COLUMBIA CLINIC

NAME:____ **DATE:** ____________
Last First M.I.

BIRTHDATE:______/_____/_____ **AGE:** _____

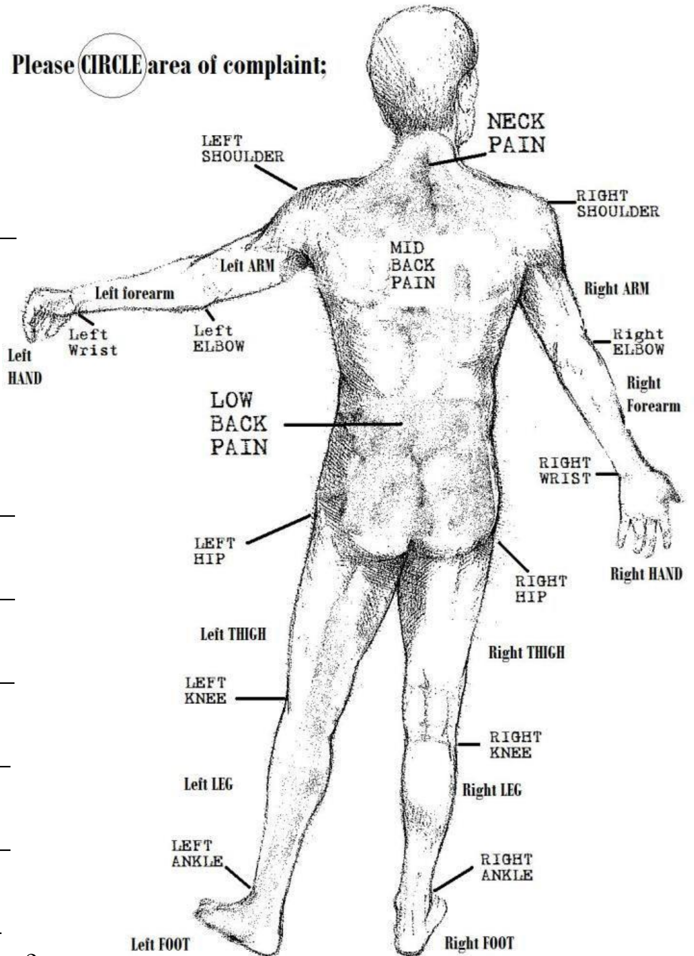
GENDER: □ Male □ Female

□ *Check box if you want to update Primary Care*

Referring Provider: ____________________ ____________ ***Primary*** *care Physician:* __________________
NAME *PHONE*

Main complaints: *(Check all that apply)*

□ **Neck** pain. □ **Back** pain. □ **Joints** pain.



I am also having;

- □ Numbness
- □ Weakness
- □ Frequent falls *if yes, how often?* _________
- □ Headaches
- □ Sleep problems because of symptoms.

How ***long*** you have the symptoms or the problem?

____

Did your symptoms got ***WORSE*** recently?

□ No □ Yes *how recently?* ________________

Did your symptoms got ***BETTER*** recently?

□ No □ Yes *how recently?* ________________

Did you have **surgery** ***BEFORE*** for this problem?

□ No □ Yes *when?* ____________________

Are you having loss of control of bowel or bladder?

□ No □ Yes *how Long?* __________________

Did you have to miss work because of this problem?

□ No □ Yes *how Long?* __________________

Where you treated before for this problem by a Specialist?

□ No □ Yes *who?* ______________________

Was this problem a **direct** result of an accident or injury?

