes.

Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions.

Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive.

Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.

Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV.

Other: _____