Patient Name:_____ Date of Birth: _____/_____/_____

Swedish Neuroscience Specialists

Personal Health History

(To be completed by patient)

Sex_____ Age_____ Date:_____/_____/_____

Referring Physician:_____

What part of your spine is your main concern today? (Check all that apply)
Low Back/Leg(s) _____ Neck/Arm(s) _____ Thoracic spine_____ Other_____

Onset

When did this set of **CURRENT** problems begin?_____
When did they become serious enough to consider seeking medical care?_____
What is your chief complaint? _____
What event(s) caused your current spine problem? (Check all that apply)

___ Gradual onset ___ Reaching ___ Lifting ___ Don't know
___ Fall ___ Twisting ___ Pushing ___ Not applicable
___ Direct blow ___ Bending ___ Pulling ___ Other_____

What were the circumstances surrounding this onset? (Check all that apply)

___ Vehicle/Boating accident ___ Recreational sport ___ Repetitive injury
___ On the job injury ___ Non-work related incident ___ No known cause
___ Other_____

Please explain these events that surrounded the onset of this spine problem:
_____
_____
_____
Do you feel your employer or another person caused this spine problem? ___ yes ___no

Prior Spine Problems

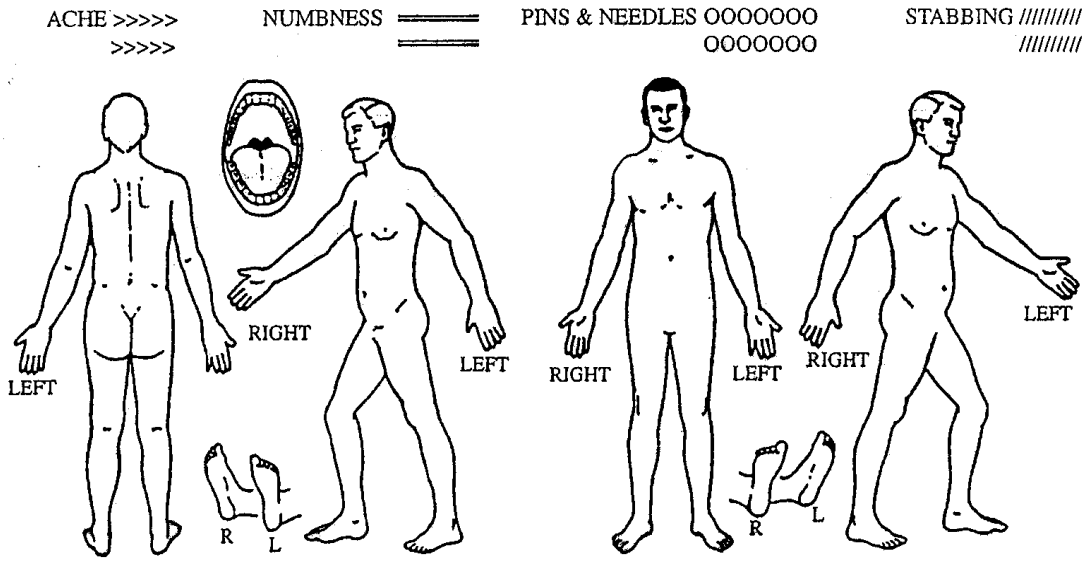
Prior to this current set of spine problems, have you had prior issues regarding **THIS CURRENT AREA** of your spine? _____ yes _____ no
Approximately when did these problems begin? _____
What were the circumstances surrounding the onset of these problems?
_____
_____
_____

How many prior surgeries have you had in the area of the spine that is being addressed today? _____
Have your current spine problems been **on-going** since they first started _____yes _____no

Patient Name:_____ Date of Birth: _____/_____/_____

Current Status

Mark the area on your body where you feel your **typical** pain. Include all affected areas. Use the appropriate symbols indicated below



Pain Severity

1. **If 10 is the worst pain imaginable, and 0 is no pain, please note your pain over the last TWO WEEKS:**
   a) Please range your WORST pain. 0 1 2 3 4 5 6 7 8 9 10
   b) Please rate your LEAST pain. 0 1 2 3 4 5 6 7 8 9 10
   c) Please rate your overall or AVERAGE pain. 0 1 2 3 4 5 6 7 8 9 10