□ No □ Yes *If yes please* describe: ____

____

Prior treatments have included:
- □ did **NOT** try medicines, therapy, manipulations, injections, or braces.
- □ **The following treatments: (*Check all that apply*)**

Medications: □ Pain medication frequently ***Like*** Vicodin/Percocet/Morphine/Oxycodone/Methadone
□ Steroids □ Anti-inflammatory (NSAIDs) □ Muscle relaxant
□ Amitriptaline □ Lyrica or Neurontin

Therapy or braces: □ **Physical** therapy if yes, when was last time ______________
□ Massage & ultrasound □ TENS unit □ Braces □ Traction □ Chiropractor

Previous workup/Tests:
□ **MRI** (Lumbar) Low Back □ **MRI** (cervical) Neck if yes, when was last time ________
□ X-Ray □ CT scan □ Bone scan □ EMG/NCS□ *Upper* □ *Lower* □ Other_

Injection OR manipulations,: ***If helped*** *symptoms, how long lasted?*

- □ Spine ***Epidural*** steroid injections_______times................ _________
- □ Shoulder/Elbow/Wrist ***JOINT*** injections _________
- □ Hip/Knee/Foot ***JOINT*** injections _________

PLEASE GO ON TO THE NEXT PAGE

Initial History and Physical Note

Previous doctors seen about this problem: ☐ **None**

Doctor	Specialty	Treatments	City	Phone Number
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A. SOCIAL HISTORY

Are you **Right** handed *or* **Left** Handed

PLEASE CIRCLE

1. **Work** status:
   - ☐ Homemaker ☐ Retired ☐ Disabled ☐ on leave
   - ☐ Unemployed
   - ☐ Working: Full time Part time; Occupation: ___________________

ANY ALLERGY TO MEDICATION

NO YES

____

2. **Marital** status:
   - ☐ Married ☐ Single ☐ Widowed ☐ Divorced
3. **Number** of living children: ________
4. I **live**: ☐ Alone ☐ With: ______________
5. **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).

HEIGHT:__________FT

WEIGHT__________LBS

6. **Alcohol**: ☐ Never or rare ☐ Social
   - ☐ Frequent (more than twice a week)
   - ☐ Heavy dinking (daily >2 drinks/day)

Office Use Only

BP__/______ P

__________ RR

____

7. **Drug** use/abuse:
   - ☐ Never ☐ Currently ☐ In the past
8. Because of this **problem**, I have filed or plan to file:
   - ☐ A lawsuit ☐ A Worker's Compensation claim
   - ☐ Neither a lawsuit nor a Worker's Compensation claim

B. FAMILY HISTORY: *(Check all that apply).* ☐ None apply

☐ Stroke ☐ Mental illness ☐ Alcoholism
☐ Heart trouble ☐ High blood pressure ☐ Gout ☐ Kidney trouble or stones
☐ Arthritis ☐ Muscle disease ☐ Nerve disease:____ ☐ Spine problems
☐ Diabetes ☐ Bleeding disorders ____ ☐ Cancer _____________

PLEASE GO ON TO THE NEXT PAGE

Please Initial here: __________

C. SURGICAL HISTORY: ☐ None

Previous surgeries for this problem - list procedure, surgeon, and date if known.

OPERATION	SURGEON	DATE *(Month/Year)*
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--	--------------------------	---------------------------
--	--------------------------	---------------------------
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D. MEDICAL HISTORY *[these are problems **you were told** you have]*

(Please check all that apply)

☐ None apply, to my knowledge. Date of Last Physical exam:____________*(Month/Year)*

GENERAL DSIORDERS:

☐ Diabetes if yes what is last **HgA1C____** ☐ High blood pressure ☐ Cancer

☐ Thyroid trouble ☐ Alcoholism ☐ Drug Addition
☐ Liver trouble ☐ Serious injuries (accidents) ☐ Mental

illness BLOOD DISEASES:

☐ Bleeding disorders ☐ Anemia
☐ Blood clot in leg ☐ Blood clot in lung ☐ Sickle cell disease

EYE/EAR/MOUTH:

☐ Glaucoma ☐Glasses or contacts
☐ Dentures/Bridges ☐ Loose teeth, capped ☐ Problems with hearing

NEUROLOGIC DISEASES:

☐ Stroke ☐ Seizures ☐ Tremors
☐ Carpal Tunnel Syndrome ☐ Peripheral neuropathy ☐ Sciatica

HEART DISEASES:

☐ Heart attack ☐ Heart failure ☐ Murmur ☐ Irregular Heart rhythm

LUNG DISEASES:

☐ Lung disease ☐ Asthma ☐ COPD (Chronic Obstructive Lung Disease)

INFECTIOUS DISEASES:

☐ HIV (AIDS) ☐ Hepatitis ☐

Tuberculosis JOINTS & BONE DISEASES:

☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Ankylosing spondylitis ☐
☐ Osteoporosis ☐ Major Fracture ☐ Joint replacement. ☐ Gout

KIDNEY DISEASES:

☐ Kidney failure ☐ Kidney stones

STOMACH DISEASES:

☐ Stomach ulcers ☐ Ulcers or hiatus hernia ☐ Acid Reflux

disease OTHER DISEASES: ☐ Other: ___________________________________

Initial here: ___________

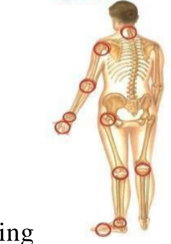
PLEASE GO ON TO THE NEXT PAGE

COLUMBIA CLINIC
SPINE & JOINT SPECIALISTS

E. REVIEW OF SYSTEMS *[these are symptoms **you would like** to tell us about] (check all that apply)*

GENERAL:

☐ Recent unexplained weight loss ☐ Difficulty with stairs because of weakness
☐ Frequent falling ☐ gait difficulties ☐ Fainting spells

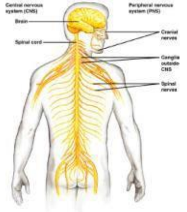


JOINTS SYMPTOMS:

☐ Joint pain ☐ Joint redness ☐ restriction of joint motion
☐ Joint tenderness ☐ Joint weakness ☐ Joint stiffness ☐ Joint swelling

MUSCLE SYMPTOMS:

☐ muscle atrophy ☐ muscle cramps ☐ muscular pain ☐ muscle weakness ☐ muscle swelling

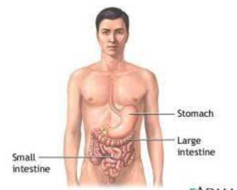


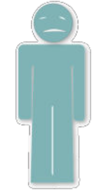
NEUROLOGICAL:

☐ Double vision ☐ double vision ☐ memory loss ☐ seizures ☐ speech difficulties
☐ Complaints of tremor (Shakes) ☐ Restless leg at night ☐ Paralysis of limb
☐ Dizziness ☐ Headaches ☐ Loss of balance ☐ Loss of coordination

GI/GU (Stomach/Intestine/Urinary symptoms)

☐ Frequent heartburn (acid reflux) ☐ complaints of Urinary incontinence
☐ Chronic constipation ☐ Recent sexual difficulties (impotence or decrease libido)





PSYCOLOGICAL:

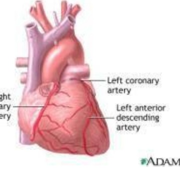
☐ Mood swings ☐ Extreme nervousness or anxiety ☐ Panic attacks ☐ Depressed mood ☐ Crying spells

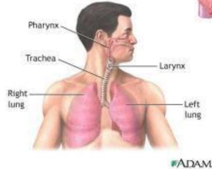
SLEEP TROUBLE:

☐ Decreased need for sleep ☐ difficulty falling asleep due to pain
☐ Difficulty staying asleep ☐ Early morning awakening
☐ Awakening in the middle of the night ☐ Snoring ☐ Daytime somnolence.

