Anchorage Fracture & Orthopedic Clinic
The Strength of Experience

New Spine History Form

PATIENT NAME: ______________________ DATE: ______________
BIRTH DATE: _____/_____/_____ HEIGHT: ____ FT. ____ IN. WEIGHT: ______________

A. 1. Requesting doctor's full name and address: ______________________
If not referred, how did you choose this office? ______________________
2. Internist or family doctor's full name and address: ______________________

3. Chief complaint (check all that apply): ☐ neck pain arm: ☐ pain ☐ numbness ☐ weakness
☐ back pain leg: ☐ pain ☐ numbness ☐ weakness Other: ______________
4. Your age: _____ Years _____ Months
5. Your sex: ☐ Male ☐ Female
6. How long has the pain (or your problem) been present? ______________________
7. Has your problem worsened recently? ☐ No ☐ Yes How recently? ______________
8. What started the pain (or problem)? ______________________

B. For patients with NECK OR ARM pain, numbness, or weakness:
(If you are seeing the doctor for back or leg pain, go to **"C"**)

1. What % of your pain is neck pain and what % is arm pain? (check appropriate box)
☐ neck 0%, arm 100% ☐ neck 10%, arm 90% ☐ neck 25%, arm 75% ☐ neck 40%, arm 60%
☐ neck 50%, arm 50% ☐ neck 60%, arm 40% ☐ neck 75%, arm 25% ☐ neck 90%, arm 10%
☐ neck 100%, arm 0%

2. There is: ☐ no arm pain ☐ arm pain is as follows (check the appropriate box):
a. ☐ right 0%, left 100% ☐ right 10%, left 90% ☐ right 25%, left 75% ☐ right 40%, left 60%
☐ right 50%, left 50% ☐ right 60%, left 40% ☐ right 75%, left 25% ☐ right 90%, left 10%
☐ right 100%, left 0%
b. The arm pain is present in (check appropriate box):
Right: ☐ upper back ☐ shoulder ☐ upper arm ☐ forearm ☐ hand/finger
Left: ☐ upper back ☐ shoulder ☐ upper arm ☐ forearm ☐ hand/finger

3. Raising the arm: ☐ improves the pain ☐ worsens the pain ☐ does not affect the pain

4. Moving the neck: ☐ improves the pain ☐ worsens the pain ☐ does not affect the pain

5. There is: ☐ no weakness of the arms and hands ☐ weakness of the (check appropriate box):
Right: ☐ shoulder ☐ upper arm ☐ forearm ☐ hand/finger
Left: ☐ shoulder ☐ upper arm ☐ forearm ☐ hand/finger

6. There is: ☐ no numbness of the arms and hands ☐ numbness of the (check appropriate box):
Right: ☐ upper arm ☐ forearm ☐ thumb ☐ index finger ☐ long finger ☐ ring finger ☐ small finger
Left: ☐ upper arm ☐ forearm ☐ thumb ☐ index finger ☐ long finger ☐ ring finger ☐ small finger

7. There ☐ is / ☐ is no difficulty picking up small objects like coins or buttoning buttons.

8. There ☐ is / ☐ is no problem with balance or tripping frequently.

9. There are ☐ frequent ☐ occasional ☐ no headaches in the back of the head.

END OF NECK QUESTIONS—PLEASE GO TO "D"

C. For patients with BACK OR LEG PAIN, numbness, or weakness.
(If you are seeing the doctor for neck problems, please complete section **"B"**)

1. What % of your pain is back pain and what % is leg or buttock pain? (check appropriate box):
☐ back 0%, leg 100% ☐ back 10%, leg 90% ☐ back 25%, leg 75% ☐ back 40%, leg 60%
☐ back 50%, leg 50% ☐ back 60%, leg 40% ☐ back 75%, leg 25% ☐ back 90%, leg 10%
☐ back 100%, leg 0%

2. There is ☐ no leg pain ☐ leg pain as follows (check appropriate box):
a. ☐ right 0%, left 100% ☐ right 10%, left 90% ☐ right 25%, left 75% ☐ right 60%, left 40%
☐ right 50%, left 50% ☐ right 60%, left 40% ☐ right 75%, left 25% ☐ right 90%, left 10%
☐ right 100%, left 0%
b. The pain is present in (check appropriate box):
Right: ☐ buttock ☐ front thigh ☐ back thigh ☐ calf ☐ foot
Left: ☐ buttock ☐ front thigh ☐ back thigh ☐ calf ☐ foot

3. There is: ☐ no weakness of the legs ☐ weakness of (check appropriate box):
Right: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ big toe
Left: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ big toe

