NEW SPINE PATIENT

Hartford HealthCare

Name: _____ _____
Last First, MI

Age: _____ Sex: _____ Date of birth: _____ Are you right or left-handed?: ☐ Right ☐ Left

Height _____ Weight _____ Referring physician _____

Reason for Visit: Which part of your body is your main concern today? (Circle ONLY ONE)
Low back Mid/Upper back Neck Legs Arms Other _____

Onset of spine problem:
How long have you had this/these problem(s)? _____Days / Weeks / Months / Years
In general the problem has been: the same / getting better / getting worse
Have your symptoms changed since onset? _____
Have you had prior episodes of this condition? _____
What caused the problem in the first place? a) Automobile-related injury b) work-related injury c) Other
Please explain: _____

Please rate the severity of your pain
If 10 is the worst pain possible and 0 is no pain at all, please mark a "|" on the line below indicating the intensity of your pain over the **last two weeks**:

a) Please rate your **AVERAGE** amount of back/ neck pain:

0 1 2 3 4 5 6 7 8 9 10

b) Please rate your **AVERAGE** amount of leg/ arm pain:

0 1 2 3 4 5 6 7 8 9 10

Pain Diagram:
Draw the exact **location and pattern** of your symptoms on your body where you **now feel** your **typical symptoms.** Include all affected areas. Use the appropriate symbols indicated below.

SYMBOLS:

ACHE
>>>>>>>
>>>>>>>

NUMBNESS
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STABBING PAIN
//////////
//////////

PINS & NEEDLES
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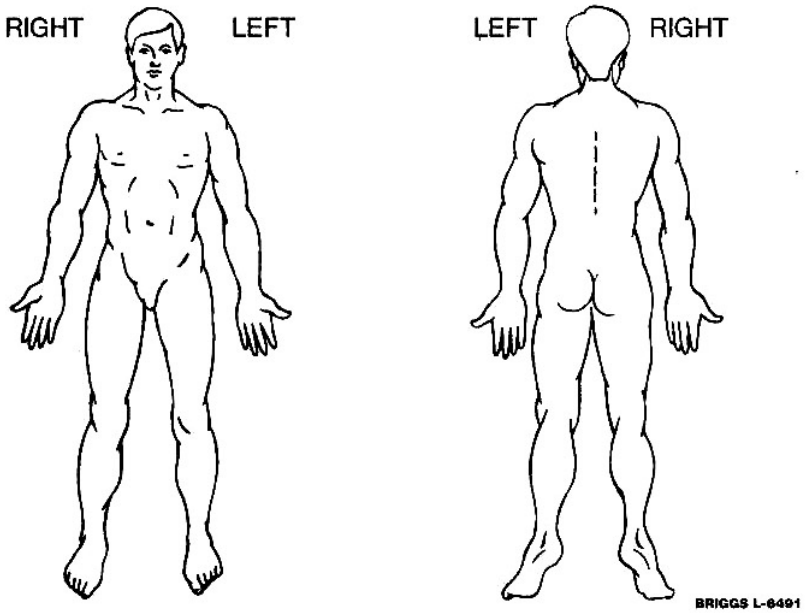

PATIENT SELF HISTORY

What is your occupation:_____

Do you use tobacco?: ☐No ☐Yes. If yes, How?_____ Amount daily:_____

Do you drink alcohol?:☐No ☐Yes. If yes, amount daily:_____ Do you use any other drugs?: ☐No ☐Yes

Notes:_____

_____

Have you ever been told you have cancer or tumors? ☐ Yes ☐ No

Have you ever been told you have soft bones (osteopenia or osteoporosis)? ☐ Yes ☐ No

Are you having difficulty walking? ☐ Yes ☐ No

Are you having difficulty with your hands? ☐ Yes ☐ No Describe: _____

Are you having difficulty using the bathroom? ☐ Yes ☐ No

With urinating/voiding? Describe _____ with bowels? Describe _____

What makes your pain / problem(s) **better**?

☐ standing ☐ sitting ☐ bending (forward / backward / side-to-side)

☐ lying down ☐ heat/ice ☐ stretching / exercising

☐ medications (which ones?) _____ ☐ other _____

What makes your pain / problem(s) **worse**?

☐ standing ☐ sitting ☐ bending (forward / backward / side-to-side)

☐ lying down ☐ heat/ice ☐ stretching / exercising

☐ lifting ☐ twisting ☐ other _____

What time of day is your pain at its best? morning afternoon evening nighttime

What time of day is your pain at its worst? morning afternoon evening nighttime

What medications do you take or have you taken for your pain (problem)? **(Attach medication list if not in EPIC).**

a) medications that have **helped**: _____

b) medications that have **not helped**: _____

Do you have a pain contract with any provider? ☐ Yes ☐ No Who: _____

Which of the following tests have you had for your spine problem?

☐ X-rays (date) _____ ☐ CAT scan (CT) (date) _____ ☐ MRI (date) _____

☐ EMG (date) _____ ☐ other _____

Which of the following treatments have you tried?

☐ physical therapy ☐ chiropractor ☐ spine injections ☐ other _____

Have you ever had a spine surgery in the past? ☐ Yes ☐ No If Yes, Date _____ Surgeon _____

Is anyone else treating you for this condition? ☐ Yes ☐ No If Yes, who? _____

Do you have any of the following problems?