HEART and CIRCULATION:

☐ Difficulty with Stairs (due to shortness of breath) ☐ Sleeping on more than one pillow
☐ Waking at night with shortness of breath ☐ Ankle Swelling
☐ Chest pain at rest or exercising





LUNGS or BREATHING:

☐ Cough or Coughing up phlegm ☐ Shortness of breath at rest or exercising

BLEEDING SYMPTOMS:

☐ Bleeding tendency or easy bruising ☐ Blood transfusions

The following medications CAN cause bleeding tendency please mark if any;

☐ Aspirin *(including Goody's Powder)* ☐ Coumadin (warfarrin) ☐ Plavix
☐ Ticlid ☐ Metformin (Glucophage)

RECENT INJURIES: *(Within past 6 months only please)*

Please specify mechanism of injury

☐ struck by a falling object ☐ sports activity ☐ contact sports activity
☐ an altercation ☐ assault

FALLS:

☐ slipped and fell ☐ tripped and fell ☐ fall from a height

AUTOMOBILE ACCIDENT:

☐ struck from behind ☐ struck on the their side ☐ struck on the opposite side
☐ Frontal impact ☐ Vehicle was overturned
☐ restrained ☐ unrestrained ☐ airbag deployed

For females: Are you pregnant? ☐ Yes ☐ No Date of last menstrual period: _____________

MOBILITY AIDS *(if any)*:

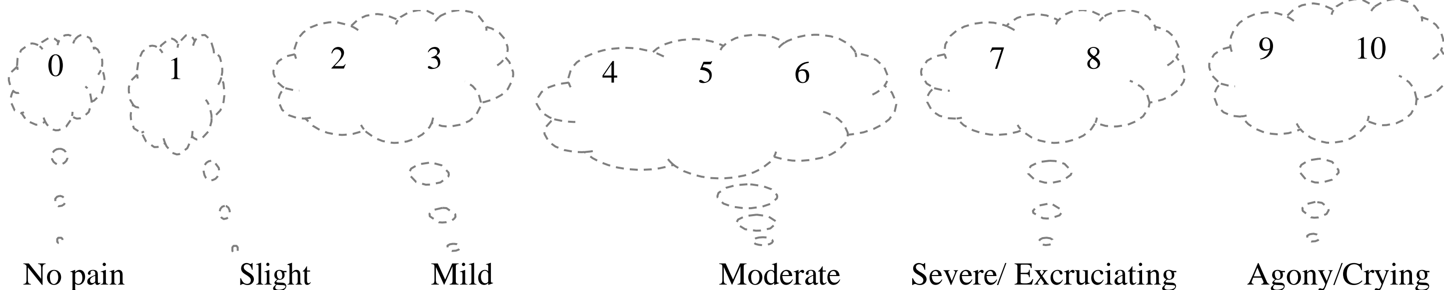
☐ Single Cane ☐ Quad Cane ☐ Crutches
☐ Walker ☐ Wheel chair ☐ Motorized Wheel chair