4. There is: ☐ no numbness of the legs ☐ numbness of (check appropriate box):
Right: ☐ thigh ☐ calf ☐ foot
Left: ☐ thigh ☐ calf ☐ foot

5. The worst position for the pain is: ☐ sitting ☐ standing ☐ walking

6. How many minutes can you stand in one place without pain? ☐ 0 – 10 ☐ 15 – 30 ☐ 30 – 60 ☐ 60+

7. How many minutes can you walk without pain? ☐ 0 – 10 ☐ 15 – 30 ☐ 30 – 60 ☐ 60+

8. Lying down: ☐ eases the pain ☐ does not ease the pain ☐ sometimes eases the pain.

9. Bending forward: ☐ increases the pain ☐ decreases the pain ☐ does not affect the pain.

D. * * * ALL PATIENTS SHOULD ANSWER THE FOLLOWING * * *

1. Coughing or sneezing ☐ increases ☐ sometimes increases ☐ does not increase the pain.

2. There is: ☐ no loss of bowel or bladder control ☐ loss of bowel or bladder control since ______________________

3. I have: ☐ not missed any work because of this problem ☐ missed work. How much? ______________________

4. Treatments have included: ☐ No medicines, therapy, manipulations, injections, or braces.

Neck	Back	Neck	Back
☐	☐ Physical therapy, exercise	☐	☐ Anti-inflammatory medications
☐	☐ Massage & ultrasound	☐	☐ Narcotic medication
☐	☐ Traction	☐	☐ Epidural steroid injections (times: ___)
☐	☐ Manipulation	☐	which relieved the pain for (how long?) ______________
☐	☐ TENS unit	☐	☐ Trigger point injections (times: ___)
☐	☐ Shoulder injections	☐	which relieved the pain for (how long?) ______________
☐	☐ Braces	☐	☐ Other: ______________

5. List pain medications and dose taken for your spine problem: ☐ None

Medication	Dose

6. Previous doctors seen about this problem: ☐ None

Doctor	Specialty	City (if not Anchorage)	Treatments

7. Tests done to evaluate your problem, dates, and location where they were done: ☐ None

	Neck	Back	#1 DATE WHERE	#2 DATE WHERE	#3 DATE WHERE
Plain X-rays	☐	☐			
Myelogram	☐	☐			
CT scan	☐	☐			
MRI scan	☐	☐			
EMGs	☐	☐			
Bone scan	☐	☐			

E. REVIEW OF SYSTEMS: Check all that apply. ☐ None apply.

☐ Reading glasses
☐ Change of vision
☐ Loss of hearing
☐ Ear pain
☐ Hoarseness
☐ Nosebleeds
☐ Difficulty swallowing
☐ Morning cough
☐ Shortness of breath
☐ Fever or chills
☐ Heart to chest pain
☐ Abnormal heartbeat
☐ Swollen ankles
☐ Calf cramps w/walking
☐ Poor appetite
☐ Toothache
☐ Gum trouble
☐ Nausea or vomiting
☐ Stomach pain
☐ Ulcers
☐ Frequent belching
☐ Frequent diarrhea
☐ Frequent constipation
☐ Hemorrhoids
☐ Frequent urination
☐ Burning on urination
☐ Difficulty starting urination
☐ Up more than once/ night to urinate
☐ Frequent headaches
☐ Blackouts
☐ Seizures
☐ Frequent rash
☐ Hot or cold spells
☐ Recent weight change
☐ Nervous exhaustion

Women only:
☐ Irregular periods
☐ Vaginal discharge
☐ Frequent spotting

Other: ______________________

F. MEDICAL HISTORY: Check all that apply. ☐ None apply.

☐ Heart attack
☐ Heart failure
☐ High blood pressure
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Ankylosing spondylitis
☐ Gout
☐ Osteoporosis
☐ Diabetes
☐ Stroke
☐ Seizures
☐ Mental illness
☐ Kidney stones
☐ Kidney failure
☐ Cancer
☐ Alcoholism
☐ Lung disease
☐ HIV
☐ AIDS
☐ Tuberculosis
☐ Asthma
☐ Blood clot in leg
☐ Blood clot in lung
☐ Stomach ulcers
☐ Liver trouble
☐ Hepatitis
☐ Thyroid trouble
☐ Bleeding disorders
☐ Anemia
☐ Serious injuries (explain) ______________________
☐ Other: ______________________

G. SURGICAL HISTORY: Previous surgeries—list procedures, surgeon, and date.

OPERATION	SURGEON	DATE

H. FAMILY HISTORY: Check all that apply. ☐ None apply.

☐ Stroke
☐ Heart trouble
☐ High blood pressure
☐ Diabetes
☐ Arthritis
☐ Gout
☐ Seizures
☐ Spine problems
☐ Mental illness
☐ Kidney trouble or stones
☐ Cancer
☐ Bleeding disorders
☐ Alcoholism
☐ Other: ______________________

