CALIFORNIA PACIFIC ORTHOPAEDICS

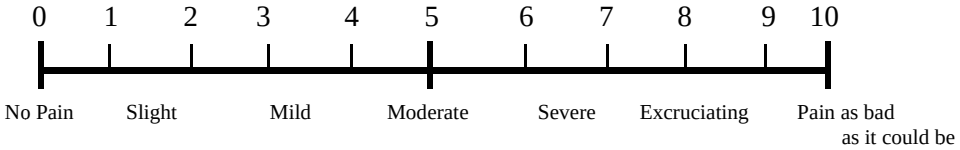
ADULT SPINE HISTORY

NAME:_____ **DATE:** _____

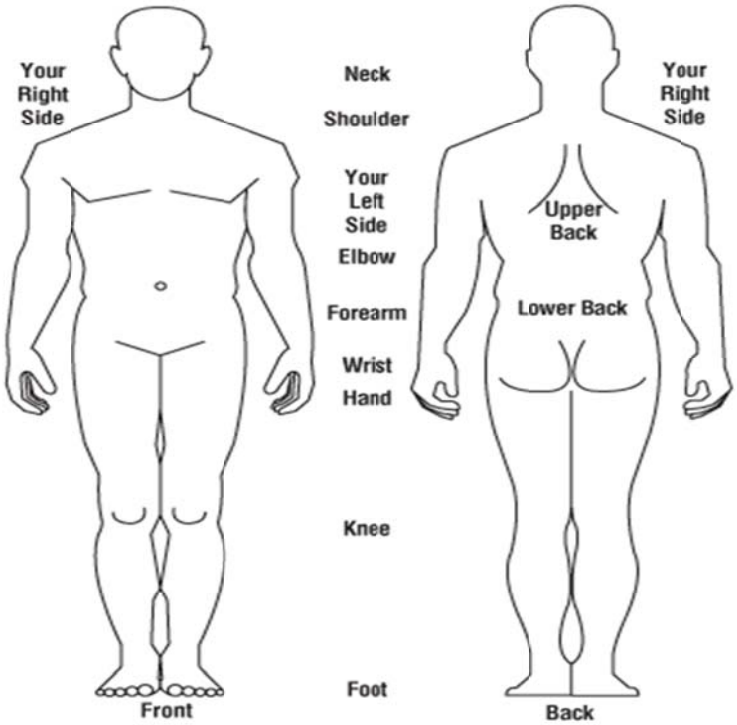
EMAIL: _____

1. Why are you seeing the doctor today: _____
2. How long has the pain/condition been present: _____
3. Has the pain/condition worsened recently:
   ☐ No ☐ Yes, how recently: _____
4. What started the pain/condition: _____

IF THERE IS SPINAL PAIN PRESENT, HOW WOULD YOU RATE IT?



5. Quality of the Pain: ☐ Sharp ☐ Burning ☐ Dull ☐ Aching ☐ Other: _____
6. Location of Pain/Condition:



Stabbing pain	////
Burning pain	OOO
Aching pain	XXX
Pins & needles	VVV
Numbness	===

How much of your pain is present in your Neck or Arm: Please give a percentage: (e.g. 50%)
Neck: _____ Arm and which side: _____
How much of your pain is present in your Back or Leg: Please give a percentage: (e.g. 50%)
Back: _____ Leg and which side: _____

7. What makes the pain/condition better: _____

8. What makes the pain/condition worse: _____

9. Is the pain/condition:

☐ Continuous ☐ Activity Related ☐ Night Pain ☐ Other: _____

10. Did the pain start at work: _____

11. Have you filed a worker's compensation claim: _____

12. Have you ever lost bowel or bladder control: _____

13. Do you have trouble with fine motor movements/buttons/writing/balance: _____

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

Check all that apply:	**When?**
☐ Physical therapy, exercise	_____
☐ Anti-inflammatory medications	_____
☐ Massage & ultrasound	_____
☐ Narcotic medication	_____
☐ Traction	_____
☐ Manipulation	_____
☐ Tens Unit	_____
☐ Shoulder injections	_____
☐ Braces	_____
☐ Epidural steroid injections	_____
How many times _____, which relieved the pain for (how long)?	_____
☐ Trigger point injections	
How many times _____, which relieved the pain for (how long)?	_____
☐ Other _____	

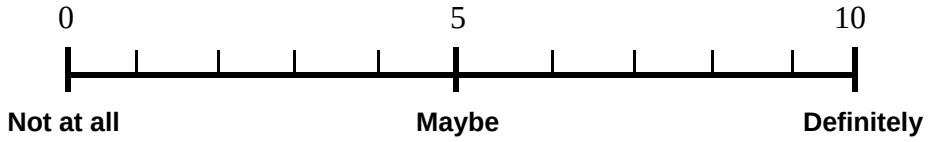
If you have seen other specialists or surgeons for this problem and were not happy, why?

- ☐ Didn't answer my questions
- ☐ Had no suggestions on what to do
- ☐ Personality issues
- ☐ Office staff problems
- ☐ Spent too little time with me
- ☐ Other _____

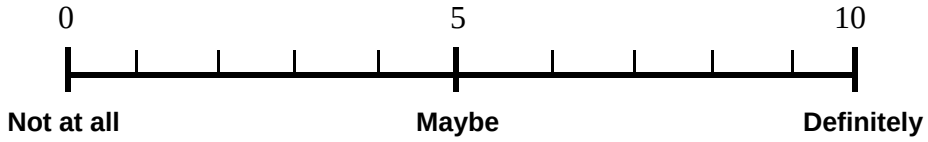
My main goal(s) today is (are) to get (check all that apply):

- ☐ Second opinion
- ☐ Recommendation for Physical therapy
- ☐ Medications
- ☐ Injection treatments
- ☐ Surgery
- ☐ Other: _____

If recommended, please rate how interested you are in having **SURGERY** to treat your problem:



If recommended, please rate how interested you are in having **INJECTIONS** to treat your problem:



Please take time to review the questionnaire for completeness. Your complete medical information is very important to us! Thank you!

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient/family:

Physician Signature:_____ Date: _____