NEUROSURGERY AND SPINE NORTHWEST

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RETURN THIS FORM AT LEAST 1 WEEK PRIOR TO APPT BY MAIL, FAX, OR HAND

PATIENT NAME: ____________________________________DATE OF BIRTH: ______________ DATE: ________________

Briefly describe your current symptoms & reason for this appointment: ____

____

Where is your pain located? Check all that apply & circle "R" for right or "L" for left

□ neck
□ upper back/between shoulders
□ shoulder: R / L
□ arm: R / L
□ hand: R / L
□ lower back
□ buttock: R / L
□ hip: R / L
□ upper leg/thigh: R / L
□ shin/calf: R / L
□ foot: R / L
□ other ___________________

If more than one location, where is your pain the worst? ____

Severity of Pain: *(0= no pain 10= worst pain)* On Average: _______ Up to: _______

The pain is: □ constant □ intermittent

Description of pain: □ sharp/stabbing □ dull/aching □ burning □ other ___________________________

Do you experience numbness or tingling? □ yes □ no If yes, check all that apply & circle "R" for right or "L" for left

□ arm: R / L □ hand/fingers: R/L □ neck □ low back □ other ___________________________

□ leg: R / L □ foot/toes: R / L □ mid-back

Do you experience weakness? □ yes □ no If yes, where? Check all that apply & circle "R" for right or "L" for left

□ arm : R / L □ hand: R / L □ leg: R / L □ foot: R / L □ other ____

The symptoms have been present for:

Specific date:___/___/___ or approx (circle): 1 2 3 4 5 6 7 8 9 10 days/months/years (circle), other ____________

It began as a result of:

□ an injury at work □ motor vehicle accident □ an injury outside of work □ spontaneously - no known cause

Describe how it occurred: ____

____

____

Symptoms worsen when you: □ stand □ walk □ sit □ lie down □ change positions □ never worsen
□ other ____________

Symptoms improve when you: □ stand □ walk □ sit □ lie down □ change positions □ never improve
□ other ____________

Has there been any change to your daily activities due to these symptoms? □ yes □ no

What aspects of your daily routine are you unable to perform? ____

Since the onset of symptoms, have you had any NEW problems urinating or having bowel movements? □ yes □ no

PATIENT NAME: ____ DATE: _______________

PREVIOUS TREATMENT

**If any of these treatments were within the last 2 years,*
*please make sure our office has the records, failure to do so may delay your appointment**

Have you had chiropractic treatments for this condition? ◻ yes ◻ no If yes, did your symptoms improve: Y / N
When did you attend & for how long: _______________ Chiropractor's name: _____________________________

Have you had physical therapy for this condition? ◻ yes ◻ no If yes, did your symptoms improve: Y / N
When did you attend & for how long: _______________ Therapist or clinic name: __________________________

Have you had epidural steroid injections (ESI) for this condition? ◻ yes ◻ no
If yes, did your symptoms improve: ◻ yes ◻ no ◻ temporarily, for how long ___________
When were they performed: _____________________ Provider: ____
What area was injected: ◻ neck ◻ mid back ◻ low back ◻ other ____________________________

Have you had an Electromyogram (EMG) for this condition? ◻ yes ◻ no If yes, when and where___________________
Have you seen another neurosurgeon for this condition? ◻ yes ◻ no If yes, who and when______________________

MEDICAL HISTORY

Have you been diagnosed (or treated) with any of the following? ◻ yes (check all that apply) ◻ no

◻ anemia
◻ congestive heart failure
◻ coronary artery disease
◻ heart disease
◻ COPD
◻ liver disease
◻ fibromyalgia
◻ rheumatoid arthritis
◻ blood clots
◻ ulcerative colitis

◻ angina/chest pain
◻ diabetes
Type: I II
◻ kidney disease
◻ cancer
type: ___________
date: ___________
◻ HIV/AIDS
◻ tuberculosis
◻ prostate enlargement

◻ arrhythmia/irregular heartbeat
describe: ______________________
◻ heart attack
date: ___/___/__________
◻ depression
◻ stroke/CVA/TIA
date: ___/___/__________
◻ hypothyroid
◻ stomach ulcers/reflux

◻ asthma
◻ high cholesterol
◻ high blood pressure
◻ osteoarthritis
◻ osteoporosis
◻ psychiatric disorder
type: _____________
◻ anxiety
◻ hyperthyroid

◻ other medical condition(s): ____
*If you see a cardiologist, who do you see and when was your last appointment? _________________________________

PAST SURGICAL HISTORY

Have you had any surgeries/operations? ◻ yes ◻ no

Date of Surgery	Surgeon's Name	Detailed description, including type of surgery, body area and left/right
___/___/_______	__________________	____
___/___/_______	__________________	____
___/___/_______	__________________	____
___/___/_______	__________________	____
___/___/_______	__________________	____
___/___/_______	__________________	____

PATIENT NAME: ____ DATE: _______________

MEDICATION HISTORY

List all medications you are currently taking, including "over the counter" and prescription medicines, and any dietary supplements such as vitamins. Or provide your own list.

