COLORADO CENTER FOR SPINE MEDICINE
4820 Riverbend Rd. 2nd Floor Boulder CO 80301
#303-444-2955 Fax# 303-889-5103

NAME:_____ **AGE:** _____

DESCRIBE THE REASON FOR TODAY'S VISIT:

_____

_____

CURRENT PROBLEM IS THE RESULT OF AN ACCIDENT: ☐NO ☐YES

ONSET OF SYMPTOMS OR INJURY: _____/_____/_____
MONTH DAY YEAR

HOW LONG DO YOU HAVE THIS CONDITION? _____YEARS_____MONTHS

HAVE YOU HAD THE FOLLOWING TREATMENTS FOR YOUR CONDITION? (CHECK ALL THAT APPLY)

☐BRACING ☐MASSAGE ☐PHYSICAL THERAPY ☐CHIROPRACTIC MANIPULATIONS

☐SPINAL INJECTIONS ☐ALTERNATIVE MEDICINE THERAPIES ☐NONE ☐OTHER_____

SURGERIES AND MEDICAL PROBLEMS

_____
_____
_____
_____
_____
_____
_____

PREFERRED PHARMACY_____ **CITY/CROSS STREETS** _____

MEDICATIONS THAT YOU ARE CURRENTLY TAKING:	**DOSE**	**TIMES/ DAY**

DO YOU HAVE ANY DRUG ALLERGIES? ☐NO ☐YES IF YES, PLEASE LIST_____

_____

ARE THERE ANY MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY? ☐NO ☐YES IF YES, PLEASE DESCRIBE:_____

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NAME:_____ **AGE:** _____

PLEASE CIRCLE THE NUMBER THAT BEST INDICATES THE LEVEL OF YOUR **CURRENT PAIN**

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN

IF YOU ARE EXPERIENCING NECK, LOW BACK, ARM OR LEG PAIN, PLEASE ANSWER THE FOLLOWING:

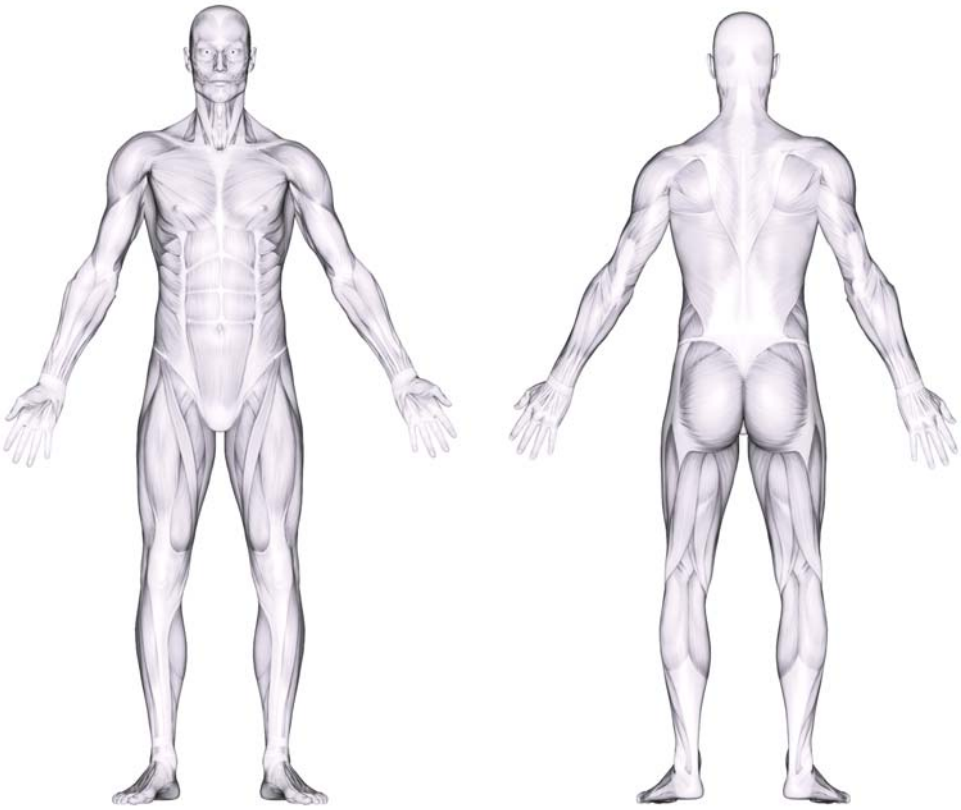
What percentage of your pain is in the NECK or LOW BACK? _____%

What percentage of your pain is in the ARM or LEG? _____%
Total must equal 100%

ARE YOU EXPERIENCING THE FOLLOWING SYMPTOMS?
☐WEAKNESS IN YOUR ARMS ☐LEGS ☐ARMS ☐LEFT ☐RIGHT
☐DIFFICULTIES WITH BOWEL AND/ OR BLADDER

IF YOU ARE EXPERIENCING NECK, LOW BACK, ARM OR LEG PAIN, PLEASE ANSWER THE FOLLOWING:
PLEASE MARK THESE DRAWINGS ACCORDING TO WHERE YOU HURT USING THE KEY BELOW TO ILLUSTRATE THE CHARACTER OF YOUR PAIN. MARK A CIRCLED "X" IN THE ONE PLACE YOUR PAIN IS MOST SEVERE.

