ALEXANDER ORTHOPAEDIC ASSOCIATES
SPINE HISTORY & PHYSICAL

Room # _____
Provider _____
X-ray taken _____
XR/MRI brought yes no
Facility _____
(for office use only)

TODAY'S DATE: _____
PATIENT NAME: _____ **AGE:** _____ **DOB**: _____
(please circle): **M** **F** Right handed Left handed **HEIGHT:**_____ **WEIGHT:** _____**BLOOD PRESSURE:**_____

RACE/ETHNICITY (please circle): **WHITE** **HISPANIC** **AFRICAN AMERICAN** **PACIFIC ISLANDER** **OTHER** _____

PRIMARY CARE _____

PREFERRED LANGUAGE (please circle): **ENGLISH** **SPANISH** **OTHER** _____

PLEASE CIRCLE THE PROBLEM YOU ARE SEEKING TREATMENT FOR TODAY:

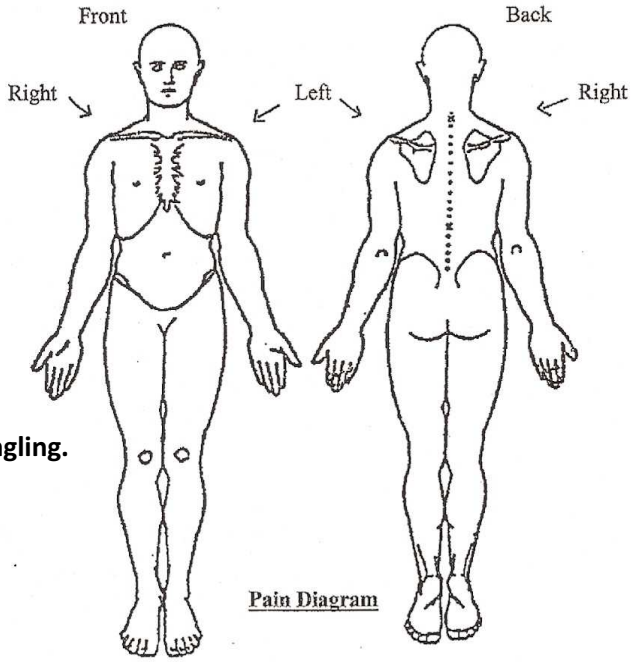
Neck Pain **Arm Pain (R or L)** **Arm Numbness (R or L)**
Low Back or buttock pain **Leg Pain (R or L)** **Leg Numbness (R or L)**
Difficulty Walking

HAVE YOU EVER HAD PROBLEMS WITH THIS AREA IN THE PAST? (please circle): **Yes** **No**
BRIEFLY DESCRIBE WHAT CAUSED YOUR SYMPTOMS

YOUR PAIN IS BEST DESCRIBED AS: (please circle)
Dull ache **Sharp** **Burning** **Electric Shock**

ONSET OF PAIN: How did you current symptoms start?
Injury (at work) _____**exact date of injury**
Injury (not at work) _____**exact date of injury**
Motor Vehicle Accident _____ **exact date of accident**
Undetermined Other _____

WHERE IS YOUR PAIN NOW? (Use the diagram to the right)
Place an X in the area(s) you feel the most pain.
Place an O on the body diagram where you feel numbness/tingling.



Pain Diagram

WHAT IS THE PERCENTAGE OF YOUR PAIN? (totaling 100%)
Neck _____ **+** **Arm(s)** _____ = 100%
Back _____ **+** **Leg(s)** _____ = 100%

SEVERITY OF PAIN:
-In general, what is the intensity of your pain (circle one)?
NO PAIN **0 1 2 3 4 5 6 7 8 9 10** ***WORSE POSSIBLE PAIN***

-In general, how is this problem affecting your life (circle one)?
Nuisance **Minor Problem** **Major Problem** **Catastrophe**

TIMING OF PAIN: How often do you have your pain (circle one)?
Occasionally (less than 30% of the time) **Nearly constantly** (60-95% of the time)
Intermittently (30-60% of the time) **Constantly** (100% of the time)

PATIENT NAME: _____

PHARMACY NAME:_____
ADDRESS: _____
PHONE#: _____

RELIEVING AND AGGRAVATING FACTORS: How do the following affect your pain (please check one for each item):

	IMPROVES PAIN	NO CHANGE	WORSENS PAIN
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
COUGHING/SNEEZING			
BOWEL MOVEMENTS			

Have you had any **recent** change in bowel or bladder habits? (please circle)
No **Yes** (please describe)_____

Have you experienced any of the following? (please circle)

Clumsiness in your hands difficulty with buttons changes in handwriting
Changes in the way you walk unsteadiness

ACTIVITIES AND YOUR PAIN: (please circle)

-How many blocks can you walk?
Less than a block 1-2 blocks 2-5 blocks 5-10 blocks Greater than 10 blocks

-To assist walking, I use a:
Cane Walker Wheelchair No assistance device

-How long can you stand for?
5 minutes 10 minutes 30 minutes 1 hour 1 hour +

-How often during the day do you lie down because of pain?
Never Seldom Sometimes Often Constantly

-I am NOT able to perform the following activities of daily living (please circle all that apply)

