PATIENT HISTORY FORM

Brain & Spine Specialists
Neurological Associates, Inc.

MRN:_____ APPT DATE:_____

Patient's Name: _____ Age: _____ Date: _____ Page 1

Is this a Workers Compensation injury/Illness? _____Yes _____ No if yes, please complete the following:

CLAIM NUMBER: _____ DATE OF INJURY/ILLNESS: ____/_____/_____

CLAIMS MANAGER: _____ EMPLOYER/JOB TITLE: _____

Did a Motor Vehicle Accident cause your injuries? _____Yes _____No Date of Accident: _____/_____/_____

1. Chief Complaint: (reason for visit): _____

2. Referring Physician: _____ Address: _____Phone: _____

3. Family Physician: _____ Address: _____Phone: _____

4. History of Present Illness
History From: Patient Name and Relationship to patient, if other than patient: _____

5. Do you have pain? ☐Yes ☐ No If you have no symptoms of pain please go to question #6.

Where is the one place it hurts the most? _____

Does the pain radiate to other parts of your body? Where?_____
What kind of pain do you have? ☐ aching ☐ stabbing ☐ throbbing ☐ sharp ☐ dull ☐ burning ☐ constant ☐ comes and goes

On a scale of 1-10 (1=mild, 10=intense) describe your pain: 1 2 3 4 5 6 7 8 9 10 (circle the number that applies)
How long have you had these symptoms? _____

How did the symptoms start? or What brought the symptoms on? _____
What makes the symptoms worse? _____Better?_____

Do you have numbness? tingling? Where? _____
Do you have any weakness? Where? _____

***What medications and/or treatments have you tried to help relieve your symptoms?

Medication(s) (Prescription and/or over the counter)	Did it help?	How long have you been taking this medication?
_____	☐ yes ☐no ☐ some	Start date: _____Stop date:_____/or☐Still taking
_____	☐ yes ☐ no ☐ some	Start date: _____Stop date:_____/or☐Still taking
_____	☐ yes ☐ no ☐ some	Start date: _____Stop date:_____/or☐Still taking
Physical Therapy-☐Yes ☐No Facility name: _____	Did it help? ☐ yes ☐ no ☐ some	How long have you been going to physical therapy? Start date: _____Stop date:_____/or☐Still going
Chiropractor-☐Yes ☐No Dr. name: _____	Did it help? ☐ yes ☐ no ☐ some	How long have you been going to a chiropractor? Start date: _____Stop date:_____/or☐Still going
Pain Clinic-☐Yes ☐No Facility/Dr.: _____	Did it help? ☐ yes ☐ no ☐ some	How long have you been going to pain clinic? Start date: _____Stop date:_____/or☐Still going
Did you have any spine injections? ☐ Yes ☐No	Did it help? ☐ yes ☐ no ☐ some	How many injections did you have? _____ Date(s) of injections_____
Rest and adjusting your activity ☐ Yes ☐No	Did it help? ☐ yes ☐ no ☐ some	How long have you tried decreasing your lifting and other strenuous activities?_____
Have you fallen within the last year? ☐ Yes ☐No	Did the fall result in significant injury? ☐ yes ☐ no	Type of injury sustained? _____ Date(s) of fall(s):_____

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Patient's Name: _____ Age: _____ Date: _____ Page 2

