

COASTAL SPINE & PAIN CENTER

INITIAL OFFICE VISIT PATIENT INFORMATION SHEET

Name: _____ Age: _____ Sex: _____

Referred By : _____ Today's Date: _____

Current Problems

List your chief complaint(s) and/or symptom(s):

1. _____

2. _____

3. _____

4. _____

History of Present Illness

Date of Initial Symptoms: _____

If you answered the accident/personal injury section please skip, otherwise describe in your words:

Motor Vehicle Accident History

Are you being evaluated for pain resulting from a motor vehicle accident? Yes No If no, skip to the next section

Date of Accident: _____ Did you have loss of consciousness? Yes No

Restrained Driver Unrestrained Driver Restrained Passenger Unrestrained Passenger Pedestrian

Immediate medical care was obtained: Yes No If yes, hospital: _____

Were you admitted to the hospital? Yes No Did you have X-Rays or a CT done? Yes No

On the Job/Personal Injury History

Are you being evaluated for pain resulting from a work or personal injury? Yes No If no, skip to the next section

Date of Accident: _____

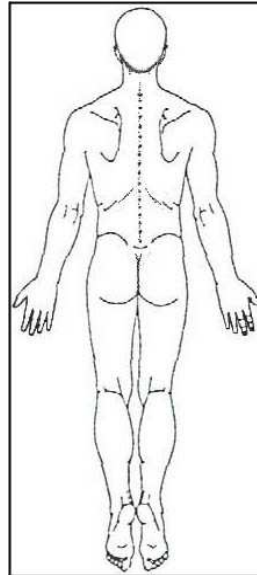
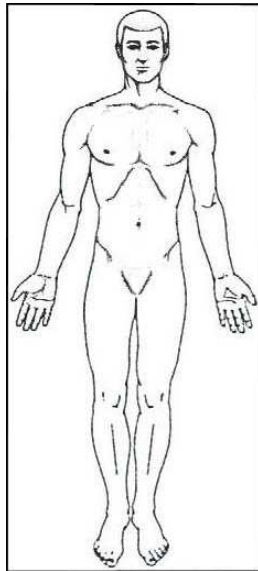
Description of accident – (please briefly describe how your injury occurred) _____

When did you first seek care? Immediately Same Day Next Day Other _____

Where did you seek care? Emergency Room Doctor's Office Other _____

What treatment did you initially receive? _____

(over)



Circle the number that best describes your pain at its **worst during the last month:**

0	1	2	3	4	5	6	7	8	9	10
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Circle the number that best describes your pain on **average during the last month:**

0	1	2	3	4	5	6	7	8	9	10
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Pain Description(circle all that apply): Constant – Intermittent – Sharp – Burning – Shooting – Achy – Knife-like
 Electric – Twisting – Pressure – Lancinating – Buzzing – Gnawing – Toothache – Pressure – Deep - Heavy

Prior Treatment

Have you been treated by another physician for this? Yes No If yes, please list physician(s) name(s):

Please describe previous treatment for the condition that brings you to our office: _____

Have you had any of the following types of therapy? (check all that apply)

<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Epidural Injections
<input type="checkbox"/> Massage Therapy	<input type="checkbox"/> Facet Injections
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Other Spinal Injections
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Braces/Supports
<input type="checkbox"/> Trigger Point Injections	<input type="checkbox"/> TENS Unit

(over)

Activity Limitations

How does your condition affect your daily activities? (Including leisure) _____

Previous Work – Up/Diagnostic Studies

Have you ever had any of the following diagnostic test/work-ups or studies? (check all that apply)
If yes: please give the approximate month and year of the study:

<input type="checkbox"/> X-Rays:	<input type="checkbox"/> EMG/NCV:
<input type="checkbox"/> Myelogram:	<input type="checkbox"/> CAT-SCAN:
<input type="checkbox"/> EEG:	<input type="checkbox"/> Bone Scan:
<input type="checkbox"/> MRI:	<input type="checkbox"/> Discogram:
<input type="checkbox"/> Recent Blood Work:	<input type="checkbox"/> Other(describe):

