

Spine & Sports Medical Group Health Questionnaire

Patient First Name: _____ Last Name: _____ DOB (MM/DD/YY): _____

Today's Date (MM/DD/YY): _____

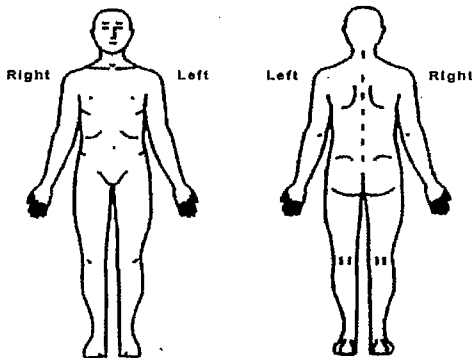
Referred by: _____ Primary Care Physician: _____

Functional Goals (ex. walk, sports): _____

PAIN BACKGROUND: List your top 3 pains. #1 (worst pain), #3 (least pain)

#	Location	Pain Started (MM/YY) and Reason	Lowest and Highest Pain Levels	Pain worsened by	Pain made better by
1			(None) 0 1 2 3 4 5 6 7 8 9 10 (ER)		
2			(None) 0 1 2 3 4 5 6 7 8 9 10 (ER)		
3			(None) 0 1 2 3 4 5 6 7 8 9 10 (ER)		

Shade in Pain Regions



Past Pain Treatments

- Surgery Epidural injections Trigger Point Injections
- Physical Therapy TENS Heat/Ice Home Exercise
- Massage Osteopathy Chiropractics Acupuncture
- Hypnotherapy Medications Psychotherapy Meditation
- Other: _____

Images obtained (Please submit a copy of all reports)

- MRI X-Ray CT EMG
- Other: _____

PHARMACY Name & Address: _____ **Tel:** _____

MEDICATIONS & SUPPLEMENTS (list all, use a separate sheet if necessary)

<u>Medication</u>	<u>Strength (mg/mcg)</u>	<u># Tabs</u>	<u>Frequency (x/day)</u>	<u>Prescribing Doctor</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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ALLERGIES TO MEDICATIONS

<u>Medication</u>	<u>Reaction</u>	<u>Medication</u>	<u>Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY

- Hypertension Pacemaker Hyperlipidemia Myocardial Infarction
- Kidney Disease Kidney Failure Dialysis (M/T/W/Th/F) Hepatitis A/B/C Cirrhosis
- Diabetes I/II Hypothyroidism Hyperthyroidism Cancer: Location, Stage _____
- Rheumatoid Arthritis Osteoarthritis Fibromyalgia Chronic Fatigue Syndrome Lyme's
- Back/neck pain Carpal Tunnel R/L Peripheral Neuropathy Post-laminectomy syndrome
- Migraines Seizure Stroke Parkinsons Lupus Mysethena Gravis
- Depression Anxiety Bipolar I/II Insomnia OCD ADHD ADD
- Other(s): _____

SURGICAL HISTORY

<u>Surgery</u>	<u>Date (MM/YY)</u>	<u>Surgeon</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

	ALIVE		DECEASED	
	Age	Health	Age	Cause
Father				
Mother				
Brother/Sister				
Brother/Sister				
Other				

Family member with history of drug or alcohol abuse (explain): _____

SOCIAL HISTORY

- Employed:** Full Time Part Time Unemployed Disability Retired
- Employer:** _____ **Title:** _____
- Relationship Status:** Single Married Widowed **Number of children** _____
- History of Addiction:** tobacco (current) tobacco (year quit: _____) alcohol (current) alcohol (year quit: _____) drugs (current) drugs (year quit: _____) other (current) _____ other _____