USC Center for Spinal Surgery
New Patient History Form

Please take the time to answer all questions that apply to your problem as completely as possible. Thank You.

Date____________ Referring Doctor/Primary Doctor______________________

Name____ Age__________

Chief Complaint________________________________ Date of Injury__________

Injured at_________________ County of___________ Time of Injury_________

When did the symptoms originally begin?__________________________________

Did your pain start gradually?________ Suddenly?_________

Are your symptoms now worse?_______ Better?_______ No Change?_____

What is the degree of pain that you are currently experiencing:
____none ____mild ____moderate ____severe

What is your pain on a scale of 1-10, with 10 being the worst pain?_________

How often do you experience the pain: ____intermittent _____constant

Describe the quality of your pain (i.e. dull, burning, sharp, etc.)________________

What is your back pain to leg pain ratio? (i.e. 100% back/0% leg)?
____100/0 ____90/10 ____80/20 ____70/30 ____60/40 ____50/50

____40/60 ____30/70 ____20/80 ____10/90 ____0/100

What is your neck pain to arm pain ratio? (i.e. 100% neck/0% arm)?
____100/0 ____90/10 ____80/20 ____70/30 ____60/40 ____50/50

____40/60 ____30/70 ____20/80 ____10/90 ____0/100

Where is your pain located?

____neck ____neck and arm(s) R or L ____Arm(s) only- R or L

____back ____back and leg(s) R or L ____Leg(s) only- R or L

What aggravates your pain? (standing, sitting, etc.)_________________________

What relieves your pain? (lying down, sitting, etc.)__________________________

Do you have night pain?_______ Does it wake you up from sleep?_________

Do you have numbness? If so, where?____________________________________

Do you have weakness? If so, where?_____________________________________

Do you have any bowel or bladder problems?______________________________
_____incontinence _____constipation _______hesitancy

Are there any associated signs or symptoms (i.e. nausea, loss of balance, etc.)____

What treatments in the past have made your pain better?____________________

What treatments in the past have made your pain worse?____________________

Have you been in a physical therapy program? ____yes ____no
When/Where/How often?__________________________ Did it help you?________

Are you currently working? ____no ____yes → what type____________________
____Full Duty _____Modified Duty →__________________________________

Date last worked________Are you able to perform your usual duties?______

WORK COMP INFORMATION

Employer at time of injury___________________ Length of time on job________

Job description_____________________________ Job title___________________

Movements required for your job:

___twisting ___pushing ___pulling ___sitting
___standing ___stooping ___crawling ___lift____pounds
___bending ___crouching ___climbing stairs ___grasping
___balancing ___squatting ___kneeling ___climbing ladders
___reaching above shoulders ___repeated wrist/hand movements

Sitting time___________ Standing time____________ Machines used________

Describe how you were injured____
____
____
If work comp, who is your attorney?_______________________________________
If work comp, who is your case manager?__________________________________

MEDICAL/SURGICAL HISTORY

Have you had spine surgery in the past?______________ How many?____________

Please list types of spine surgeries and dates/doctor/hospital of surgeries:

1.____
2.____
3.____
4.____
5.____

Please list all medical problems:____

___high blood pressure ___rheumatoid arthritis
___thyroid ___stroke ___diabetes ___heart attack
___asthma ___stomach ulcer ___cancer →what type__________________
___seizure ___kidney stones ___blood clots in leg or lungs

Please list other previous surgeries/year:_____________________________________

___Tonsils	___head/neck cancer	___brain surgery
___appendectomy	___cardiac/heart	___lung cancer
___ulcer	___gall bladder	___kidney
___bladder	___abdominal cancer	___prostate
___hernia	___hysterectomy	___hip/knee replacement
___shoulder	___peripheral vascular	___knee
___ankle	___elbow	___wrist
___c-section	___melanoma	___hand
___foot	___hip fracture	___infection

Current medications:____

Have you tried Anti-inflammation medications (ibuprofen, etc.)_________________

Does it help?___________ Does it upset your stomach?____________

Allergies:____

Are you married?_________ Children?___________

Who do you live with at home?________________________________

Do you smoke?__________ How much? (pack/day)_________

Do you drink alcohol?______ How much?_________

Review of symptoms:

___fever	___chills	___sore throat
___weight loss	___night sweats	___headaches
___blurred vision	___double vision	___coordination loss
___fainting	___shortness of breath	___chest pain
___palpitations	___dizziness	___loss of consciousness
___bloody stools	___stomach pain	___diarrhea
___tarry stools	___light color stools	___pain in joints
___joint swelling	___bloody urine	___severe stiffness

other:____

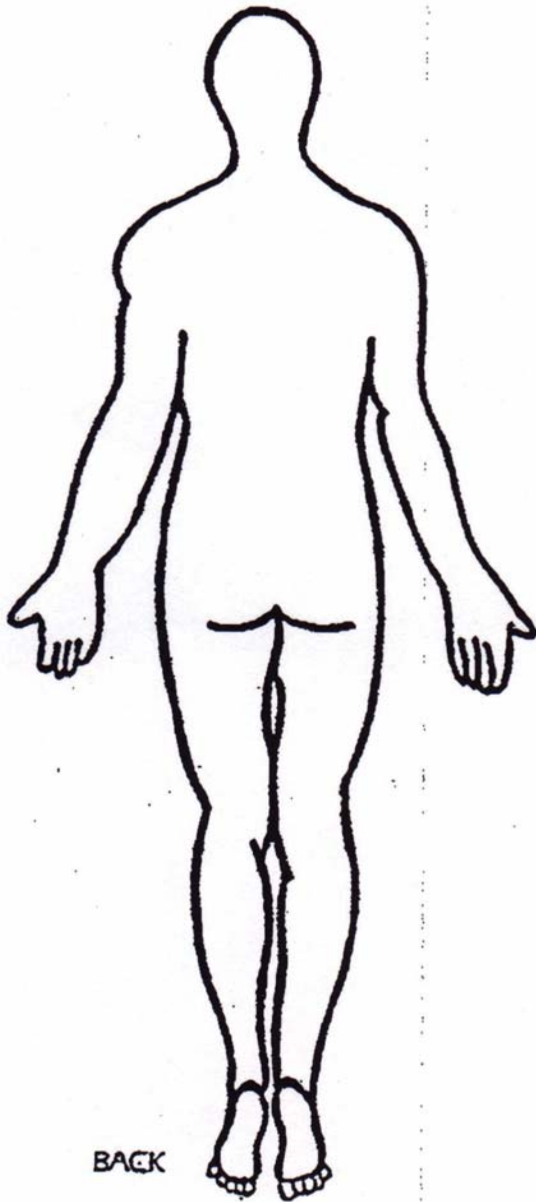
Who referred you to this office?_______________________________________

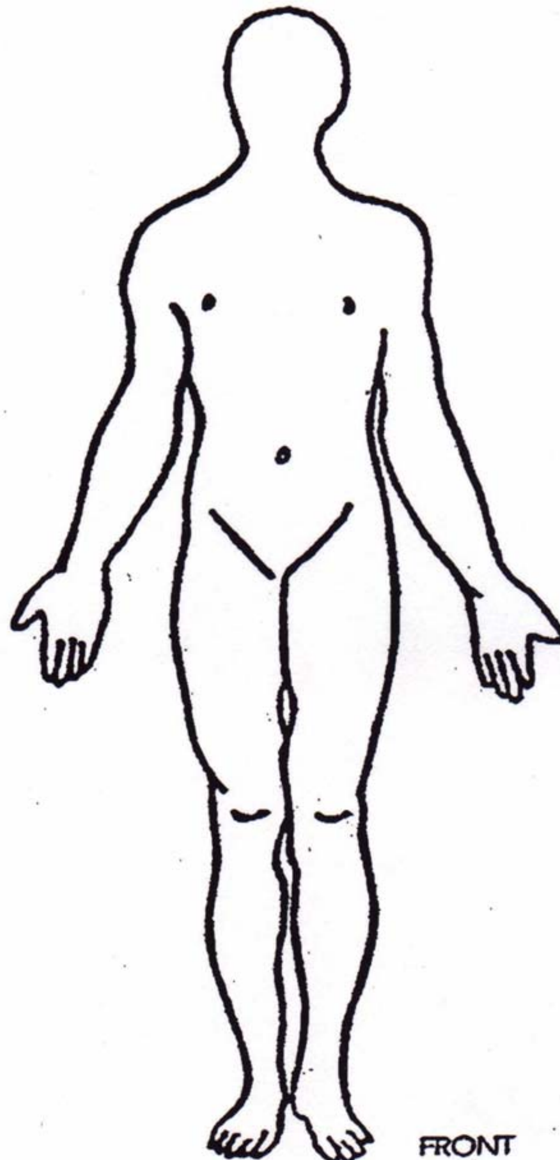
What other doctors have seen you and/or treated you for this problem?________
____

What has happened since your last exam?___________________________________
Have you had any recent tests or X-rays? _____yes _____no
What tests? ____MRI ____CT scan _____Bone Scan Other__________

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw your face.

NUMBNESS	PINS & NEEDLES	BURNING	STABBING
—	oooo	xxxx	////
—	oooo	xxxx	////
—	oooo	xxxx	////





-----Patients, please do not write below this line-----

SPINE EXAMINATION

Constitutional:
Appearance____________________________________
Weight______________
Psychiatric:____________________________________
HEENT:____________________________________
Lymphatic:____________________________________
Skin:____________________________________
Incisions:____normal/intact ___healed ___healing other________________

Musculoskeletal:
Alignment/Scoliosis/Rib Hump____

Gait______________________ Heel/Toe Walk____________________
Tandem___________________ Heel/Toe Raise____________________
Myelopathy________________
Cranial nerves:______________

Palpation: ____nontender ____tender → ______________________________
Carotid bruit____
ROM: Neck- Flexion______ Ext_______ Rot_______ Lat Flexion_______

Back- Flexion____/90 Extension____/30 Sidebending/Rotation____________

Shoulder/Elbow/Wrist ROM___Normal ___Abnormal →______________________
Hip/Knee/Ankle ROM ___Normal ___Abnormal →______________________
Neurologic:
Strength:

	C5	C5, C6	C7	C6	C7	C8	T1
	D	**B**	**T, ECU**	**WE/ECRL/L**	**WF/FCR**	**FF/FDSP/FCU**	**IO**
R							
L							
	L1,**L2**	L2,L3,L4	L3	L4	L5	L5	S1
	HF/IP	**HADD**	**Q**	**TA**	**EHL, EDL**	**HABD**	**GS,FHL,HE**
R							
L							

Sensory: ____intact _____not intact →location__________________________
Vibratory: ____inatct _____not intact →location__________________________
Pulses: RUE_____ LUE_____ RLE_____ LLE_____

DTR: Biceps Triceps Brachiorad Knee Ankle
R _______ _______ _______ _______ _______
L _______ _______ _______ _______ _______
Cross Adductor_____ Tibialis______ Abdominal_______
Special Tests: Babinski______ Clonus______
Hoffmans______ Sh Abd Test______ Adsons______ Spurling______
SLR__________ Leseague________ CRAM_______ FABER________
Rectal Exam__________________________ BCR_________________________

XRAY/MRI Findings:____

DIAGNOSIS:1.____________________ 2._____________________3. ________________

RECOMMENDATIONS: PT Meds_______________ RTC_____________
____

DISABILITY STATUS:____