Past Medical History

List any medical problems past and present which require(d) medical treatment: _____

Have you ever had any surgery? Yes No If yes, list surgery type and date: _____

Medications

List any medications you are now taking: _____

Are you allergic to any medications? Yes No If yes, list: _____

Do you have any severe side effects from medications? Yes No If yes, list: _____

Family History

Are there any members of your family with the same or similar problems or conditions as yours? Yes No

If yes, please explain:

Personal/Social History

Do you use Tobacco? Yes No If yes, how much: _____

Do you use alcohol? Yes No If yes, amount: _____

Do you have a history of substance abuse (including alcohol)? Yes No _____

Are you receiving disability benefits from any source? Yes No If yes, explain below:

Are you now working? Yes No If yes: Full Time Part Time

What type of work do you perform? _____

Have you had to limit your work because of your condition? Yes No

Please describe these limitations: _____

If not employed, when were you last employed? ___/___/____. What type of work was that? _____

Review of Systems (Please circle all that apply to you):

General:	Fever, Chills, Weight change, Weakness, Fatigue
Ophthalmology:	Blind spots, Pain from light, Drainage from eye, Double vision, Blurred vision
Respiratory:	Cough, Sputum, Wheezing, Asthma, Shortness of breath
Cardiology:	High blood pressure, Swelling of ankles, Murmurs, Irregular heartbeat, Chest pain
Dermatology:	Itching, Rash, Dry skin, Skin color changes
Endocrinology:	Diabetes, Hyper or Hypo Thyroid, Hot/Cold intolerance, Frequent urination, Thirst
Gastrointestinal:	Heartburn, Constipation, Nausea, Vomiting, Bloody stools, Incontinence of stool
Genitourinary:	Incontinence of Urine, Bloody urine, Burning with urination, Kidney Disease, Sexual Dysfunction
Musculoskeletal:	Pain in: (Low back, Mid back, Upper back, Neck, Shoulder, Arm, Elbow, Wrist, Hand, Hip, Leg, Knee, Ankle, Heel, Foot) Weakness, Loss of range of motion, Muscle pain, Spasms, Stiffness
Neurology:	Numbness, Pins and Needles, Seizures, Blackouts, Dizziness, Vertigo, Impaired concentration, Memory loss, Headaches, Light/Noise sensitivity,
Psychology:	Depression, Anxiety, Panic attacks, Difficulty sleeping, History of Drug/Alcohol Abuse
Hematology:	Swollen glands, Bleeding problems, Bruising, Infection, Liver Disease

Please leave the physical examination, assessment and plan sections blank and proceed to the signature pages.

Physical Examination

Vital Signs:

Height _____ Weight _____ Temp _____ Blood Pressure _____ Pulse _____

General: AO x 3 Cooperative In no acute distress Comments: _____

HEENT: PERRLA EOMI **Respiratory:** respirations regular unlabored abn _____

Cardiovascular: Heart rate regular No edema Pulses: UE _____ LE _____

Musculoskeletal:

Spurling's Maneuver: Negative Positive: _____

ROM: cervical _____ thoracic _____ lumbar _____

ROM: LUE _____ RUE _____

ROM: LLE _____ RLE _____

Tenderness: cervical _____ thoracic _____

lumbar _____

Spasm: cervical _____ thoracic _____

lumbar _____

Pain with extension and rotation: cervical R / L _____ thoracic R / L _____ lumbar R / L _____

Pain with flexion: cervical R / L _____ thoracic R / L _____ lumbar R / L _____

SIJ: tenderness: ____ R/ ____ L Gaenslen's test: ____ R/ ____ L Fortin test: ____ R/ ____ L

Tenderness: LUE _____ RUE _____

Shoulder: Neer's test: _____ Hawkins's test: _____ Drop-arm test: _____ Empty Can: _____

