The Spine and Orthopedic Center

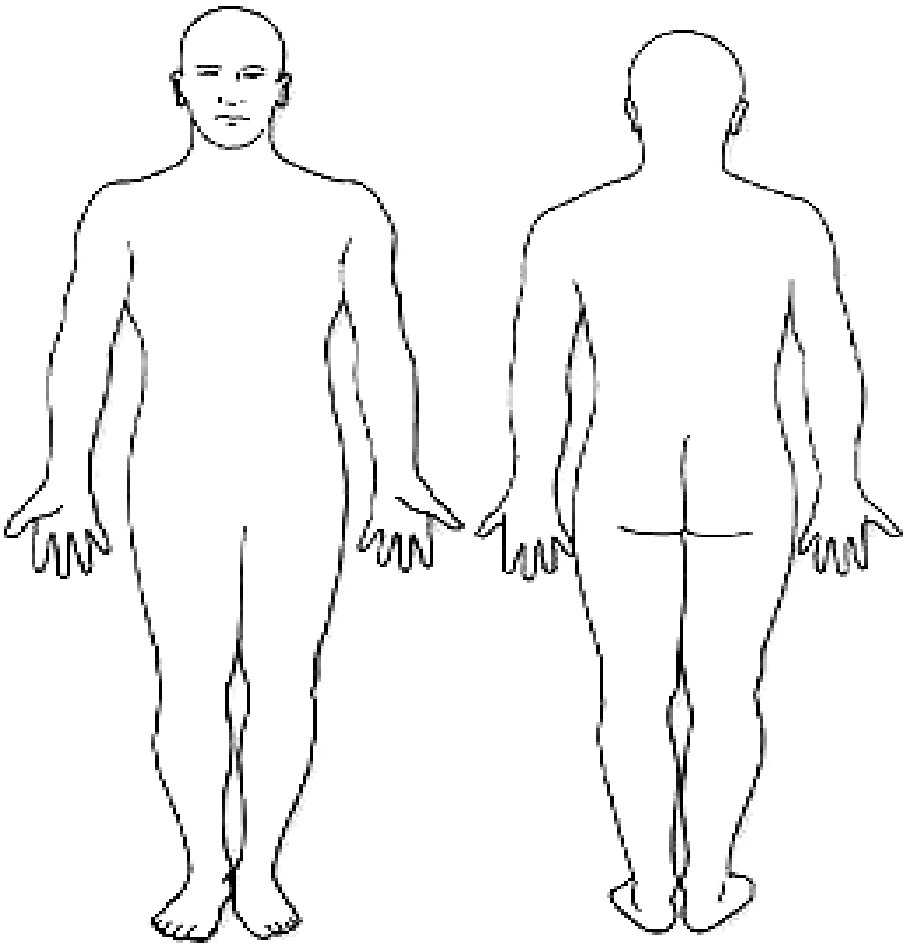
COMPREHENSIVE INTERVAL HISTORY FORM

PATIENT_____DOB _____Today's Date_____
Last Name, First Name

Mark these drawings using the symbols that best describe your pain:

Numbness	= = = = = = =	Aching	^ ^ ^ ^ ^ ^	Pins and needles	o o o o o o
Stabbing	/ / / / / / / / / / / /	Burning	x x x x x x	Cramping	●●●●●●●

FRONT **BACK**



Describe any symptom changes since your last visit:

_____

_____

_____

What is the reason for your follow-up visit?

_____

_____

_____

Circle the number that best describes your current Pain with "10" being the most severe.

Back/Leg 0 1 2 3 4 5 6 7 8 9 10
Neck/Arm 0 1 2 3 4 5 6 7 8 9 10

Circle what percent better or worse:
0 10 20 30 40 50 60 70 80 90 100%

Are you working? Yes / No

Full Duty _____ Modified Duty_____

When did you last work? _____

How long/far can you:

Sit_____Stand_____Walk_____

Are you affected by lack of sleep? Yes / No

If so, how many hours do you sleep? _____

How does the lack of sleep affect you? _____

If you are using topical creams or lotions, please answer the questions in this box:

Which topical cream(s) or lotion(s) are you using – please list:

_____

_____

Does the topical cream or lotion help to decrease your pain level? Yes / No

Does this help you to sleep better? Yes / No

Does this allow you to take fewer oral medications (pills)? Yes / No

Does this help your level of function (ability to do more things)? Yes / No

Additional comments on how the cream helps you:

_____

_____

_____

_____

_____

Please list any medications you are currently getting from The Spine and Orthopedic Center:

Medication #1:

Name: _____ Dose: _____ Frequency: _____

How does this medication help your pain? _____

_____

If I take this medication, my pain level is _____ on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is ___ on a scale from 0 to 10, with 0 being less pain and 10 being more pain.

This medication helps me NOT AT ALL / A LITTLE / MODERATELY / A LOT / TREMENDOUSLY *(circle one)*

How does this medication help you with function? Please list all ways that this Medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.:

_____

_____

Please list any side effects you experience from this medication: _____

_____

Medication #2:

Name: _____ Dose: _____ Frequency: _____

How does this medication help your pain? _____

_____

If I take this medication, my pain level is _____ on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is ___ on a scale from 0 to 10, with 0 being less pain and 10 being more pain.

This medication helps me NOT AT ALL / A LITTLE / MODERATELY / A LOT / TREMENDOUSLY *(circle one)*

How does this medication help you with function? Please list all ways that this Medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.:

Please list any side effects you experience from this medication:

Do you have stomach pain? Yes / No

Have you had any nausea or vomiting since your last visit? Yes / No
If yes, what is the cause? Please explain:

Have you had any recent weight loss, fever, chills, or night sweats? Yes / No

Do you have any problems with your bowels/bladder? Yes / No
If yes, please explain:

Circle all that apply since your last visit:

None apply | Frequency Diarrhea | Seizures | Frequent Constipation

Frequent Headaches | Swollen ankles or legs | Bleeding w/ Bowel Movement

Thoughts of hurting myself or others | Other:

Are you receiving physical therapy or chiropractic treatment? Yes / No

If so where: How many days per week:

What physical therapy or chiropractic treatments are you receiving?

Have you had any acupuncture since your last visit? Yes / No

Are you using any aids, such as : corset / cane / walker / body jacket / collar (circle)

Have you had any medical tests since your last visit such as x-rays, MRI, blood tests, etc.? Yes / No
What and Where?

Have you seen any other doctors since your last visit? Yes / No

What has been changed or treated? _____

Have you been treated at a hospital since your last visit? Yes / No

Please explain: _____

Have you had any spinal injections since your last visit? Yes / No

If yes, are you: Better □ Worse □ Same □

Any additional comments: _____

_____

_____