I. MEDICATIONS YOU TAKE: ☐ None

____

____

J. ALLERGIES TO MEDICATIONS: ☐ No known drug allergies

MEDICATION	Rash	Swelling, wheezing, or shock	Upset stomach	Unknown reaction	OTHER
____________	☐	☐	☐	☐	____________
____________	☐	☐	☐	☐	____________
____________	☐	☐	☐	☐	____________
____________	☐	☐	☐	☐	____________

K. SOCIAL HISTORY:

1. Work status: ☐ homemaker ☐ retired ☐ disabled ☐ on leave
☐ unemployed ☐ working: ___ full-time ___ part-time

Occupation: ______________________________________

2. Marital status: ☐ married ☐ single ☐ cohabitating
☐ widowed ☐ divorced

3. Number of living children: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

4. I live: ☐ alone ☐ with: ______________________________

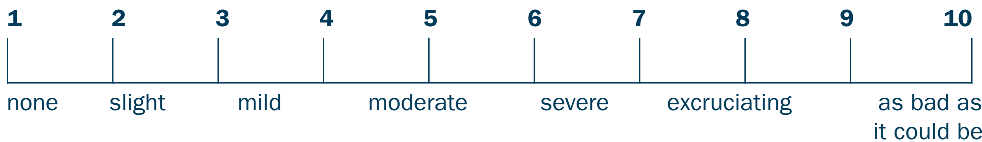
5. Tobacco use ☐ never (skip to #6)
☐ cigar ☐ chew ☐ pipe ☐ cigarettes
________ pack(s) per day for ________ years
☐ quit—when? __________ after smoking
________ pack(s) per day for ________ years (total)

6. Alcohol: ☐ Never or rare
☐ social ☐ frequently drunk (more than twice a week)
☐ alcoholic ☐ recovering alcoholic

7. Drug overuse/abuse: ☐ never ☐ currently ☐ in the past

8. Because of this problem, I have filed or plan to file:
☐ a lawsuit ☐ a workers' compensation claim
☐ neither a lawsuit nor workers' compensation claim

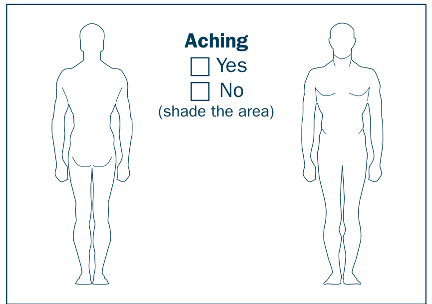
MY PAIN / DISCOMFORT IS (circle number)

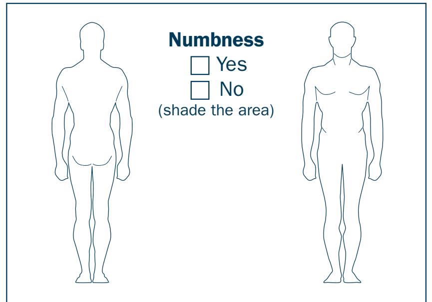


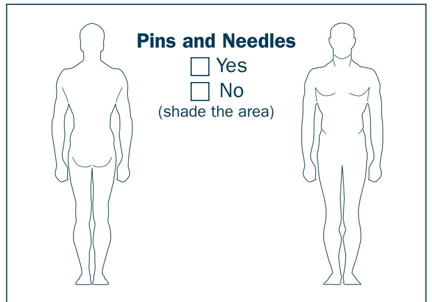
none slight mild moderate severe excruciating as bad as it could be

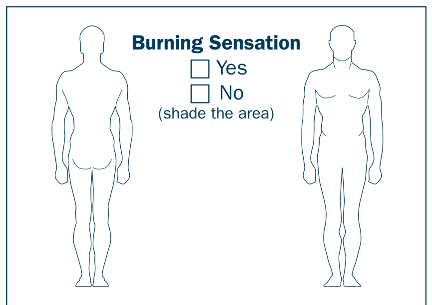
______________________________ ______________
Doctor Signature Date

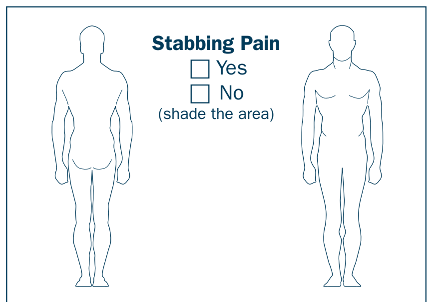
______________________________ ______________
Patient Signature Date











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