Denver Spine Surgeons

David Wong, MD, Sanjay Jatana, MD, Gary Ghiselli, MD

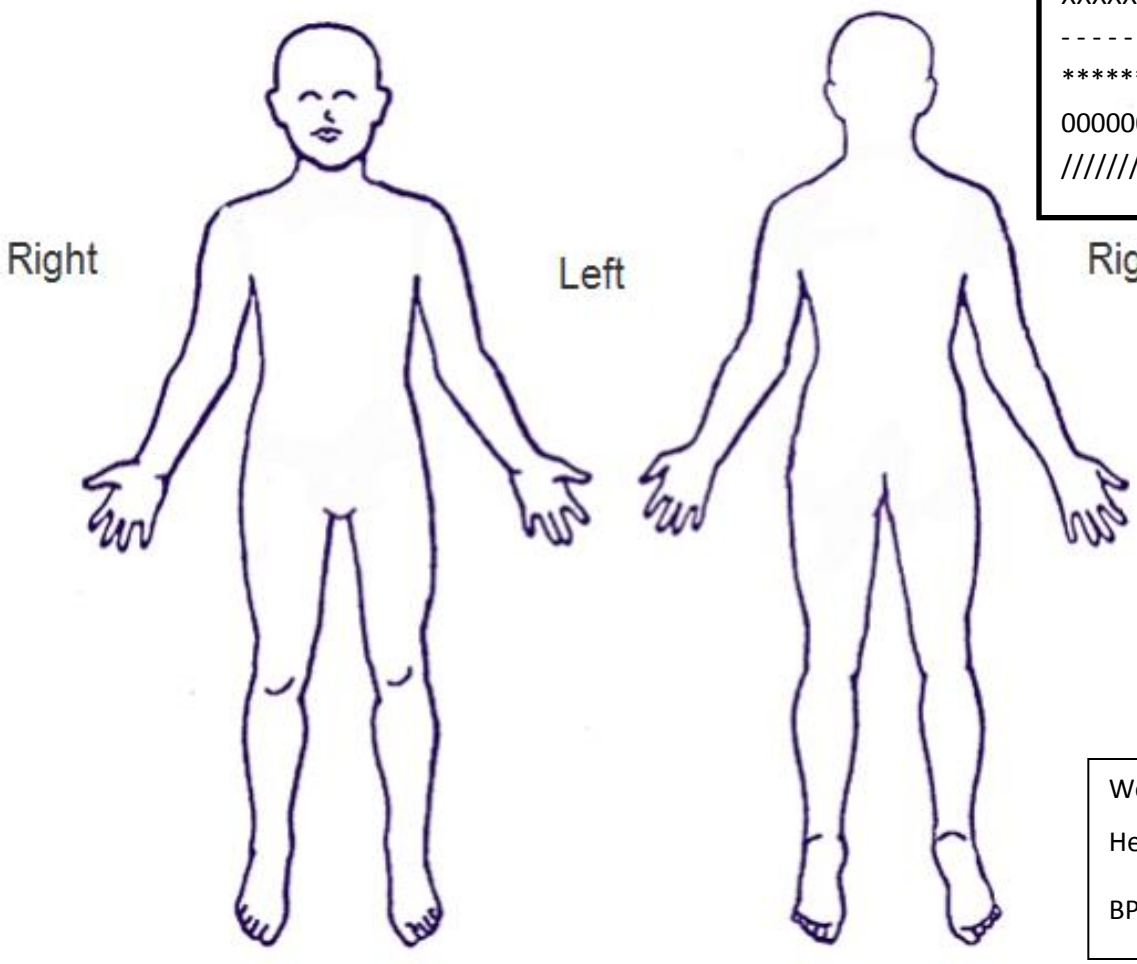
Pain Drawing

Name:_____ Today's Date:_____

How where you referred to our office?_____

Please be sure to fill this out as accurately as possible. This will become part of your permanent medical record and will be used to compare your progress throughout your treatment. Mark the area on your body where you feel the described sensations(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas.

XXXXXXX	Pain (Sharp/ Stabbing)
- - - - - - -	Numbness
********	Pins and Needles
00000000	Ache (Dull)
/////////	Burning



Weight: _____ lbs

Height: ___ ft ____ inches

BP: / Pulse:

Visual Analog Scale

Please mark on the pain level that most accurately represents your pain

	NO PAIN										UNBEARABLE PAIN
Today's Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Best Pain	0	1	2	3	4	5	6	7	8	9	10

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Chief Complaint

Reason for todays's visit:_____

_____

_____

History of Present Illness

What is your occupation?_____

When did your symptoms start?:_____

Symptoms (specific problems):_____

_____

_____

_____

Is your current problem the result of an accident? (Please circle) ☐ No ☐ Yes

Date of Accident	Type (Work, Car, Other)	Description of Injury

Are you currently working? ☐ Yes, Full-time ☐ Yes, Part-time ☐ No ☐ N/A

Are you on modified duty? ☐ Yes ☐ No

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What is the ratio of back pain versus leg pain? (ie. 80:20)_____

Leg Pain

I have pain in my	☐ Right	☐ Buttocks	☐ Leg	☐ Foot
	☐ Left	☐ Buttocks	☐ Leg	☐ Foot
I have numbness in my	☐ Right	☐ Buttocks	☐ Leg	☐ Foot
	☐ Left	☐ Buttocks	☐ Leg	☐ Foot
I have weakness in my	☐ Right	☐ Buttocks	☐ Leg	☐ Foot
	☐ Left	☐ Buttocks	☐ Leg	☐ Foot

Leg Symptoms are worse when	☐ Sitting / Driving			
	☐ Standing	☐ Walking	☐ Laying Down	
Leg Symptoms are better when:	☐ Sitting / Driving			
	☐ Standing	☐ Walking	☐ Laying Down	

Back Pain

I have back pain in the ☐ Middle of my back ☐ To the Right ☐ To the Left ☐ On both sides

Back Symptoms are worse when	☐ Sitting / Driving			
	☐ Standing	☐ Walking	☐ Laying Down	
Back Symptoms are better when:	☐ Sitting / Driving			
	☐ Standing	☐ Walking	☐ Laying Down	

I have noticed problems with: ☐ Gait / Walking / Balance ☐ Bowel or bladder incontinence

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If you tried any of the **treatments** below, Please let us know if they are/were helpful?

	Was it helpful?	Comments
Physical Therapy		
Massage Therapy		
Osteopathic Manipulation		
Chiropractic Care		
Bracing		
TENS Unit		
Acupuncture		
Pilates / Yoga		

Have you had a trial of **medications** for this problem? ☐ No ☐ Yes . If yes, please list in the table below

Name	Strength	Formulation	Frequency	How long?	Did it help?

Have you had any **imaging** for this problem?

Date	CT/Xray/MRI	Where were these done?	Did you Bring them with you?

Have you had pain **injections**?

Date	Physician	Type of Injection	Immediate Relief during the first hour?	How long did the relief last?

Have you had a recent **EMG**? ☐ No ☐ Yes . If yes, who did it and when?_____

Have you ever had **spinal** surgery before? ☐ No ☐ Yes . If yes, please list in the table below

Date	**Type of Surgery**	**Surgeon**

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Medications

Please fill in the table with medications that you are **currently** taking

Name	Strength	Formulation	Frequency

Past Medical History

Please list any major or significant illnesses and/or injuries (ie. Diabetes, cancer, heart disease, high blood pressure)

		Date if applicable
1		
2		
3		
4		
5		
6		
7		
8		
9		

Allergies

Please list any allergies to either medications (ie. Penicillin, sulfa) and/or non-medications (ie. shellfish, eggs, latex)

Agent	**Reaction**

Have you had any problems with anesthesia? ☐ No ☐ Yes, _____

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Surgical History/ Hospitalizations

Please list **surgical** history

Date	Type of Surgery

Please list any **hospitalizations** for reasons other than surgery or childbirth (ie. Pneumonia, heart failure, infection)

Date	Reason for hospitalization

Family History

Please list any significant family illnesses or conditions (ie. Scoliosis, heart disease, diabetes, stroke). If they are healthy, there is no need to fill in that portion of the form.

Family Members	Status (Healthy/Deceased)	Current Age / Age at Death	Health Conditions
Mother			
Father			
Grandmother (Father's)			
Grandfather (Father's)			
Grandmother (Mother's)			
Grandfather (Mother's))			
Sister / Brother			
Sister / Brother			

Social History

Marital Status: ☐ Single ☐ Married ☐ Widowed

Do you smoke cigarettes?
- ☐ No
- ☐ Not now, I quit ___ years ago.
- ☐ Yes, I smoke _____ packs of cigarettes a day and have done this for _____ years.

Do you use marijuana? ☐ No ☐ Yes - ☐ recreational or ☐ medical

Do you use tobacco products? ☐ Yes , I use _____

Do you drink alcohol?
- ☐ No, never or rarely
- ☐ Yes ……. ☐ Daily ☐ 1 or more times a week ☐ 1 or more times a month

Do you use street drugs? ☐ No ☐ Yes

Residence ☐ House ☐ Apartment ☐ Assisted Living

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Review of Systems

Please fill in the following form. If you have none of the symptoms listed, please leave the box blank.

General/Constitutional

- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight loss
- ☐ Other _____

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Exposure to Hepatitis
  - ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
- ☐ Heartburn / GERD
- ☐ Rectal Bleeding
- ☐ Other_____

ENT

- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Nosebleeds
- ☐ Other_____

Genitourinary

- ☐ Blood in Urine
- ☐ Painful Urination
- ☐ Other_____

Endocrine

- ☐ Excessive Sweating
- ☐ Excessive thirst
- ☐ Irregular Menses
- ☐ Diabetes
- ☐ Other_____

Musculoskeletal

- ☐ Broken Bones
- ☐ Carpal Tunnel
- ☐ Leg Cramps
- ☐ Painful Joints
- ☐ Other_____

Respiratory

- ☐ Chest Pain
- ☐ Wheezing
- ☐ Other_____

Peripheral Vascular

- ☐ Decreased Sensation in extremities / peripheral neuropathy
- ☐ Ulceration of feet
- ☐ Swelling in feet
- ☐ Other_____

Cardiovascular

- ☐ Chest Pain
- ☐ Cyanosis
- ☐ Irregular Heart Beat
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Other_____

Neurologic

- ☐ Memory Loss
- ☐ Seizures
- ☐ Tremor
- ☐ Previous Brain Injury
- ☐ Concussion
- ☐ Other_____