Doing yard work or shopping Performing household chores Going to work
Socializing with friends Participating in recreational activities Exercising

TREATMENTS FOR YOUR SPINE TO DATE: (please circle all that apply)

Physical Therapy Tens Unit Facet Blocks Back Injections
Epidural Steroid Injections Chiropractor Medications Spine Surgery (describe below)

Date of Spine Surgery	Title of Spine Operation	Hospital

PATIENT NAME: _____

PREVIOUS SURGERIES:

PAST MEDICAL HISTORY: (please check all that apply)

- ☐ Arthrits
- ☐ Asthma
- ☐ Bleeding Disorders/Blood
- ☐ Clots
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ GERD
- ☐ GI Disorders
- ☐ Heart Attack
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Neurological Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Other

ALLERGIES: (circle all that apply) **Aspirin Codeine Latex Penicillin Sulfa None Other:** _____

Reaction: _____

CURRENT MEDICATIONS (name, strength and dose):

1._____ **2.**_____ **3.**_____

4._____ **5.**_____ **6.**_____

7._____ **8.**_____ **9.**_____

REVIEW OF SYSTEMS

Have you ever had any of these symptoms? If no, mark NONE **NONE YEAR Details/Comments**

1.	**GI**	☐Heartburn, Ulcers	☐Nausea, Vomiting	☐Blood in Stool		☐	____	_____
2.	**ENDO**	☐Thyroid Disease	☐Heat or Cold Intolerance			☐	____	_____
3.	**EYE**	☐Blurred Vision	☐Double Vision	☐Vision Loss		☐	____	_____
4.	**ENT**	☐Hearing Loss	☐Hoarseness	☐Trouble Swallowing		☐	____	_____
5.	**CV**	☐Chest Pain	☐Palpitations			☐	____	_____
6.	**RS**	☐Chronic Cough	☐Pneumonia	☐Shortness of Breath		☐	____	_____
7.	**GU**	☐Painful Urination	☐Blood in Urine	☐Kidney Problems		☐	____	_____
8.	**SK**	☐Frequent Rashes	☐Skin Ulcers	☐Lumps	☐Psoriasis	☐	____	_____
9.	**NEU**	☐Headaches	☐Dizziness	☐Seizures	☐Numbness	☐	____	_____
10.	**PSY**	☐Depression/Anxiety	☐Drug/Alcohol Addiction		☐Sleep Disorder	☐	____	_____
11.	**HEM**	☐Easy Bleeding	☐Easy Bruising	☐Anemia		☐	____	_____
12.	**CON**	☐Weight Loss	☐Loss of Appetite	☐Fatigue		☐	____	_____

13. Are you HIV Positive? ☐Yes ☐No

Have you ever had Hepatitis A, B, or C? ☐Yes ☐No If yes what type? _____

14. Are you pregnant? ☐Yes ☐No

15. Are you Claustrophobic? ☐Yes ☐No

FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, list your relative

☐Diabetes _____ ☐High Blood Pressure _____ ☐Rheumatoid Arthritis _____

☐Difficulty with anesthesia_____ ☐Bleeding Problems_____ ☐None known

SOCIAL HISTORY (please circle): **Smoking** Qty_____ **Drinking** Qty_____ **Drugs** Type/Qty_____

MARITAL STATUS (please circle): **Single Married Divorced Widow Separated**

EMPLOYMENT STATUS (please circle): **Employed Unemployed Disabled Retired Occupation** _____

Patient Assessment

The physicians at Alexander Orthopaedic Associates are concerned about your orthopaedic health and want to make sure that we are evaluating those factors which may impact your orthopaedic wellbeing. The following questions are intended to give the physicians at Alexander Orthopaedic Associates information about your general health.

Please circle the correct answer or fill in the blanks.

1. What is your height _____ weight _____ Prefer not to answer _____

2. Have you had a Bone Density Study (also known as a Dexa scan) for osteoporosis at least once since age 60?
   Yes _____ No _____
   If yes, in what year did you have the most recent Bone Density Study? _____

3. Have you been on medicine to treat osteoporosis? **Yes _____ No _____**
   If yes, has it been prescribed within 12 months? **Yes _____ No _____**
   What medicine are you taking to treat your osteoporosis? _____

4. Do you take Calcium and Vitamin D? **Yes _____ No _____**

5. Have you ever had a fracture of your arm, hip, or spine? **Yes _____ No _____**

6. Have you fallen more than twice or fallen and hurt yourself in the past year? **Yes _____ No _____**

7. Have you had the influenza vaccination for the current flu season? **Yes _____ No _____**

8. Have you ever had the pneumococcal vaccine? **Yes _____ No _____**

9. Do you have an Advanced Care Plan? **Yes _____ No _____**

10. Have you used or smoked tobacco products in the last 24 months? **Yes _____ No _____**
    If yes, are you a tobacco smoker? **Yes _____ No _____**

11. Do you consume alcoholic beverages? **Yes _____ No _____**
    If yes, how much per setting? _____ Per week? _____

Please understand that smoking and consuming alcoholic beverages can impair your general health as well as your orthopaedic health.

Please understand that smoking can impair your general health as well as your orthopaedic health.

Are you interested in quitting? **Yes _____ No _____**

Print name: _____

Patient signature: _____

Date: _____