Name of Medicine | Strength or Dosage | Directions for taking (how many per day and how often)

____

____

____

____

____

When did you receive a pneumonia vaccination? ____

When was your last flu shot? ____

List any OTHER anti-inflammatories, immunosuppressants, herbal supplements, or blood thinners NOT listed above:
(these will need to be stopped at least 1 week before spine surgery)

____

____

ALLERGIES/ADVERSE REACTIONS

Are you allergic to any medications? □ yes □ no

Name of Medication | Reaction

____

____

____

Are you allergic to: (check all that apply and specify) □None □ topical iodine □ IV contrast dye □ latex □ tape □ metals □ environmental ___________________ □ food _________________ □ other _________________________

Reaction? ____

Have you ever had an allergic reaction to a blood product or is there any reason you cannot receive blood or blood products? □ yes □ no If yes, please explain: ____

Have you ever had an adverse reaction to anesthesia? □ yes □ no If yes, when, and what was your reaction?

____

Have you ever had blood clots, excessive bleeding, or a wound infection following surgery? □ yes □ no If yes, describe ____

Have you ever been diagnosed or treated for MRSA/methicillin resistant staph aureus? (A very specific infection that is difficult to treat) □ yes □ no If yes, when, and describe _______________________________________

Have you ever received treatment for drug and/or alcohol problems? □ yes □ no If yes, please explain:

PATIENT NAME: ____ DATE: _______________

Are you currently or have you recently experienced any of the following?: (check all that apply)

- Fever
- Unexplained weight change
- Changes in vision
- Headaches
- Difficulty swallowing
- Dental problems
- Chest pain
- Palpitations
- Shortness of breath
- Cough
- Allergic to food or environment
- Respiratory infection
- Nausea
- Vomiting
- Diarrhea
- Difficulty controlling bowels
- Urinary urgency
- Painful urination
- Difficulty controlling bladder
- Rash
- Skin infection
- Easy bruising or bleeding
- Loss of balance
- Dizziness
- Joint pain
- Joint swelling
- Excessive thirst
- Excessive urination
- Anxiety
- Depression

How many falls have you had in the past 12 months? ____

SOCIAL HISTORY

Do you live alone? ◻ yes ◻ no **Do you have any children?** ◻ yes ◻ no

Do you currently use or have you used tobacco or nicotine products in the past? ◻ current ◻ formerly ◻ never

If yes, please specify: ◻ cigarettes ◻ chewing tobacco ◻ snuff tobacco ◻ cigars ◻ pipe ◻ e-cigarettes

How much per day: ______________ For how many years ______or what age did you start/stop? _______/________

Would you like to receive tobacco cessation counseling?____

Do you currently drink alcohol? ◻ yes ◻ no ◻ recovering alcohol Date of Sobriety: ___/___/___

If yes, please specify ◻ beer ◻ wine ◻ hard liquor How many drinks per week? ______________________

Do you currently use recreational drugs? ◻ yes ◻ no **Have you used in the past?** ◻ yes ◻ no If yes, quit date?____

How much per day? _______________ For how many years? ______________

Specify: ◻ marijuana ◻ cocaine ◻ speed ◻ hallucinogens ◻ narcotics ◻ other

WORK HISTORY

◻ **Currently employed** ◻ **Retired** ◻ **Disabled** ◻ **Other** _______________

Previous or current occupation: ____

If currently employed, are you on light duty or off work temporarily? ◻ yes, as of ___/___/___ ◻ no

How would you describe your occupation: ◻ sedentary ◻ light activity ◻ moderate activity ◻ heavy labor

FAMILY MEDICAL HISTORY

Please list any significant medical conditions or diagnosis for your following family members.

Father: ____

Mother: ____

Brother(s): ___________________________________ Sister (s):____

Your children: ____

X ______________________________

Patient Signature