SETON SPINE & REHABILITATION CENTER - PATIENT HISTORY FORM

Name: _____ **Date:** _____ **DOB:** _____

Chief Complaint:

Pain in: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Mid back
☐ Low back ☐ Buttock ☐ Leg ☐ Other_____

History of Present Illness:

When did your pain begin?_____ ☐ work-related?

How did your pain begin?
☐ No apparent reason ☐ Bending ☐ Lifting ☐ Fall
☐ Motor Vehicle Accident ☐ Other_____

Have you had a similar episode before? ☐ Yes ☐ No

What have you been told is wrong? _____

Prior tests for your pain:

Test/Results:

☐ X-ray_____

☐ MRI_____

☐ CT_____

☐ Lab_____

☐ Other_____

Prior treatment for your current problem:

Anti-inflammatory: ☐ Ibuprofen ☐ Aleve ☐ Celebrex ☐ Mobic
☐ Other_____ Results: _____

Steroids: ☐ Cortisone pills ☐ Cortisone injection
☐ Other_____ Results: _____

Other medications: _____ Results: _____

Injections: ☐ Epidural ☐ Facet ☐ Other Results: _____

Spinal surgery: ☐ Year/Procedures/Results_____

Physical therapy: ☐ Year/Procedures/Results_____

Chiropractic: ☐ Year/Procedures/Results_____

Other Treatments: ☐ Year/Type/Results _____

Has your pain : ☐ Improved ☐ Worsened ☐ Not changed

Is your pain: ☐ Constant ☐ Intermittent

How do the following affect your pain?

	Worse	Better	No change
Cough/sneeze	☐	☐	☐
Sitting	☐	☐	☐
Sit to Stand	☐	☐	☐
Bending forward	☐	☐	☐
Morning	☐	☐	☐
Lifting	☐	☐	☐
Bending backward	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Lying on stomach	☐	☐	☐
Nighttime	☐	☐	☐
Looking down	☐	☐	☐
Looking up	☐	☐	☐
Turning head	☐	☐	☐

What level would you rate your pain right now? (please circle)

None 0 1 2 3 4 5 6 7 8 9 10 Most severe

Family Medical History: ☐ Heart disease ☐ Cancer ☐ Lupus ☐ Diabetes
☐ Arthritis ☐ Abnormal bleeding ☐ Muscle disease ☐ Scoliosis
☐ Rheumatoid Arthritis ☐ Drug allergies ☐ Other _____

Living parents? Mother ☐ Yes ☐ No; Died at age _____ of _____
Father ☐ Yes ☐ No; Died at age _____ of _____

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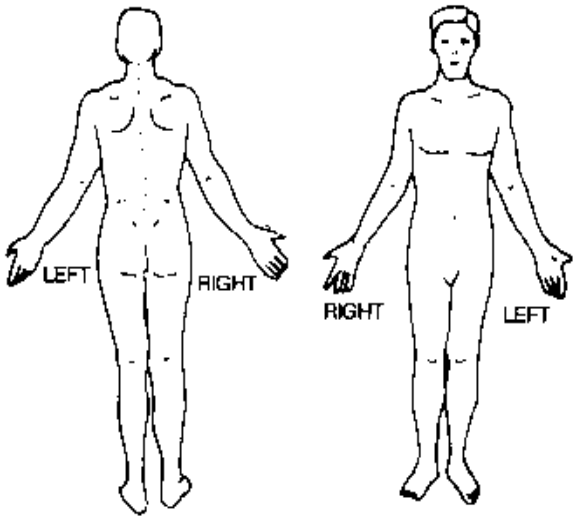
Please fill out the pain drawing below

Use these symbols on the drawings:

>>>> Ache **☐ ☐ ☐ ☐ Numbness**

X X X X Burning **0 0 0 0 Pins and Needles**

///////// Stabbing



Name: _____ **Date:** _____ **DOB:** _____

Current Work Status:

Employer _____ Job Title_____ Time at this position _____

☐ Regular Duty ☐ Modified Duty - Date began:_____ ☐ Off work – Date began:_____

Description of your Normal Job Activities

	Sitting	Standing	Walking	Driving	Lifting
Total hours in a normal work day					
Max. time at one time at work					

* If lifting at work, what is the average weight? _____lbs. How many times per hour? _____

Lifestyle Habits:

☐ Tobacco _____ (# of cigs/day) ☐ Sleep _____ (hours/day)

How long have you smoked? _____ (years)

☐ Alcohol _____ (# of drinks/day) ☐ Caffeine beverages _____ (#/day)

Are you currently exercising regularly? ☐ Yes; how long: _____

☐ No; last regular exercise:_____

Has your condition prevented you from doing exercise? ☐ Yes ☐ No

Past Medical History:

☐ Cancer ☐ Arthritis ☐ Alcoholism ☐ Kidney disease

☐ Diabetes ☐ Seizures ☐ Lung Disease ☐ Thyroid Disease

☐ Ulcers ☐ Glaucoma ☐ Heart Disease ☐ Tuberculosis

☐ AIDS/HIV ☐ Hepatitis ☐ Diverticulitis ☐ High Blood Pressure

☐ Stroke ☐ Anemia ☐ Pacemaker ☐ Joint Replacement

☐ Blood Thinners ☐ Depression/Anxiety

☐ Other_____

Surgeries/Hospitalizations:

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

Injuries/Fractures/Dislocations:

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

List all medications you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug Allergies: ☐ No ☐ Yes; _____

Review of Systems: (Please check all that apply):

Constitutional: ☐ Fever ☐ Night sweats ☐ Unexplained weight loss

Eyes: ☐ Abrupt change in vision

Ears, Mouth, and Throat: ☐ Abrupt change in hearing ☐ Difficulty swallowing ☐ Sore throat

Cardiovascular: ☐ Chest Pain ☐ Poor circulation

Respiratory: ☐ Cough ☐ Difficulty breathing

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Bleeding ☐ Diarrhea

Musculoskelatal: ☐ Pain/swollen joints

Skin ☐ Rash

Neurologic: ☐ Dizziness ☐ Numbness ☐ Muscle weakness

Endocrine: ☐ Hot flashes

Hematologic/Lymphatic: ☐ Bruise easy

Allergic/Immunologic: ☐ Allergies to pollen, etc

Genitourinary: ☐ Burning on urination ☐ Loss of bladder/bowel control

Infection (recent): ☐ Urinary tract ☐ Respiratory ☐ Skin ☐ Immune system dysfunction ☐ Other _____

Psychosocial: ☐ Depression ☐ Anxiety ☐ Difficulty sleeping

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