6. Diagnostic Studies:

CT Scan **Type/Date of films: _____ Place of testing: _____**

MRI **Type/Date of films: _____ Place of testing: _____**

X-Ray **Type/Date of films: _____ Place of testing: _____**

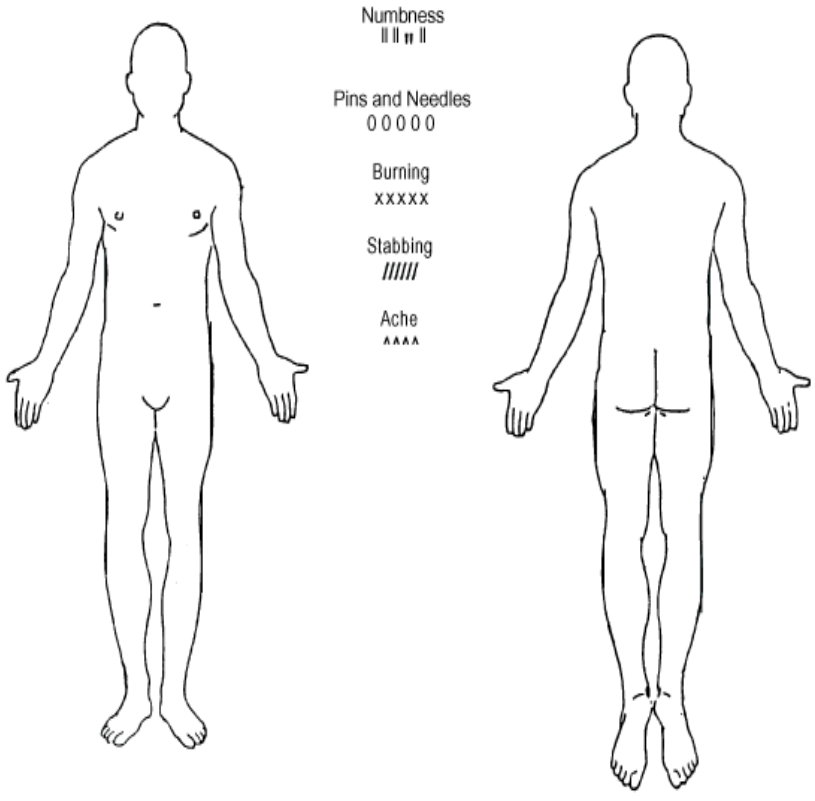
EEG **Type/Date of films: _____ Place of testing: _____**

EMG **Type/Date of films: _____ Place of testing: _____**

15. Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

/// stabbing	xxx burning	ooo pins and needles	+++ aching	=== numbness	… other

DRAW IN YOUR FACE



Do you get pain at the top of your tailbone/top of head?
O Yes O No

Does your whole leg/arms ever become painful?
O Yes O No

Does your whole leg/arms ever become numb?
O Yes O No

Does your leg/arms ever give way?
O Yes O No

In the past year have you had any spells with very little pain?
O Yes O No

Have you had any intolerance/reaction to your treatment?
O Yes O No

Have you had an emergency room visit with back/neck trouble since it started?
O Yes O No

The information on this form provided by the patient and or family members was personally reviewed and or amended by me.

Reviewed by: _____ Date: _____

Patient's Name: _____ **Age:** _____ **Date:** _____ **Page 3**

7. Past Medical History Circle only the items that apply.
Anesthesia Complications (please describe)
Anxiety Disorder
Bleeding Disorder
Cancer (where?)
Carpal Tunnel (left or right)
Cervical Neck Pain
Mid Thoracic Back Pain
Low Lumbar Back Pain
Diabetes
Depression
Gastric Reflux Disease (GERD)
Gastric Ulcers
Heart Arrhythmia
Heart Attack
Heart Disease
Hepatitis
High Cholesterol
High Blood Pressure
Kidney Disease
Liver Disease
Lung Disease
Migraine Headaches
Osteoarthritis
Rheumatoid Arthritis
Thyroid Disease
Scoliosis
Seizure
Sleep Apnea
Stroke
Please list others not listed above:

8. Prior Surgical History Please circle all that apply and provide the date of the surgery and the Dr. who performed the surgery.
Appendectomy
Breast Surgery
Carotid Artery Surgery
Carpal Tunnel Surgery (left or right)
Caesarian Section Surgery
Cataract Surgery
Colon Surgery
Cranial (brain) Surgery
D&C
FLU SHOT (Date :_____) or PNA SHOT (Date :_____)
Gallbladder Surgery
Heart Bypass Surgery
Heart/Cardiac Catheterization
Heart Stents
Hemorrhoidectomy
Hip Replacement Surgery (left or right)
Hysterectomy
Knee Surgery (left or right)
Low Back Surgery
Neck Surgery
Pacemaker
Shoulder Surgery (left or right)
Thyroid Surgery
Tubal Ligation
Tonsillectomy
Hernia repair
Please list other surgery not listed above:

9. Family History– Please answer each item. If you do not know any family members with the illness, leave all boxes unchecked.