Patient's signature Date: **Physician's** signature

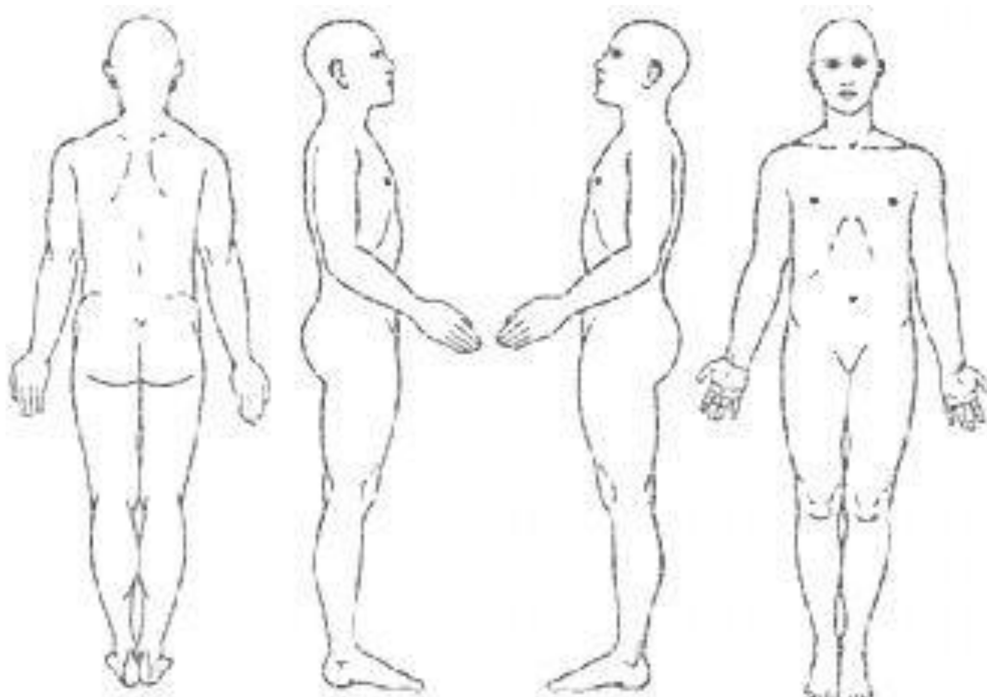
______________________________ __________ ___________________________________

MY PAIN/DISCOMFORT IS (circle number)

No Pain — Definitely Hurts — Writhing Agony



No pain — Slight — Mild — Moderate — Severe/ Excruciating — Agony/Crying



Use Diagram to describe area of symptoms according to the following symbols

Sharp--------------- XXX

Dull ………….. ////////

Numbness -------- OOOO

Electrical …….. ZZZZZ

DESCRIBE TO THE BEST OF YOUR ABILITY, YOUR DOCTOR WILL DISCUSS WITH YOU IN DETAILS

Dull	Sharp	Shooting
Aching	Electrical like	
Diffuse	Localized	Unable to localize
Occasional	*Intermittent*	*All the time*
Worse in the morning	**Worse in afternoon**	**Worse at bedtime**

Circle MARK ALL THAT APPLIES

PLEASE GO ON TO THE NEXT PAGE

Initial here: __________

COLUMBIA CLINIC
SPINE & JOINT SPECIALISTS

For patients with **LOW BACK or LEG** pain, numbness, or weakness:

*(If you are not having symptoms in these area, please **SKIP** this page.)*

1. ***What % of your symptom is low back pain and what % is Hip/Thigh/Leg or Foot symptoms?*** (Check appropriate box)

☐ Low Back *only* **NO** Hip/Thigh/Leg or Foot symptoms ☐ Hip/Thigh/Leg or Foot *only* **NO** Low Back symptoms

☐ Low Back **50%** & Hip/Thigh/Leg or Foot about **50%**

☐ BOTH but Low back symptoms are *WORSE* ☐ BOTH but Hip/Thigh/Leg or Foot symptoms are *WORSE*

2. There is:
- ☐ *No* Hip/Thigh/Leg or Foot pain
- ☐ *Hip/Thigh/Leg or Foot pain is as follows (check the following):*
  - ☐ Left 100%, Right 0% ☐ Right 100%, Left 0%
  - ☐ BOTH but **LEFT** *WORSE* ☐ BOTH but **RIGHT** *WORSE*

The leg pain is present in the (check the following):

Walking:	☐ Improves the pain	☐ Worsens the pain	☐ Does not affect the pain
Setting:	☐ Improves the pain	☐ Worsens the pain	☐ Does not affect the pain
Lying down:	☐ Improves the pain	☐ Worsens the pain	☐ Does not affect the pain
Changing body position:	☐ Improves the pain	☐ Worsens the pain	☐ Does not affect the pain

3. There is:
- ☐ ***No weakness*** of the thighs/legs or foot
- ☐ ***Weakness*** of the thighs/legs or foot (check the following):

