

NEW MEXICO SPINE

New Patient Evaluation

Date: _____

Name: _____

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

Height: _____ Weight: _____

Referred By: _____

Primary Care Physician: _____

History:

What are you here to see the Doctor for?

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:

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

Standing: _____

Sitting: _____

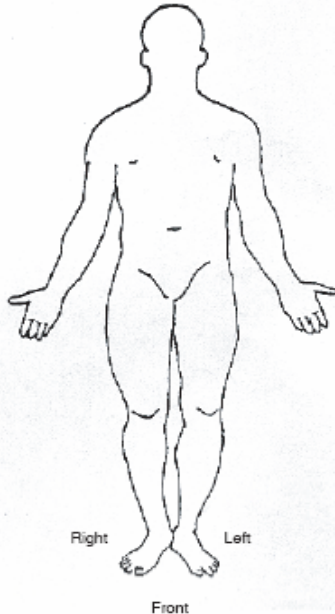
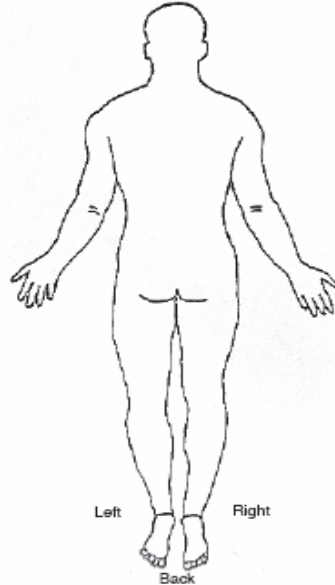
Walking: _____

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 ///
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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

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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 had, and 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 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: _____

Would you like help to quit smoking? Yes No

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

Do you have any of the following conditions?

General

Weight Loss yes no
 Night Sweats yes no
 Chills yes no
 Fevers 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