SHOOTING-STABBING	**BURNING / ACHING**	**PINS & NEEDLES**	**NUMBNESS**
//////////	/\/\/\/\/\	+++++++	oooooo



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NAME:_____

SOCIAL HISTORY **Do you live alone? Yes or No**

ARE YOU: Married Divorced Widowed Separated Single Partner (PLEASE CIRCLE ONE)

DO YOU HAVE CHILDREN? ☐NO ☐I HAVE _____CHILDREN

☐**I HAVE SMOKED _____PACK(S) PER DAY FOR _____YEARS** ☐**I NEVER SMOKED** ☐**QUIT ___YEARS AGO**
☐**I DO NOT DRINK ALCOHOL** ☐**I DRINK ONLY SOCIALLY** ☐**I DRINK DAILY. IF CHECKED, HOW MUCH?**_____

ARE YOU AT RISK FOR HIV/AIDS? (BLOOD TRANSFUSIONS, DRUG USE, ETC.)? IF YES, PLEASE EXPLAIN_____

REVIEW OF THE SYSTEMS (PLEASE CHECK CONDITIONS THAT YOU CURRENTLY HAVE)

1. GENERAL
☐RECENT FEVER/ CHILLS
☐RECENT WEIGHT LOSS
☐RECENT WEIGHT GAIN
☐SLEEP PROBLEMS

2. EYES
☐EYE INFECTIONS
☐EYE INJURIES
☐CATARACTS
☐GLAUCOMA

3. EAR, NOSE, THROAT AND MOUTH
☐WEAR HEARING AIDS
☐HEARING LOSS
☐EAR PAIN
☐EAR INFECTIONS
☐RINGING IN THE EARS
☐RT ☐LT
☐BALANCE DISTURBANCE
☐NOSEBLEEDS
☐INABILITY TO SMELL

4. PSYCHOLOGICAL
☐ANXIETY
☐DEPRESSION
☐CLAUSTROPHOBIA
☐TROUBLE CONCENTRATING

5. ENDOCRINE
☐DIABETES
☐THYROID DISEASE

6. MUSCULOSCELETAL
☐BACK PAIN
☐LEG PAIN
☐RT ☐LT
☐LEG WEAKNESS
☐RT ☐LT
☐NECK PAIN
☐ARM PAIN
☐RT ☐LT
☐ARM WEAKNESS
☐RT ☐LT
☐ARTHRITIS

7. NEUROLOGICAL
☐HEADACHE
☐LOSS OF CONSCIOUSNESS
☐DIZZINESS/ VERTIGO
☐SEIZURES
☐DIFFICULTY WITH SPEECH
☐DOUBLE/ BLURRED VISION
☐PARALYSIS
☐FACE WEAKNESS

8. BLOOD AND LYMPH
☐ANEMIA
☐HEMOPHILIA
☐BLEEDING TENDENCIES
☐SWOLLEN GLANDS OR LYMPH NODES
☐IMMUNOLOGIC DISORDERS

9. CARDIOVASCULAR
☐HEART DISEASE
☐CHEST PAIN, ANGINA
☐SHORTNESS OF BREATH
☐DATE OF LAST EKG_____
☐HIGH BLOOD PRESSURE
☐LOW BLOOD PRESSURE
☐IRREGULAR PULSE
☐HEART MURMUR
☐HIGH CHOLESTEROL
☐LEG SWELLING

10. RESPIRATORY
☐ASTHMA
☐EMPHYSEMA
☐BRONCHITIS
☐PNEUMONIA
☐LUNG CANCER

11. GASTROINTESTINAL
☐LIVER DISEASE
☐JAUNDICE
☐ULCERS OR GASTRITIS
☐COLON, LIVER OR STOMACH CANCER
☐BLOOD IN YOUR VOMIT

12. GENITOURINARY
☐BLOOD IN URINE
☐DIFFICULTY URINATING
☐INCONTINENCE
☐KIDNEY STONES
☐PROSTATE CANCER
☐UTERINE/ CERVICAL CANCER