



On behalf of the Community Spine Center team, we would like to welcome you. At the Community Spine Center we strive to give our patients exceptional, state-of-the-art care. Although we have received the national recognition for excellence from the National Committee of Quality Assurance, we are only as good as the treatment we provide to our current and future patients such as you.

We will try to make your treatment as helpful as possible, but we will need your active participation. As part of our assessment of your progress we will need you to complete paperwork at each visit with the doctor. This reassessment is crucial for us and gives us the tools we need to help you more; it is also a requirement to continue to be recognized as a national leader in spine care.

We strive to continue a high level of evidence-based care and excellence in the treatment of neck and back pain. Patient input is extremely valuable, so we look forward to open and direct communication with you.

If you have any questions after reviewing this, please do not hesitate to call our office. We ask that you bring the enclosed folder with you to your appointments so you have a place to store additional information we may provide to you during your care with us. Please complete the enclosed paperwork and bring it with you to your appointment. This information, filled out in advance, assists us in focusing your first visit to be as productive as possible.

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Please visit our website at www.eCommunity.com/spine for more information.

Recognition for superior care





Please list any known ALLERGIES and your REACTION:

Please list any medications you are currently taking:

Medication Name	Dosage

Please provide name and major cross streets of your preferred pharmacy:

Patient Surgical History – Please circle all that apply:

- Appendix
 - Breast Biopsy
 - Fracture Repair
 - Gallbladder
 - Joint Arthroscopy
 - Other surgeries not listed above: _____
- Open Heart Surgery
 - Neck Surgery
 - Back Surgery
 - Joint Replacement
-

Patient Medical History – Please circle all that apply:

Anxiety/Depression	High blood pressure
Asthma	HIV
Bladder infections	Irritable bowel
Bleeding disorder	Kidney disease
Blood clots	Lung disease
Cancer	Lupus
Chronic fatigue syndrome	Mitral valve prolapse
Degenerative muscle/nerve disease	Multiple sclerosis
Diabetes	Pacemaker
Dialysis	Polio
Diverticulosis	Psychological problems
Fibromyalgia	Reflux
Glaucoma	Rheumatoid arthritis
Gout	Seizures
Heart attack	Sexually transmitted disease
Heart disease	Sleep Apnea
Hemophilia	Stomach ulcers
Hepatitis C	Stroke
Hiatal hernia	Thyroid trouble
TIA	

Other medical history not listed above: _____

Family Medical History – Please mark all that apply:

- | | |
|--------------------------------------|--------------------------|
| Family History Unknown | High blood pressure |
| Alcoholism | High cholesterol |
| Anemia | Kidney/Bladder disease |
| Anesthetic problems | Lung/Respiratory disease |
| Arthritis | Migraines |
| Asthma | Osteoporosis |
| Bleeding disease | Seizures/Convulsions |
| Breast cancer | Severe Allergy/Hives |
| Colon/Rectal cancer | Stroke/CVA of the brain |
| Depression | Thyroid problems |
| Diabetes | Other Cancer |
| Heart disease | |
| Other family medical history : _____ | |

Patient Social History – Please indicate as appropriate:

ALCOHOL USE:

Drinks/Week

	Glasses of wine
	Cans of beer
	Shots of liquor

Tobacco Use :

Current Smoker
 Packs Per Day _____ How long have you smoked? _____

Former Smoker
 Packs Per Day _____ How long did you smoke _____ Year Quit _____

Passive Smoker Yes NO

Never Smoker Yes

1) Please list any other physicians you've seen for this problem:

NAME	SPECIALTY	YEAR SEEN

****Please circle all that apply****

2) Have you had physical therapy in the past for this problem? *YES *NO

3) If yes, what type of physical therapy interventions:

- *stretches *strengthening *ultra sound *cervical traction
 *lumbar traction *home exercise *McKenzie *other_____

4) What would you like to do that you cannot currently do because of your symptoms?

5) Tests or procedures I've had for this problem:

- *none *x-rays *MRI *CAT Scan *myelogram *bone scan
 *discogram *EMG *other_____

Assessment of your pain

1) Date my current episode of pain began: _____

2) Pain onset for my current episode: (Please only select ONE choice)

*awakened from sleep *gradual *on-going *progressive *sudden *unable to tell

3) Describe your pain: (Please circle all that apply)

*aching *burning *constant *cramping *crushing *discomfort *dull *headache

*heaviness *itching *jabbing *nagging *numbness *penetrating

*pins and needles *pounding *pressure *radiating *sharp *shooting *sore

*spasm *squeezing *stabbing *tender *throbbing *tightness

4) How often do you experience pain: (Please circle only ONE choice)

*continuous *rarely *once a week *several days a week *intermittent

*constant/continuous *other _____

5) My pain is worse with: (Please circle all that apply)

*sneeze/cough *bending *lifting *walking *sitting *standing *stretching

*riding in car *straightening *kneeling *squatting *lying down *exercise

*morning *daytime *evening *nighttime *other _____

6) Is your pain a result of an injury? *YES *NO

If yes, please explain _____

7) Is your pain from a work related injury? *YES *NO

Please circle all that apply:

CONSTITUTIONAL	EYES	GASTROINTESTINAL	ENDO/HEME
Fever	Blurred vision	Heartburn	Easy bruise/bleed
Chills	Double vision	Nausea	Allergies
Weight loss	Light sensitivity	Vomiting	NEUROLOGICAL
Fatigue	Eye pain	Abdominal pain	Dizziness
Sweats	Eye discharge	Diarrhea	Tingling
Weakness	Eye redness	Constipation	Tremor
SKIN	CARDIOVASCULAR	Blood in stool	Sensory change
Rash	Chest pain	GENITOURINARY	Speech change
Itching	Palpitations	Painful urination	Focal weakness
HENT	Pain in legs while walking	Bladder urgency	Seizures
Headaches	Leg swelling	Urinating more often	Loss of consciousness
Hearing loss	RESPIRATORY	Blood in urine	PSYCHIATRIC
Ringling in ears	Cough	Flank pain	Depression
Nosebleeds	Coughing up blood	MUSCULOSKELETAL	Suicidal ideas
Congestion	Shortness of breath	Muscle pain	Substance abuse
Sore throat	Wheezing	Neck pain	Hallucinations
		Back pain	Nervous/Anxious
		Joint pain	Insomnia
		Falls	Memory loss

Neck Pain Disability Index Questionnaire

Name: _____

Date: _____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check ONLY ONE answer in each section that best describes your current problem.

Section 1-- PAIN INTENSITY

0. The pain is tolerable without using any medication.
1. The pain is bad, but I can manage without having to take pain medication.
2. Pain medication provides me with complete relief from pain.
3. Pain medication provides me with moderate relief from the pain.
4. Pain medication provides me with very little relief from the pain.
5. Pain medication has no effect on my pain.

Section 2-- PERSONAL CARE

0. I can take care of myself without causing increased pain.
1. I can take care of myself but it does increase the pain.
2. It is painful to take care of myself, and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I can not get dressed, wash with difficulty and stay in bed.

Section 3-- LIFTING

0. I can lift heavy weights without pain.
1. I can lift heavy weights but it causes pain.
2. Pain prevents me from lifting anything heavy off the floor, but if they are conveniently positioned, I can manage.
3. Pain prevents me from lifting anything heavy, but I can still manage medium weights if they are conveniently positioned.
4. I can only lift light weights.
5. I cannot lift or carry anything at all.

Section 4--READING

0. I can read as much as I want to without any pain in my neck.
1. I can read as much as I want to with slight pain in my neck.
2. I can read as much as I want to with moderate pain in my neck.
3. I can't read as much as I want because of the moderate pain in my neck.
4. I can't read as much as I want because of the severe pain in my neck.
5. I can't read at all due to my neck pain.

Section 5--HEADACHES

0. I do not have any headaches.
1. I have slight headaches which are infrequent.
2. I have moderate headaches which are infrequent.
3. I have frequent headaches which are moderate in pain.
4. I have frequent headaches which are severe.
5. I have headaches all the time.

Section 6--CONCENTRATION

0. I have no difficulty concentrating fully when I want to.
1. I have slight difficulty in concentrating fully when I want to.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. It is almost impossible for me to concentrate when I want to.
5. I can not concentrate at all.

Section 7--SLEEPING

0. I have no trouble sleeping and have no pain.
1. I can sleep well only by using pain medication.
2. My sleep is slightly disturbed (<1 hr sleepless).
3. My sleep is moderately disturbed (2 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. Pain prevents me from sleeping at all.

Section 8-- SOCIAL LIFE

0. Pain has no effect on my social life.
1. My social life is normal, but increases the degree of my pain.
2. Pain has limited me from my more energetic interests (e.g., dancing, etc.)
3. Pain prevents me from going out very often.
4. Pain has restricted my social life to my home.
5. I have no social life due to my pain.

Section 9--DRIVING

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I can **NOT** drive my car as long as I want because of the pain in my neck.
4. I can hardly drive at all due to the severe pain in my neck.
5. I cannot drive at all.

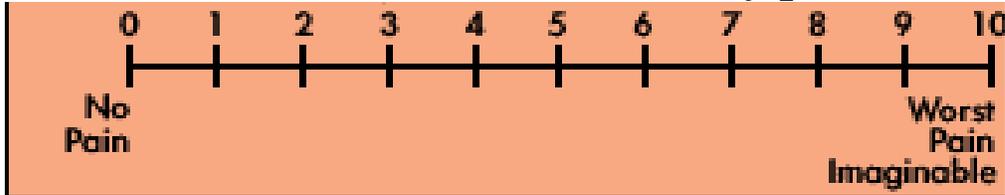
Section 10-- CHANGING DEGREE OF PAIN

0. My pain is rapidly getting better.
1. My pain fluctuates, but overall is definitely getting better.
2. My pain seems to be getting better, but improvement is slow at the present time.
3. My pain is stable (no better, no worse).
4. My pain is gradually getting worse.
5. My pain is rapidly getting worse.

Name: _____

Date: _____

1. Most of the time I would rate my pain as:



2.

Please shade in where your pain is located, and place 'x' marks over areas of numbness.

