CENTRAL TEXAS BRAIN & SPINE

# HISTORY OF PRESENT ILLNESS (SPINE)

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| Name: | Age: / Sex: M F | Height/Weight: | Right or Left Handed?: |
|---|---|---|---|
| Referring Physician: | Primary Care Physician (if different): | | Preferred Pharmacy: |

Reason for visit:

Please use the pen tool to mark the areas on your body where you typically feel the sensations described below.

Please draw the appropriate symbol to indicate all affected areas.

**ACHE** Λ Λ Λ Λ Λ Λ

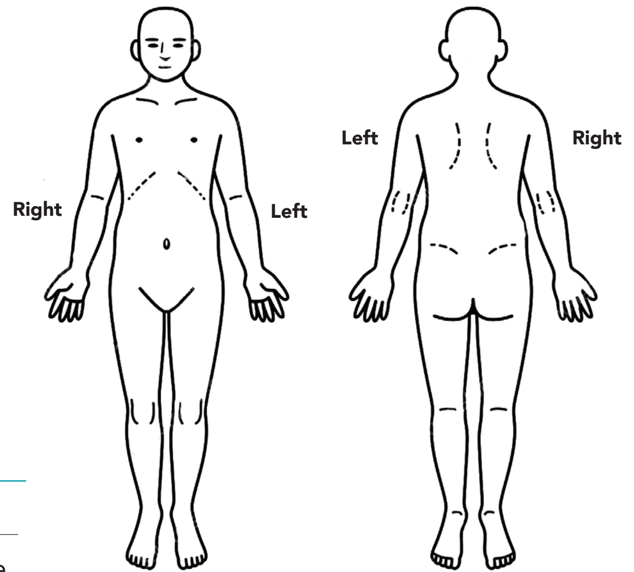
**PINS & NEEDLES** - - - - - - - - - -

**NUMBNESS** oooooooooo

**BURNING** XXXXXXXX

**STABBING** /////////////

Or you may type in the area below to describe your symptomatic areas.



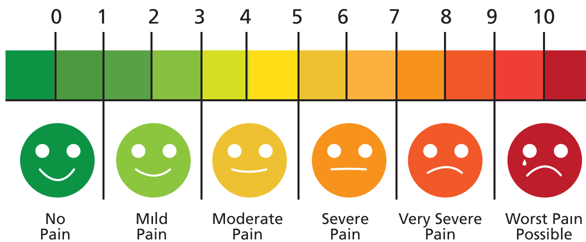

When did your symptoms begin? ____________________

Have your symptoms: ❑ Improved ❑ Worsened ❑ Stayed Same

Are you experiencing: ❑ Weakness of arms or legs ❑ Difficulty walking ❑ Difficulty controlling your fingers

Based on the chart below,
what is your pain level at its worst? ________

What is your pain level at its best? ________




Which activities **worsen** your pain?
❑ Sitting ❑ Standing ❑ Walking
❑ Bending ❑ Reaching ❑ Lying Down
❑ Other

**FOR NECK/ARM PAIN:**
what percentage is in your neck?
what percentage is in your arms?
________ % Neck Pain *(i.e. 60%)*
\+ ________ % Arm Pain (i.e. 40%)
**=100%**

Which activities **improve** your pain?
❑ Sitting ❑ Standing ❑ Walking
❑ Bending ❑ Reaching ❑ Lying Down
❑ Other

**FOR BACK/LEG PAIN:**
what percentage is in your back?
what percentage is in your legs?
________ % Back Pain *(i.e. 60%)*
\+ ________ % Leg Pain (i.e. 40%)
**=100%**

Did your symptoms begin after an accident or injury? If yes, please explain:

Have you received treatment for your condition in the past? *(steroid injections, physical therapy, chiropractic care, etc.)*

Please list all treatments and physicians:

Name: ______________________________ DOB: ______________

**Medical History** *(Please list all existing medical conditions or any condition requiring medication)*:

**Surgical History** *(Please list all previous surgeries)*:

**Medications** *(Please list all medications and their dosage if taken regularly)*:

**Allergies** *(Please list all medication allergies)*:

**Family Medical History** *(Please list all illnesses diagnosed in family members):*

**Social History** *(Please answer questions below)*:

Are you currently employed? ❑ Yes ❑ No What is your occupation? ______________

Are you married? ❑ Yes ❑ No Children? ❑ Yes ❑ No List ages: ______________

Do you smoke? ❑ Yes ❑ No If so, how much/often? __________ # of years? __________

Do you use illicit drugs? ❑ Yes ❑ No If so, how much/often? __________ # of years? __________

Do you drink alcohol? ❑ Yes ❑ No If so, how much/often? __________ # of years? __________

**Worker's Comp Detail** *(Please answer questions below)*:

Is this a work related injury? ❑ Yes ❑ No

Is there an attorney or lawsuit involved? ❑ Yes ❑ No

**Other Health Complaints:**

- ❑ Runny nose
- ❑ Sore throat
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Palpitations
- ❑ Chronic or frequent coughs
- ❑ Wheezing
- ❑ Nausea
- ❑ Abdominal pain
- ❑ Vomiting
- ❑ Black/tarry stools
- ❑ Diarrhea
- ❑ Urinary loss control
- ❑ Difficulty starting/ending stream
- ❑ Increase urinary frequency
- ❑ Urinary irregularity
- ❑ Urinary urgency
- ❑ Joint swelling
- ❑ Joint stiffness/Pain
- ❑ Bruising
- ❑ Tingling in limbs
- ❑ Paralysis
- ❑ Loss of consciousness
- ❑ Seizures
- ❑ Depression
- ❑ Anxiety
- ❑ Excessive thirst
- ❑ Night sweats
- ❑ Swollen glands
- ❑ Fever
- ❑ Chills
- ❑ Change in sleeping habits
- ❑ Weight change
- ❑ Unusual stress
- ❑ Other symptoms not mentioned above:

**FOR PHYSICIAN USE ONLY:**

I have read and reviewed the patient's health history ______________________ / Date ______________________