Patient Name:
DOB:
Age: Sex:
Date:

OrthoSouth

Chart #:________________

SPINE HISTORY

1. My main problem is:

Neck Pain ☐ Left Arm ☐ Upper Back ☐ Left Leg ☐ Other: ________________

Scoliosis ☐ Right Arm ☐ Lower Back ☐ Right Leg ☐ ________________

2. Please describe the distribution of your pain.

Back ________ % + Leg ________ % = **100**

Neck ________ % + Arm ________ % = **100**

3. Date of injury or onset of symptoms: ________________

4. Was there an injury? Yes ☐ No ☐

5. Are your symptoms work related? Yes ☐ No ☐

6. If work related, how are your symptoms related: ________________

7. Quality of pain? ☐ Aching ☐ Burning ☐ Sharp ☐ Dull ☐ Throbbing ☐ Shooting ☐ Stiffness

(Check all that apply)

8. Since the onset of symptoms, your pain has: ☐ Increased ☐ Decreased ☐ Remained the same

9. What activities make the pain worse? (Check all that apply)

a. During Exercise	☐	e. Walking	☐	i. Sneezing	☐
b. After Exercise	☐	f. Bending forward	☐	j. Housework	☐
c. Sitting	☐	g. Bending backward	☐	k. Sexual activities	☐
d. Standing	☐	h. Coughing	☐		

10. What activities reduce your pain? (Check all that apply)

a. Lying down	☐	e. Manipulation	☐	i. Aspirin	☐
b. Sitting	☐	f. Physical Therapy	☐	j. Other ________________	
c. Standing	☐	g. Pain pills	☐	k. Nothing	☐
d. Walking	☐	h. Muscle relaxers	☐		

11. Do you feel stiffness in the morning? Yes ☐ No ☐

I feel best in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

I feel worst in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

11. Do you have numbness in your:

Right Arm ☐ Where: ________________ Right Leg ☐ Where: ________________

Left Arm ☐ Where: ________________ Left Leg ☐ Where: ________________

12. Do you have weakness in your:

Right Arm ☐ Where: ________________ Right Leg ☐ Where: ________________

Left Arm ☐ Where: ________________ Left Leg ☐ Where: ________________

13. Is your bowel and bladder normal? Yes ☐ No ☐

14. How many hours do you sleep at night?________ Does the pain awaken you from sleep at night? Yes ☐ No ☐

15. Are you on Workers' Compensation? Yes ☐ No ☐ 16. Are you working now? Yes ☐ No ☐

17. Do you receive disability income? Yes ☐ No ☐

18. Do you have legal representation for this medical problem? Yes ☐ No ☐

Are legal proceedings pending? Yes ☐ No ☐

19. What doctors have you seen regarding this problem?

Patient Name: DOB: Chart:

20. Which of the following diagnostic studies have been performed?

Exam	Yes	No	Date	Location / Hospital
X-Rays	☐	☐		
CT Scans	☐	☐		
Myelogram	☐	☐		
EMG	☐	☐		
MRI	☐	☐		
Bone Scan	☐	☐		
Discogram	☐	☐		

21. Which of the following treatments have you received?

Type	Yes	No	How Many?	Effect (Check appropriate response)		
Hotpacks	☐	☐		☐ Better	☐ Worse	☐ No Response
Ice	☐	☐		☐ Better	☐ Worse	☐ No Response
Ultrasound	☐	☐		☐ Better	☐ Worse	☐ No Response
Whirlpool	☐	☐		☐ Better	☐ Worse	☐ No Response
Electrical Stimulation	☐	☐		☐ Better	☐ Worse	☐ No Response
Massage	☐	☐		☐ Better	☐ Worse	☐ No Response
Manipulation	☐	☐		☐ Better	☐ Worse	☐ No Response
Exercise Program	☐	☐		☐ Better	☐ Worse	☐ No Response
Pain Management Program	☐	☐		☐ Better	☐ Worse	☐ No Response

22. Medications

Type of Medication	Yes	No	How Many?	Effect (Check appropriate response)		
Anti-Inflammatory	☐	☐		☐ Better	☐ Worse	☐ No Response
Motrin/Ibuprofen	☐	☐		☐ Better	☐ Worse	☐ No Response
Naprosyn/Aleve	☐	☐		☐ Better	☐ Worse	☐ No Response
Celebrex	☐	☐		☐ Better	☐ Worse	☐ No Response
Mobic	☐	☐		☐ Better	☐ Worse	☐ No Response
Voltaren	☐	☐		☐ Better	☐ Worse	☐ No Response
Muscle Relaxants	☐	☐		☐ Better	☐ Worse	☐ No Response
Soma	☐	☐		☐ Better	☐ Worse	☐ No Response
Flexeril	☐	☐		☐ Better	☐ Worse	☐ No Response
Skelaxin	☐	☐		☐ Better	☐ Worse	☐ No Response
Pain Medications	☐	☐		☐ Better	☐ Worse	☐ No Response
Darvocet	☐	☐		☐ Better	☐ Worse	☐ No Response
Percocet	☐	☐		☐ Better	☐ Worse	☐ No Response
Lortab	☐	☐		☐ Better	☐ Worse	☐ No Response

