

NEW MEXICO SPINE

New Patient Evaluation

Date: _____

Name: _____

Birth Date ____/____/____ Age: ____ Sex: ____

Height: _____ Weight: _____

Referred By: _____

Primary Care Physician: _____

History:

Why are you here to see the Doctor today?

What caused your symptoms?

When did it occur? _____

Where did it occur? _____

Is this a recurrent problem? Yes No

Did your injury happen at work? Yes No

Is there or will there be an attorney involved? Yes No

Describe what your symptoms are like:

(Location, how it feels, is it constant, numbness/weakness, etc.)

Describe activities that **IMPROVE** your symptoms

Describe activities that **WORSEN** your symptoms

Are your symptoms (Circle all that apply):

Constant Intermittent Varies
Improving Worsening Staying the Same

Functional Impairment due to symptoms (Circle one):

Mild Moderate Severe

How long can you perform these activities before your pain forces you to stop (in time or distance)

Standing: _____

Sitting: _____

Walking: _____

List other Health Care Providers you have seen about your symptoms:

Where Are Your Symptoms Now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.

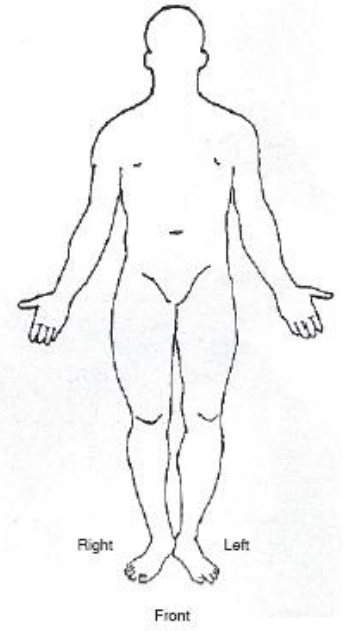
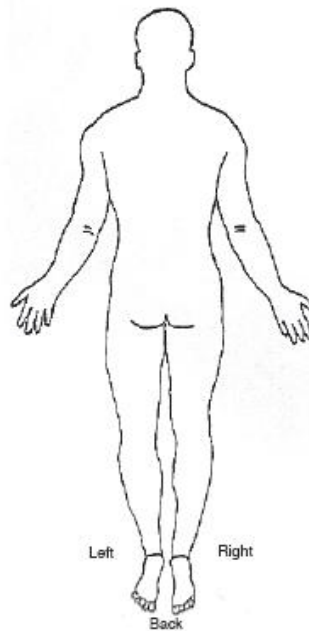
Aching
△△△

Numbness

Pins and Needles
OOO

Burning
XXX

Stabbing
///



BACK/NECK Pain

Rate Pain (0=no pain to 10=severe)

0 1 2 3 4 5 6 7 8 9 10

LEG/ARM Pain

Rate Pain (0=no pain to 10=severe)

0 1 2 3 4 5 6 7 8 9 10

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____

Anesthesiologist Signature: _____

Date: _____

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Which **DIAGNOSTIC TESTS** have you had to evaluate your symptoms? (Circle all that apply)

X-Ray Laboratory/Blood Test Myelogram
MRI CT Scan EMG/NCS
Other: _____

PREVIOUS TREATMENTS (Circle all that apply):

Physical Therapy Chiropractor Acupuncture
Massage TENS unit Facet Injections
Trigger Point Injections Epidural Injections
Other: _____

List your **MEDICAL HISTORY** (Diabetes, Hypertension, etc.)

List all **PREVIOUS SURGERIES** you have had (including dates)

Does your pain affect your ability to:

Eat? Yes No Dress yourself? Yes No
Bathe? Yes No Use the toilet? Yes No
Get up from a chair or out of bed? Yes No

List any **FAMILY MEMBERS** major medical illnesses

Do any of your family members have a similar problem to yours?

Yes No

SOCIAL HISTORY

Marital Status: _____
Occupation: _____

PRIME- MD PHQ (2 Question Screen)

Over the last two (2) weeks, how often have you been bothered by any of the following problems?

1 During the past 2 weeks, have you been bothered by feeling down, depressed or hopeless? Yes No

2. During the past 2 weeks, have you often been bothered by little interest or pleasure in doing things? Yes No

Do you drink alcohol? Yes No Amount: _____

Do you smoke? Yes No Amount: _____

Do you have a history of drug or alcohol abuse? Yes No

Would you like help to quit smoking? Yes No

Do you have any of the following conditions?

General

Weight Loss Yes No
Night Sweats Yes No
Chills Yes No
Fever Yes No

Eyes

Vision or eye problems Yes No
Glasses or Contacts Yes No

Ears/Nose/Throat

Ear or hearing problems Yes No
Dentures Yes No
Sore Throat Yes No

Musculoskeletal

Swollen/Painful joints Yes No
Stiffness Yes No
Edema Yes No

Skin

Rash/Lesions Yes No

Heart/Circulation/Chest

Severe chest pain or pressure Yes No
Heart disease or murmur Yes No
Rapid or Irregular pulse Yes No
Blood clots or vein problems Yes No
Do you have a pacemaker Yes No

Respiratory

Chronic cough (over 1 month) Yes No
Shortness of breath Yes No

Gastrointestinal

Abdominal pain (severe/recurrent) Yes No
Heartburn Yes No
Change in bowel function Yes No
Blood in stool Yes No
Hernia Yes No

Bladder

Change in bladder function Yes No

Blood Disorder

Anemia Yes No
Bleeding Disorder Yes No
Swollen/painful nodes Yes No