Cancer
O Father
O Mother
O Brother
O Sister
O Child
__Son or __Daughter
O Grandparent

High Blood Pressure
O Father
O Mother
O Brother
O Sister
O Child
__Son or __Daughter
O Grandparent

Stroke
O Father
O Mother
O Brother
O Sister
O Child
__Son or __Daughter
O Grandparent

Diabetes
O Father
O Mother
O Brother
O Sister
O Child
__Son or __Daughter
O Grandparent

Spine Problems
O Father
O Mother
O Brother
O Sister
O Child
__Son or __Daughter
O Grandparent

Heart Disease
O Father
O Mother
O Brother
O Sister
O Child
__Son or __Daughter
O Grandparent

Psychiatric
O Father
O Mother
O Brother
O Sister
O Child
__Son or __Daughter
O Grandparent

Aneurysm
O Father
O Mother
O Brother
O Sister
O Child
__Son or __Daughter
O Grandparent

10. Social History– Please answer all that apply

Marital Status: O married O divorced O single O separated O widowed

Employment Status: O employed _____

O unemployed since _____ O disabled since _____ O retired since/type of work? _____

O occupation_____

Tobacco Use: O Never has used Tobacco O Currently is a smoker O Currently uses smokeless tobacco
O Uses Tobacco Occasionally O Currently smokes cigars O Was a previous smoker and quit in _____

Alcohol Use: O Does not consume alcohol O Consumes alcohol socially O Consumes alcohol daily

Illegal Drug Use: O Does not use drugs O Uses the following: O marijuana O cocaine O heroin O amphetamines
O barbiturates O other: _____

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11. **Current Medications**– List all medications you are currently taking, along with the dosages and how often you take the med. Include all prescriptions, over the counter meds, herbal supplements and vitamins.

Medication	**Dose**	**How many per day?**

12. **Allergies**– List all allergies to medication you have.

Please describe what type of reaction you have (hives, rash, upset stomach, etc).

Do you have any food allergies? Please List

Are you allergic to:
Tape?

Latex?

X-ray Dyes?

Other?

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13. Vitals: Height: _____ Weight: _____ BP: _____/_____ Pulse Rate: _____

14. Review of Systems– Please mark all that apply for recent symptoms, if none please leave blank.

General:
- O fever
- O chills
- O appetite loss
- O weight loss
- O fatigue

Head:
- O history of head trauma
- O frequent headaches
- O visual changes
- O decreased facial sensation
- O loss of muscle control to the face

Eyes:
- O vision loss in 1 eye
- O vision loss in both eyes
- O double vision
- O blurred vision
- O use of contacts
- O use of glasses

Gastrointestinal:
- O indigestion
- O constipation
- O incontinence of stool
- O blood present in stool

Urinary:
- O increased frequency
- O hesitancy
- O urinary incontinence
- O blood present in urine
- O history of kidney stones

Neurological:
- O loss of sensation
- O numbness
- O tingling
- O tremors
- O weakness
- O fainting
- O confusion
- O seizures

Musculoskeletal:
- O weakness
- O joint pain
- O decreased range of motion
- O history of arthritis
- O fracture

ENT:
- O recent loss of hearing
- O feelings of imbalance
- O frequent nose bleeds
- O persistent clear nasal drainage
- O loss of smell
- O difficulty swallowing
- O change in taste

Respiratory:
- O shortness of breath
- O coughing up blood
- O emphysema
- O tuberculosis

Cardiovascular:
- O chest pain
- O heart murmur
- O swelling in the arms
- O swelling in the legs

Endocrine:
- O thyroid problems
- O history of diabetes
- O excessive thirst

Hematological:
- O history of anemia
- O easy bruising
- O history of blood transfusion

Psychiatric:
- O mood swings
- O feelings of depression

Skin:
- O rash
- O itching
- O dryness
- O suspicious lesion

Allergic/Immunologic:
- O hay fever
- O persistent infections