23. Injections

Type of Medication	Yes	No	How Many / Location	Effect (Check appropriate response)		
	☐	☐		☐ Better	☐ Worse	☐ No Response
	☐	☐		☐ Better	☐ Worse	☐ No Response
	☐	☐		☐ Better	☐ Worse	☐ No Response

24. Surgery

Type / Level	Date	Hospital / City	Surgeon	Effect (Check appropriate response)		
				☐ Better	☐ Worse	☐ No Response
				☐ Better	☐ Worse	☐ No Response

Patient Name:
DOB:
Age:
Sex:
Date:

Chart #: ________________

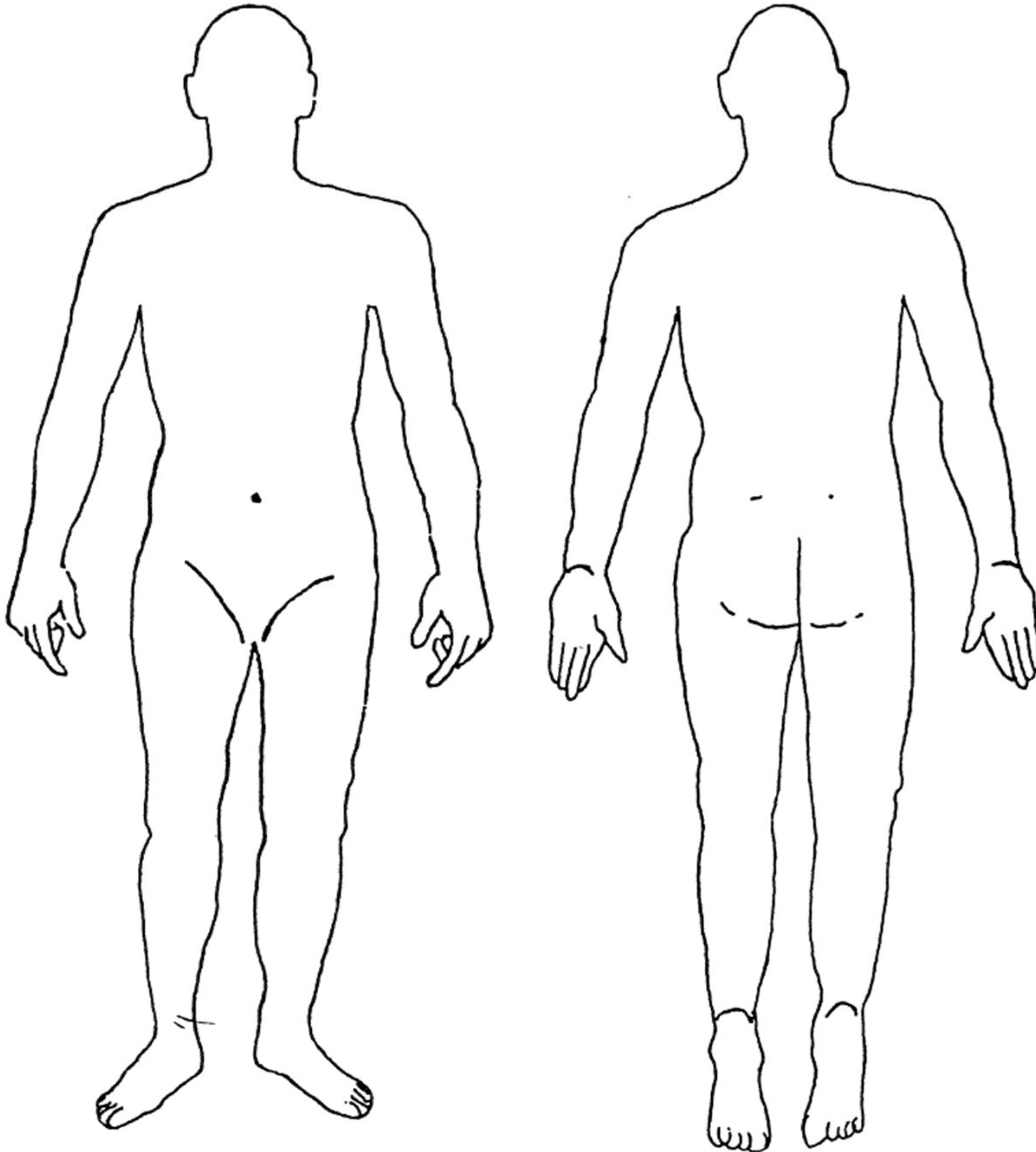
OrthoSouth

SPINE HISTORY

THE ORTHOPAEDIC DIAGRAM

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. MARK AREAS OF RADIATION. INCLUDE ALL AFFECTED AREAS.

NUMBNESS/TINGLING	_ _ _ _ _ _ _ _ _ _ _ _	**ACHING**	0 0	**STIFFNESS**	▲ ▲ ▲ ▲
BURNING	x x x x x x	**STABBING**	/ / / / / /	**DULL**	> > > > > > > >



FOR OFFICE USE ONLY	
DATE	INITIALED
__________	__________
__________	__________

Signature of Patient/Guardian: ______________________________ **Date:** ______________

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