Worse Side

WEAKNESS

LEFT	**RIGHT**
☐ Hip	☐ Hip
☐ Thigh	☐ Thigh
☐ Knee	☐ Knee
☐ Leg	☐ Leg
☐ Foot	☐ Foot

L **R**

4. There is:
- ☐ ***No Numbness*** of the thighs/legs or foot
- ☐ ***Numbness*** of the (check the following):

Worse Side

NUMBNESS

LEFT	**RIGHT**
☐ Thigh	☐ Thigh
☐ Leg	☐ Leg
☐ Big toe	☐ Big toe
☐ 2nd toe	☐ 2nd toe
☐ 3rd toe	☐ 3rd toe
☐ 4th toe	☐ 4th toe
☐ Small toe	☐ Small toe

L **R**

5. Please check appropriate box for the following:

Do you have Frequent Sleep Disturbances because of the symptoms?	☐ Yes	☐ No
Do you have problem with balance or tripping frequently/falling?	☐ Yes	☐ No
Does symptoms increases with Coughing or sneezing /straining	☐ Yes	☐ No

PLEASE GO ON TO THE NEXT PAGE

Initial here: ___________

COLUMBIA CLINIC
SPINE & JOINT SPECIALISTS

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

*(If you are not having symptoms in these area, please **SKIP** this page.)*

1. ***What % of your symptom is neck pain and what % is Shoulder/ arm/Forearm or Hand pain?*** (Check appropriate box)

☐ Neck ***only*** **NO** Shoulder/Arm/ Hand symptoms ☐ Shoulder/Arm/Hand ***only*** **NO** neck symptoms

☐ Neck about **50%** & Shoulder/Arm/forearm/hand about **50%**

☐ BOTH but **NECK** symptoms are *WORSE* ☐ BOTH but **Shoulder/Arm/forearm/hand** symptoms are *WORSE*

2. There is:
- ☐ *No* Shoulder/Arm/forearm or hand pain
- ☐ *Shoulder/Arm/forearm/hand pain is as follows (check the following):*
  - ☐ Left 100%, Right 0% ☐ Right 100%, Left 0%
  - ☐ BOTH but **LEFT** *WORSE* ☐ BOTH but **RIGHT** *WORSE*

The arm pain is present in the (check the following):

Raising the arm:	☐ Improves the pain	☐ Worsens the pain	☐ Does not affect the pain
Moving the neck:	☐ Improves the pain	☐ Worsens the pain	☐ Does not affect the pain

3. There is:
- ☐ ***No weakness*** of the Shoulder/Arm/forearm or hand
- ☐ ***Weakness*** of the (check the following):

LEFT ← ***Worse Side*** → **RIGHT**

L R

WEAKNESS

LEFT	RIGHT
☐ Upper back	☐ Upper back
☐ Shoulder	☐ Shoulder
☐ Upper arm	☐ Upper arm
☐ Forearm	☐ Forearm
☐ Hand/finger	☐ Hand/finger

4. There is:
- ☐ ***No Numbness*** of the Shoulder/Arm/forearm or hand
- ☐ ***Numbness*** of the (check the following):

LEFT ← ***Worse Side*** → **RIGHT**

NUMBNESS

LEFT	RIGHT
☐ Upper arm	☐ Upper arm
☐ Forearm	☐ Forearm
☐ Thumb	☐ Thumb
☐ Index finger	☐ Index finger
☐ Long finger	☐ Long finger
☐ Ring finger	☐ Ring finger
☐ Small finger	☐ Small finger

Left **Right**

5. Please check appropriate box for the following:

Do you have difficulty picking up small objects like coins or buttoning buttons? ☐ Yes ☐ No

Do you have problem with balance or tripping frequently? ☐ Yes ☐ No

Do you have Frequent headaches in the back of the head? ☐ Yes ☐ No

Does pain increases with Coughing or sneezing /straining ☐ Yes ☐ No

PLEASE GO ON TO THE NEXT PAGE

Initial here: ___________