2. **Over the last month, how many days per week have you had your usual pain?**
   0 1 2 3 4 5 6 7

3. **In the last week, during your waking hours, about what percentage of the day were you in pain**
   ☐ Less than 10% ☐ 10 – 50 % ☐ 50 – 75% ☐ 75 – 100%
   ☐ It also bothers me at night

For Back Only

4. **Do you have both back and leg pain? ☐ Yes ☐ No**
   If yes, please answer the following 3 questions:
   a) Which is worse, your back pain or your leg pain? ☐ Back pain ☐ Leg pain ☐ About equal
   1) Do you often have just back pain without leg pain? ☐ Yes ☐ No
   2) Do you often have just leg pain without back pain? ☐ Yes ☐ No

For Neck Only

5. **Do you have both neck and arm pain? ☐ Yes ☐ No If yes, please answer the following 3 questions:**
   a) Which is worse, your neck pain or your arm pain? ☐ Neck pain ☐ Arm pain ☐ About equal
   1) Do you often have just neck pain without arm pain? ☐ Yes ☐ No
   2) Do you often have just arm pain without neck pain? ☐ Yes ☐ No

Pain Severity, continued

6. Check the worst and best times for your overall pain:

Worst	**Best**	**If you have NIGHT pain, does it:**
☐ First awakening	☐ First awakening	☐ Prevent you from falling asleep?
☐ Morning	☐ Morning	☐ Awaken you at night?
☐ Afternoon	☐ Afternoon	☐ Hurt worse when lying down at night
☐ Evening	☐ Evening	than during the day?
☐ Nighttime	☐ Nighttime	

7. What does each of the following activities do to your overall pain?

	No Change	**Relieves Pain**	**Increases Pain**
Sitting	_____	_____	_____
Standing	_____	_____	_____
Walking	_____	_____	_____
Lying Down	_____	_____	_____
Bending forward	_____	_____	_____
Bending Backward	_____	_____	_____
Lifting	_____	_____	_____
Coughing / Sneezing	_____	_____	_____
Looking up	_____	_____	_____
Looking down	_____	_____	_____
Twist/Turn	_____	_____	_____

8. What do you do to relieve your pain?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Progression:

1. How is your <u>current</u> pain, compared to when this pain episode first started?
☐ Much improved ☐ Somewhat improved ☐ No change ☐ A little worse ☐ Much worse ☐ N/A

2. How much <u>change</u> do you expect in your pain <u>6 months from now</u>?
☐ Worse ☐ No change ☐ Some improvement ☐ Marked improvement ☐Total relief

Bladder Function

Regarding your bladder function, do you:

☐ Urinate more often
☐ Have loss of control or accidents
☐ Have a sense of urgency
☐ Have a loss of sensation around groin or buttocks
☐ Have problems with sexual function
☐ Have had no problems

Patient Name:_____ Date of Birth: _____/_____/_____

Function

1. **Pain intensity** (mark only one)
   - ☐ I can tolerate the pain I have without having to use pain killers
   - ☐ The pain is bad but I manage without taking pain killers
   - ☐ Pain killers give complete relief from pain
   - ☐ Pain killers give moderate relief from pain
   - ☐ Pain killers give very little relief from pain
   - ☐ Pain killers have no effect on the pain, I do not use them

2. **Personal Care (washing, dressing, etc.)** (mark only one)
   - ☐ I can look after myself normally without it causing extra pain.
   - ☐ I can look after myself normally but it causes extra pain
   - ☐ It is painful to look after myself and I am slow and careful
   - ☐ I need some help but manage most of my personal care
   - ☐ I need some help everyday in most aspects of self care.
   - ☐ I do not get dressed, wash with difficulty, and stay in bed

3. **Lifting** (mark only one)
   - ☐ I can lift heavy weights without extra pain
   - ☐ I can lift heavy weights but it gives me extra pain
   - ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table)
   - ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
   - ☐ I can lift only very light weights
   - ☐ I cannot lift or carry anything at all

4. **Walking** (mark only one)
   - ☐ Pain does not prevent me from walking any distance
   - ☐ Pain prevents me walking more than 1 mile
   - ☐ Pain prevents me walking more than ½ mile
   - ☐ Pain prevents me walking more than ¼ mile
   - ☐ I can only walk using a stick or crutches
   - ☐ I am in bed most of the time and have to crawl to the toilet