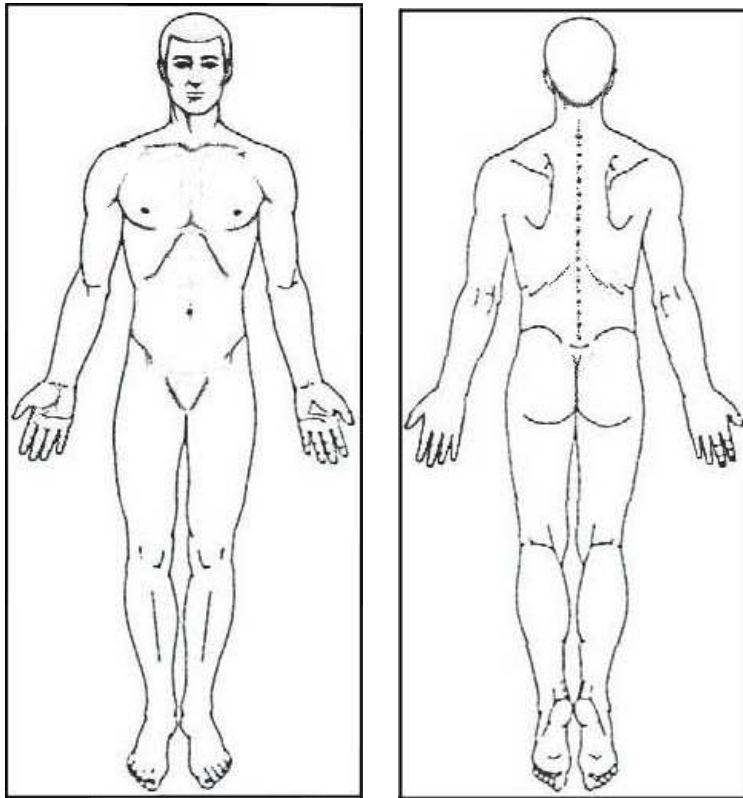
Elbow/Hand: _____

Tenderness: LLE _____ RLE _____

Hip: Patrick's test: ____ R/ ____ L Pain w/ Internal Rotation: ____ R/ ____ L Troch bursa tenderness: ____ R/ ____ L

Knee: ligament laxity: _____ effusion: _____ tenderness: _____

Ankle/Foot: _____



Neurological:

Gait: Normal Antalgic Other: _____ Tone: _____

Light touch sensory intact: LUE RUE LLE RLE

Light touch sensory deficits: LUE _____ RUE _____

LLE _____ RLE _____

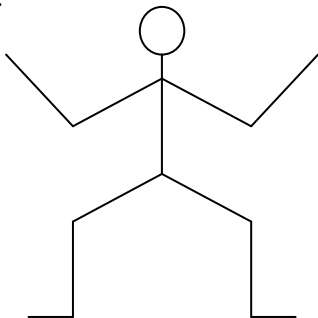
Proprioception intact: LUE RUE LLE RLE

Proprioception deficits: LUE _____ RUE _____ LLE _____ RLE _____

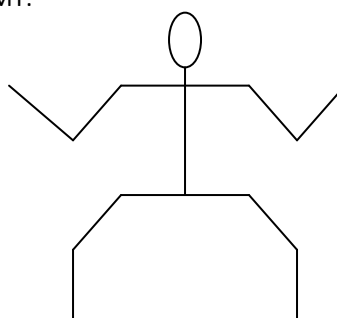
Hoffman sign: ____ R/ ____ L Clonus: ____ R/ ____ L Babinski sign: ____ R/ ____ L

seated SLR: ____ R/ ____ L supine SLR: ____ R/ ____ L L'Hermitte's sign: Positive Negative

DTR:



MMT:



Other:

ASSESSMENT:

1.

2.

3.

4.

PLAN:

Initiate conservative treatment program:

Order imaging:

Schedule procedure:

Pain medication regimen:

Other: