

# TO EXPEDITE SCHEDULING, ANSWER EVERY QUESTION



**GRACE**  
SPINE CARE  
CENTER

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Lubbock, TX 79407

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_

Name and **address** of primary care provider: \_\_\_\_\_

Main complaint: \_\_\_\_\_

Additional complaints: \_\_\_\_\_

Rate your Pain: 0 (no pain) - 10 (worst pain you can imagine): \_\_\_\_\_

What percent is in your: arm vs. neck: \_\_\_\_% / \_\_\_\_% (out of 100%)

leg vs. low back: \_\_\_\_% / \_\_\_\_% (out of 100%)

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Which **part of the day** is your pain worst? \_\_\_\_\_

How far can you walk? \_\_\_\_\_

Do you use assistive devices for walking? (cane, walker, shopping cart, scooter) \_\_\_\_\_

How long have you had the symptoms? \_\_\_\_\_

Was there any trauma before the symptoms started? \_\_\_\_\_

Were you involved in a motor vehicle accident? \_\_\_\_\_

Did you have a work-related injury? \_\_\_\_\_ If yes, date of injury: \_\_\_\_\_

Is there any active litigation? \_\_\_\_\_

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Are you right- or left-handed? \_\_\_\_\_

Do you have difficulties handling small objects (buttoning a shirt, tossing coins)? \_\_\_\_\_

Any changes in handwriting? \_\_\_\_\_

Do you have any difficulties with balance? \_\_\_\_\_

Have you experienced any falls? \_\_\_\_\_

Do you have any problems with bladder or bowel function? (describe, if yes) \_\_\_\_\_

**Previous treatments (include how much relief they provided):**

Physical therapy: yes/no; **when; for how long;** effect: \_\_\_\_\_

Chiropractic treatments: yes/no; effect \_\_\_\_\_

What medications have you tried for your spine problem (names and doses)? Have they helped?:

\_\_\_\_\_

Have you tried Neurontin (Gabapentin) or Lyrica? \_\_\_\_\_

Injections: (**bring documentation to the appointment**) dates, type of injection, name of hospital, name of physician, did it help? \_\_\_\_\_

\_\_\_\_\_

Prior neck or back surgeries: (**bring documentation to the appointment**) dates, name of operation, name of hospital, name of physician, did it help? \_\_\_\_\_

\_\_\_\_\_

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List **all health problems** that you have: \_\_\_\_\_

heart problems? \_\_\_\_\_ blood clots or excessive bleeding? \_\_\_\_\_

diabetes? \_\_\_\_\_ cancer? \_\_\_\_\_

chronic infections (hepatitis, HIV)? \_\_\_\_\_ unintentional weight loss? \_\_\_\_\_

fever or chills? \_\_\_\_\_ night sweats? \_\_\_\_\_

Is your strength today the same as several days ago? \_\_\_\_\_

History of osteoporosis? \_\_\_\_\_ bone fractures/breaks? \_\_\_\_\_

Have you had a bone density test? When? \_\_\_\_\_

Do you use any tobacco products? (if yes, what kind and how much) \_\_\_\_\_

history of IV drug use? \_\_\_\_\_ alcohol use? (how many drinks a week) \_\_\_\_\_

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**Past surgical history** (not spine related): \_\_\_\_\_

**Do you have:** Pacemaker? Implanted defibrillator? Spinal cord stimulator?

**Medications:**

Blood thinners (including Aspirin and anti-inflammatories)? \_\_\_\_\_

Prescribing doctor: \_\_\_\_\_

Steroids? \_\_\_\_\_ Other medications (attach a list): \_\_\_\_\_

**Allergies:** \_\_\_\_\_

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**Social history:**

married   single   divorced   widowed

Children: \_\_\_\_\_

Present occupation: \_\_\_\_\_ If retired, what did you use to do? \_\_\_\_\_

If on disability, for what reason? \_\_\_\_\_  
\_\_\_\_\_

**Previous imaging** (xrays, MRI, CT, myelograms, bone scans) – bring both images and reports

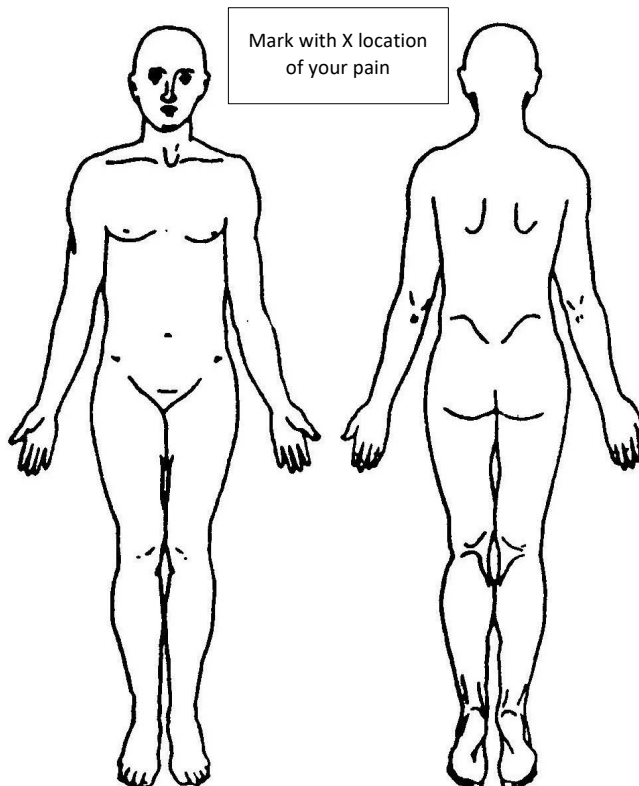
Name of the study, date: \_\_\_\_\_

**Any additional studies** (nerve conduction study, electromyography, blood work):

Name of the study, date: \_\_\_\_\_

Mark true or false to the following questions:

	True	False
I have low energy most days		
Most of time I do not get restful sleep		
I spend >12 hours a day resting and/or sleeping		
My pain causes me a great deal of suffering		
I have pain in two or more parts of my body		



I have answered the questions to the best of my ability.

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Signature \_\_\_\_\_ Date \_\_\_\_\_