☐ fever ☐ recent infection ☐ blurry vision ☐ double vision ☐ headaches

☐ difficulty swallowing ☐ change in voice ☐ persistent cough ☐ shortness of breath

☐ chest pain ☐ irregular heart beat ☐ nausea ☐ vomiting ☐ bowel incontinence

☐ bladder incontinence ☐ sexual dysfunction ☐ back pain ☐ neck pain ☐ joint pain

☐ skin easily bruises ☐ excessive bleeding ☐ difficulty clotting blood ☐ anxiety ☐ depression

☐ weakness ☐ numbness ☐ tingling ☐ seizure ☐ loss of feeling around the groin, genitals or buttocks

Brief review of medical history

a) Please report any medical history or surgeries not already addressed: _____

_____

b) Allergy history: Do you have an allergy to contrast dye or iodine? ☐ Yes ☐ No Other allergies _____

c) Are you on “blood thinning medications” such as aspirin, Coumadin, warfarin, Plavix, clopidogrel? ☐ Yes ☐ No

Function:

Pain Intensity (Check only one)

- ☐ 0 I can tolerate the pain I have without having to use pain killers
- ☐ 1 The pain is bad but I manage without taking pain killers
- ☐ 2 Pain killers give complete relief from pain
- ☐ 3 Pain killers give moderate relief from pain
- ☐ 4 Pain killers give very little relief from pain
- ☐ 5 Pain killers have no effect on the pain, I do not use them.

Personal Care (Washing, dressing, etc.)
(Check only one)

- ☐ 0 I can look after myself normally without it causing extra pain.
- ☐ 1 I can look after myself normally but it causes extra pain
- ☐ 2 It is painful to look after myself and I am slow and careful
- ☐ 3 I need some help but manage most of my personal care
- ☐ 4 I need help everyday in most aspects of self care
- ☐ 5 I do not get dressed, wash with difficulty and stay in bed

Lifting (Check only one)

- ☐ 0 I can lift heavy weights without extra pain
- ☐ 1 I can lift heavy weights but it gives extra pain
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on the table)
- ☐ 3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ 4 I can lift only very light weights
- ☐ 5 I cannot lift or carry anything at all

Walking (Check only one)

- ☐ 0 Pain does not prevent me from walking any distance
- ☐ 1 Pain prevents me walking more than 1 mile
- ☐ 2 Pain prevents me walking more than ½ mile
- ☐ 3 Pain prevents me walking more than ¼ mile
- ☐ 4 I can only walk using a stick or crutches
- ☐ 5 I am in bed most of the time and have to crawl to the toilet

Sitting (Check only one)

- ☐ 0 I can sit in any chair as long as I like
- ☐ 1 I can only sit in my favorite chair as long as I like
- ☐ 2 Pain prevents me from sitting more than one hour
- ☐ 3 Pain prevents me from sitting more than thirty minutes
- ☐ 4 Pain prevents me from sitting more than ten minutes
- ☐ 5 Pain prevents me from sitting at all

Standing (Check only one)

- ☐ 0 I can stand as long as I want without extra pain
- ☐ 1 I can stand as long as I want but it gives extra pain
- ☐ 2 Pain prevents me from standing more than one hour
- ☐ 3 Pain prevents me from standing more than thirty minutes
- ☐ 4 Pain prevents me from standing more than ten minutes
- ☐ 5 Pain prevents me from standing at all

Sleeping (Check only one)

- ☐ 0 Pain does not prevent me from sleeping well
- ☐ 1 I can sleep well only by using tablets
- ☐ 2 Even when I take tablets I have less than six hours sleep
- ☐ 3 Even when I take tablets I have less than four hours sleep
- ☐ 4 Even when I take tablets I have less than two hours sleep
- ☐ 5 Pain prevents me from sleeping at all

Employment/Homemaking (Check only one)

- ☐ 0 My normal homemaking/job activities do not cause pain
- ☐ 1 My normal homemaking/job activities increase my pain, but I can still perform all that is required of me
- ☐ 2 I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ 3 Pain prevents me from doing anything but light duties
- ☐ 4 Pain prevents me from doing even light duties
- ☐ 5 Pain prevents me from performing any job or homemaking chores

Social Life (Check only one)

- ☐ 0 My social life is normal and gives me no extra pain
- ☐ 1 My social life is normal but increases the degree of pain
- ☐ 2 Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
- ☐ 3 Pain has restricted my social life and I do not go out as often
- ☐ 4 Pain has restricted my social life to home
- ☐ 5 I have no social life because of pain

Traveling (Check only one)

- ☐ 0 I can travel anywhere without extra pain
- ☐ 1 I can travel anywhere but it gives extra pain
- ☐ 2 Pain is bad but I manage journeys over two hours
- ☐ 3 Pain restricts me to journeys less than one hour
- ☐ 4 Pain restricts me to short journeys under thirty minutes
- ☐ 5 Pain prevents me from traveling except to the doctor or hospital

SCORE_____

Patient Signature:_____ Date _____

Physician's Signature:_____Provider #: _____ Date: _____ Time: _____

Additional Notes:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems?
(Use ✓ to indicate your answer.)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

For Office Coding 0 + _____ + _____ + _____

= Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient Signature: _____ Date: _____

PATIENT SELF HISTORY

Notes:_____

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