5. **Sitting** (mark only one)
   - ☐ I can sit in any chair as long as I like
   - ☐ I can only sit in my favorite chair as long as I like
   - ☐ Pain prevents me from sitting more than one hour
   - ☐ Pain prevents me from sitting more than thirty minutes
   - ☐ Pain prevents me from sitting more than ten minutes
   - ☐ Pain prevents me from sitting at all

6. **Standing** (mark only one)
   - ☐ I can stand as long as I want without extra pain
   - ☐ I can stand as long as I want but it causes extra pain
   - ☐ Pain prevents me from standing more than one hour
   - ☐ Pain prevents me from standing more than thirty minutes
   - ☐ Pain prevents me from standing more than ten minutes
   - ☐ Pain prevents me from standing at all

7. **Sleeping** (mark only one)

   - ☐ Pain does not prevent me from sleeping well
   - ☐ I can sleep well only by using tablets
   - ☐ Even when I take tablets I have less than six hours of sleep
   - ☐ Even when I take tablets I have less than four hours of sleep
   - ☐ Even when I take tablets I have less than two hours of sleep
   - ☐ Pain prevents me from sleeping at all

8. **Employment/Homemaking** (mark only one)

   - ☐ My normal homemaking/job activities do not cause pain
   - ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me
   - ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming)
   - ☐ Pain prevents me from doing anything but light duties
   - ☐ Pain prevents me from doing even light duties
   - ☐ Pain prevents me from performing any job or homemaking chores

9. **Social Life** (mark only one)

   - ☐ My social life is normal and gives me no extra pain
   - ☐ My social life is normal but increases the degree of pain
   - ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
   - ☐ Pain has restricted my social life and I do not go out as often
   - ☐ Pain has restricted my social life to home
   - ☐ I have no social life because of pain

10. **Traveling** (mark only one)
    - ☐ I can travel anywhere without extra pain
    - ☐ I can travel anywhere but it gives me extra pain
    - ☐ Pain is bad but I manage journeys over two hours
    - ☐ Pain restricts me to journeys less than one hour
    - ☐ Pain restricts me to short journeys under thirty minutes
    - ☐ Pain prevents me from traveling except to the doctor or hospital

(MD Use) Score: _____

Patient Name:_____ Date of Birth: _____/_____/_____

Treatments:

Please list the physicians, chiropractors, and/or osteopaths you have seen within the LAST YEAR for your back/neck pain, along with the approximate dates.

Doctor's Name	Type of Doctor	Approximate Dates

Put an "X" next to each treatment you have had for your back/neck pain in the past or currently.

	Treatment		**Effect of Treatment**		
		Currently Using	Helped	No Change	Increased
____	Home exercise program	Yes	1	2	3
____	Bed rest	Yes	1	2	3
____	Hot packs/ice	Yes	1	2	3
____	TENS unit for home use	Yes	1	2	3
____	Back brace	Yes	1	2	3
____	Physical therapy	Yes	1	2	3
____	Massage	Yes	1	2	3
____	Chiropractic treatment	Yes	1	2	3
____	Osteopathic manipulation	Yes	1	2	3
____	Acupuncture	Yes	1	2	3
____	Epidural injections	Yes	1	2	3
____	Facet injections	Yes	1	2	3
____	Facet injections	Yes	1	2	3
____	Local (trigger point) injections	Yes	1	2	3
____	Under care of pain specialists	Yes	1	2	3
____	Other _____	Yes	1	2	3

Diagnostic Tests:

Which of the following diagnostic tests have been done on your back/neck? Please indicate date for "yes" answers.

Workup	**Clinician Use**		**Clinician Use**
☐ Regular x-rays	_____	☐ Bone Scan	_____
☐ MRI Scan	_____	☐ Discogram	_____
☐ CT Scan	_____	☐ EMG/SSEP	_____
☐ Myelogram/ CT	_____	☐ Bone Density	_____
☐ Other	_____		

If you have had surgery on your **Back and/or Neck** (including chymopapain), please fill in the following for each operation:

Date	**Type of Surgery and Surgeon**	**Pain After Surgery** Worse	Same	Better	***(M.D. USE ONLY)***
_____	_____	____	____	____	_____
_____	_____	____	____	____	_____
_____	_____	____	____	____	_____
_____	_____	____	____	____	_____

Patient Name:_____ Date of Birth: _____/_____/_____

Social / Environmental History

Education:

High school diploma ☐ Yes ☐ No
GED ☐ Yes ☐ No
Did not complete high school or receive a GED ☐ Yes ☐ No
What is your highest level of education or training? _____

Are you Fluent in English? ☐ Yes ☐ No Other language _____

Marital Status:

What is your marital status? ☐ Married/Partner ☐ Divorced/Separated ☐ Single ☐ Widowed
Have you had a stress or change in a significant relationship within the past 12 months? ☐ Yes ☐ No
If yes, please explain: _____
What are the ages of your children? _____

Sleep:

Have you had any of these sleep problems <u>at least half the days of the past month</u>?

- Trouble falling asleep when you first go to bed ☐ Yes ☐ No
- Waking up during the night and not easily going back to sleep ☐ Yes ☐ No
- Waking up in the morning earlier than planned or desired ☐ Yes ☐ No
- Feeling unsatisfied or not rested by your night's sleep ☐ Yes ☐ No
- Feeling excessively sleepy during the day (does not include regular naps) ☐ Yes ☐ No

How many hours per night do you sleep currently, on average? _____
Did your sleep problems exist prior to your current pain problem? ☐ Yes ☐ No ☐ No sleep problems now

Mood:

*These questions are about how you feel and how things have been with you **during the past four weeks**. For each question, please give one answer that comes closest to the way you have been feeling.*

Do you feel you might be depressed or overly anxious? ☐ Yes ☐ No
Circle the appropriate number to indicate the extent of the problem you are having with each of the following:

	NONE									SEVERE
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10

Have you ever considered yourself a victim of physical, emotional or sexual abuse? ☐Yes ☐No
Are you receiving care from a mental health professional? ☐ Yes ☐ No
If yes, please explain_____

Habits

1. Have you ever smoked? ☐ Yes ☐ No If yes, at what age did you start? _____
   (Check all that apply) ___cigarettes ___cigars ___ pipe
2. During the time you smoke(d), indicate the average number smoked daily:
   ___less than 1 pack a day ___1 pack per day ____1 to 2 packs per day ___ more than 2 packs per day
3. If you've quit smoking, at what age? _____
4. How often do you have a drink containing alcohol?
   ___never ___monthly or less ___2-4 times a month ___ 2-3 times a week ___ 4 or more times a week
5. How many drinks containing alcohol do you have on a typical day when you are drinking?
   ___ 1 or 2 ___ 3 or 4 ___ 5 or 6 ___ 7 to 9 ___ 10 or more
6. Are you concerned about your drinking patterns? ☐ Yes ☐ No
7. Have any family members or friends expressed concerned about your drinking? ☐ Yes ☐ No

Patient Name:_____ Date of Birth: _____/_____/_____

Occupational History:

Employer: _____ Date of hire: _____ Usual occupation: _____

Briefly describe your job: _____

1. How physically demanding is your job?
   - ☐ Very heavy (frequently lifting over 50 pounds)
   - ☐ Heavy (frequently lifting 25-50 pounds)
   - ☐ Moderate (frequently lifting 10- 25 pounds)
   - ☐ Light (frequently lifting under 10 pounds)
   - ☐ Sedentary (essentially no lifting)

2. Work status at the **TIME OF ONSET** of this episode of back/neck pain:
   - ☐ Regular: full time
   - ☐ Regular: part time
   - ☐ Working modified job (e.g., light duty)
   - ☐ Not currently in workforce/homemaker/student
   - ☐ Unemployed, looking for work
   - ☐ Retired
   - ☐ On public assistance
   - ☐ Permanent disability (pension, SSDI)
   - ☐ Other_____

3. Work status **TODAY**
   - ☐ Regular: full time
   - ☐ Regular: part time
   - ☐ Working modified job (e.g., light duty)
   - ☐ On active disability time loss
   - ☐ Not currently in workforce(i.e. homemaker/student)
   - ☐ Unemployed, looking for work
   - ☐ Retired
   - ☐ On public assistance
   - ☐ Permanent disability (pension, SSDI)
   - ☐ Other_____

4. How satisfied are/were you with your job?
   ☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Worst job I've ever had ☐ N/A

5. If your back/neck got completely better during the next few weeks, do you think your employer would let you return to the job you had before this episode of back/neck pain?
   ☐ Yes ☐ Probably ☐ Doubt it ☐ Definitely not ☐ N/A

6. Is your employer able and willing to offer you job accommodations (e.g., light duty, part-time work, flexible schedule, special equipment) if needed to allow you to work? ☐ Yes ☐ No ☐ Don't Know ☐ N/A

7. How certain are you that you will be working in 6 months? (circle one)

   0 1 2 3 4 5 6 7 8 9 10
   Not at all Certain Definitely

8. When do you expect to return to work?
   ☐ Next 2 weeks ☐ 2-6 weeks ☐ 6-12 weeks ☐ 3-6 months ☐ more than 6 months ☐ never ☐ N/A

9. Are you planning to apply for permanent disability such as Social Security Disability (SSDI) or other permanent disability? (e.g., worker's compensation, pension) ☐ Yes ☐ No

10. Has your employer treated you fairly?
    ☐ Yes ☐ No ☐ N/A If no, please explain: _____

11. Has anyone in your family been on disability coverage? ☐ Yes ☐ No
    If yes, what is the relationship to you? _____

12. Is a lawyer helping you with a claim or lawsuit related to your current pain or other symptoms?
    ☐ Yes ☐ No If yes, explain briefly _____

Patient Name:_____ Date of Birth: _____/_____/_____

Name: _____ DOB: _____ Date: _____

HT: _____ WT: _____ Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Reason for this visit: _____

Medical Problems: ***Check if yes. If yes, please explain:***

☐ **Heart Trouble** ☐ Heart Attack ☐ Heart Failure ☐ Stents or bypass to heart ☐ Abnormal Rhythms	
☐ **Peripheral Vascular Disease** ☐ Bypass or stents to legs	
☐ **Cerebrovascular Disease** ☐ Stroke-No residuals ☐ Permanent Paralysis ☐ Multiple Temporary Strokes	
☐ **Asthma** ☐ Do you take medication on regular basis? ☐ Do you take medications for only flare ups?	
☐ **COPD/Chronic Obstructive Pulmonary Disease** ☐ Do you take medication on regular basis? ☐ Do you require oxygen?	
☐ **Ulcers** ☐ Acid Reflux	
☐ **Diabetes** Age at onset _____ ☐ Any Organ Damage? Please list:	
☐ **Kidney Problems** ☐ Recurrent infections? ☐ Failure including dialysis?	
☐ **Inflammatory Arthritis** ☐ Lupus/Rheumatoid Arthritis ☐ Other _____ ☐ Need medication?	
☐ **Liver Disease** ☐ Mild ☐ Mod or Severe (Cirrhosis)	
☐ **Cancer** ☐ Skin ☐ Leukemia/Lymphoma ☐ Other Malignancy ☐ Metastatic	
☐ **HIV Positive Disease**	
☐ **High Blood Pressure**	
☐ **Anemia**	
☐ **Bleeding Disorders** ☐ Taking Blood Thinners	
☐ **Gout**	
☐ **Thyroid**	
☐ **Psychiatric Care** ☐ Depression ☐ Anxiety	

Medical Problems, continued

☐ **Prostate Problems**	
☐ **Neurologic** ☐ Fever Related Childhood Seizures ☐ Meningitis ☐ Head Injury ☐ Encephalitis ☐ Seizures	
☐ **Other** ☐ List:	

PRIOR SURGERIES (please list)	Approximate Date	PRIOR SURGERIES (please list)	Approximate Date

Have you EVER had any problems with surgery or anesthesia? ☐ Yes ☐ No Explain: _____

Review of systems:

*Do you **CURRENTLY** have any of the following problems? Please check if yes.*	*If yes, please explain:*
☐ **Neurological problems** (i.e. Headaches, stroke, memory loss, seizures)	
☐ **Eye** (i.e. glaucoma, cataracts, wandering or lazy eye)	
☐ **Chronic Fever** unexpected weight loss, fatigue, poor appetite, night sweats	
☐ **Ear/Nose/Throat problems**(i.e. hearing loss, sinus problems)	
☐ **Heart problems**(i.e. chest pain, irregular heart beat, tightness, trouble breathing lying flat, trouble breathing when exercising, swollen ankles)	
☐ **Respiratory problems**(i.e. shortness of breath, wheezing, coughing blood, persistent cough)	
☐ **Gastrointestinal problems**(i.e. nausea, heartburn, abdominal pain, diarrhea, change in bowel habits, excessive constipation, black or bloody stools)	
☐ **Urinary problems**(i.e. pain, incontinence, blood in urine, urinate more at night)	
☐ **Endocrine problems**(i.e. diabetes, thyroid disease, menstrual problems)	
☐ **Reproductive problems** (i.e. pregnancy, prostate problems, impotence, etc.)	
☐ **Musculoskeletal** (morning stiffness, muscle tenderness, dry eyes or mouth, white fingers in cold, skin rashes, joint pain or swelling)	

WOMEN ONLY:

☐ Does your pain increase with your menstrual periods?	
☐ Are you pregnant or possibly pregnant?	
☐ Do you take Birth Control Pills or Hormones?	
☐ Do you take at least 1000 mg of calcium daily?	

When was your last physical exam? _____ By Whom? _____

* If you have not had a physical within the last year and you have symptoms from the list, you **MUST** contact your primary doctor.

Please contact your PCP for general medical issues.

Patient Name:_____ Date of Birth: _____/_____/_____

FAMILY HISTORY:

Please indicate if history of diabetes, cancer, heart disease, seizures, neurological, or other "family" disease.

	Living?		Age or ages at death	Present health or cause of death
Father	☐ Yes ☐ No			
Mother	☐ Yes ☐ No			
Spouse	☐ Yes ☐ No			
Brothers	# Living			
	# Deceased			
Sisters	# Living			
	# Deceased			
Children	# Living			
	# Deceased			

Infection Information: If yes, please explain.

☐ Do you or any family members have a history of MRSA or Staph?
☐ Do you have any open sores or wounds?
☐ Do you have any current infections or skin infections:
☐ Have you been recently admitted to a Skilled Nursing Facility or Nursing Home (within last 12 months?)

MRI Information:

A. Do you have any metal implants such as: (please check if yes)		
☐ Aneurysm clip(s):	If yes, what year:	
☐ Cardiac pacemaker:	If yes, what year:	
☐ Neuro-stimulator:	If yes, what year:	
☐ Cochlear Implant:	If yes, what year:	
☐ SWAN/EPI catheter:	If yes, what year:	
☐ Bullets/Bullet fragments:	If yes, what year:	
B. Do you have significant claustrophobia: ☐ Yes ❒ No		Will you need sedation: ☐ Yes ☐ No
C. Do you have a previous history of working with metal? (i.e. welder, sheet metal worker, etc.) ☐ Yes ☐ No		
D. Are you allergic to IV contrast dye, Iodine or shellfish? ☐ Yes ☐ No		
E. If female, is there a chance that you could be pregnant? ☐ Yes ☐ No		

Living Situation: ☐ Live Alone ☐ With Family ☐ With Friends ☐ Homeless ☐ Other

Referring Provider: Name:	Address:	Phone:
Primary Care Provider: Name:	Address:	Phone:
Legal Next of Kin: Name:	Address:	Phone:

Patient Name:_____ Date of Birth: _____/_____/_____

Medication Record

In order to prevent mistakes with your medications, please transfer the information from the labels on your prescription bottles to this sheet. Accurate information is required for your safety.

Name of Medication (e.g.: Plavix)	Dosage/Strength: (e.g.: 250mg)	Schedule: (e.g.: 1 tablet 2x per day)	Reason for taking this medication:

ALLERGIES:

Medication Allergies (List all)	Reaction

Other Allergies (List all)	Reaction

Tobacco use:	☐ Never	☐ Previously, but quit Date stopped:		☐ Current _____packs per day.
Use of Alcohol:	☐ Daily	☐ Moderately	☐ Rarely	☐ Never
Recreational Drug Use:	☐ Never	☐ Yes	Type/Frequency:	