

8575 West 110 Street
Suite 205 Overland Park,
Kansas 66210
Phone : 913-491-3344
Fax : 913-491-3345
Web : JohnsonCountySpine.com



Johnson County Spine
Providing Excellence in Spinal Care

Date ____/____/____ Name _____ Birth Date ____/____/____ Age _____

Primary care Doctor _____ Address _____ Phone ____-_____

Referring Doctor _____ Phone ____-_____

Symptoms:

What are your symptoms? _____

Is the pain mostly in the back, neck, or elsewhere? _____

How long ago did these symptoms begin? _____

How did they begin? _____

Is the pain constant, or does it come and go? _____

What make the pain better? (position, rest, ice/heat, pills)? _____

What makes the pain worse? _____

Does the pain radiate into your arm or leg? **Y N** Describe _____

Do you have weakness, numbness, tingling in your arm or leg? **Y N** Describe _____

Have you lost control of your bowel or bladder function? **Y N** Describe _____

How long can you... Sit _____ Stand _____ Walk _____ Sleep _____

Is your pain the result of a... (Fall) (Car Accident) (Injury on the job) Other _____

Which of the following describes you presently? (Working) (Not working because of a back or neck problem) (Not working because of another health problem) (homemaker, retired or unemployed)

How long have you been at your job? _____ What is your occupation? _____

Does your job require bending, lifting, standing? _____

Employer at time of injury? _____ Is there a lawsuit pending or a problem? _____

Previous Treatments/ tests

Who first treated you for this problem? _____ City _____

What treatments did you have then? _____

What tests have you had done? CT scan _____ MRI _____

X-rays _____ EMG _____ Other _____

Please circle any of the other treatments you have had. Physical Therapy (Did/Did Not Help)

Injections (Did/Did Not Help) Special back/neck exercises (Did/Did Not Help) Other _____

List all **surgeries/ hospitalizations/ serious illnesses** _____

List all of your **current medications** (include prescriptions, over-the-counter, and herbal medicines and supplements) _____

Allergies (drugs, food, seasonal and include type of reaction) _____

Are you **allergic** to shellfish _____ iodine _____ x-ray dye _____ latex _____?

Are you taking any **blood thinners** (aspirin, ibuprofen, coumadin, lovonox, vitamin E)? Please list drug(s) _____

Have you ever had **complications** from surgery or anaesthesia? Please describe _____

Please indicate any **family history** (parents, siblings, children) of **medical conditions** such as heart disease, diabetes, cancer, stroke, etc.

Marital status _____ Number of children _____

Hobbies _____ Exercise/recreation _____

Tobacco (type/amount per day) _____ If former tobacco use, quit date _____

Caffeine intake (type/amount per day) _____ Alcohol intake (type/amount per week) _____

Height _____ Usual weight _____ Ideal weight _____

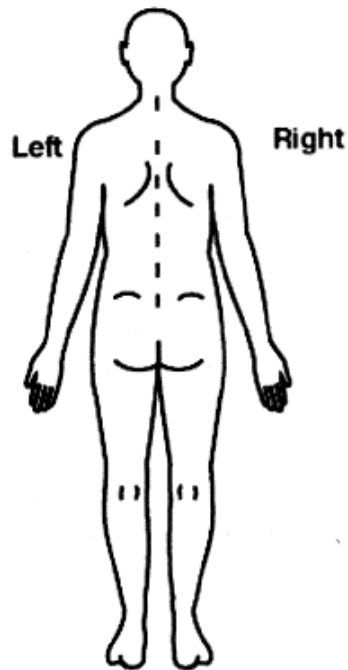
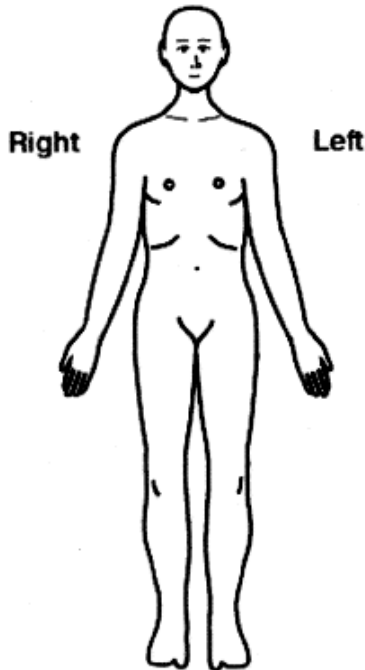
To the best of my knowledge, the questions on this form have been answered correctly. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary healthcare services I may need.

_____/_____/_____
Patient's signature Date Physician's/Examiner's signature Date

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



Stabbing pain /////
 Burning pain 0000
 Aching pain xxxxx
 Numbness =====
 Pins & needles v v v



Circle your **current pain** on the graph

0	1	2	3	4	5	6	7	8	9	10
No pain					Severe pain					

Circle your **worst pain** on the graph

0	1	2	3	4	5	6	7	8	9	10
No pain					Severe pain					

Circle your **least pain** on the graph

0	1	2	3	4	5	6	7	8	9	10
No pain					Severe pain					

Medical history

Do you have a history of or do you currently have any of the following health problems?

	Yes	No		Yes	No
Heart disease	_____	_____	Diabetes	_____	_____
High blood pressure	_____	_____	Bleeding disorder	_____	_____
Stroke	_____	_____	Hepatitis	_____	_____
Blood clots	_____	_____	Stomach ulcers	_____	_____
Anemia	_____	_____	Thyroid disease	_____	_____
Lung disease	_____	_____	Kidney disease	_____	_____
Asthma/bronchitis	_____	_____	Liver disease	_____	_____
Emphysema/COPD	_____	_____	Skin disease	_____	_____
Tuberculosis	_____	_____	Infections	_____	_____
HIV/AIDS	_____	_____	Seizures	_____	_____
Arthritis	_____	_____	Cancer	_____	_____
Obesity	_____	_____	Depression/Anxiety	_____	_____
Rheumatic fever	_____	_____	Psychiatric problems	_____	_____
Heart murmur	_____	_____	Sickle cell anemia	_____	_____
Irregular heart beat	_____	_____	Prior blood transfusion	_____	_____
Chest pain	_____	_____	Dizziness/fainting	_____	_____
Heart attack	_____	_____	Polio	_____	_____
Recent cold/flu	_____	_____	Illicit drug use	_____	_____
Steroid medication	_____	_____	Other	_____	_____