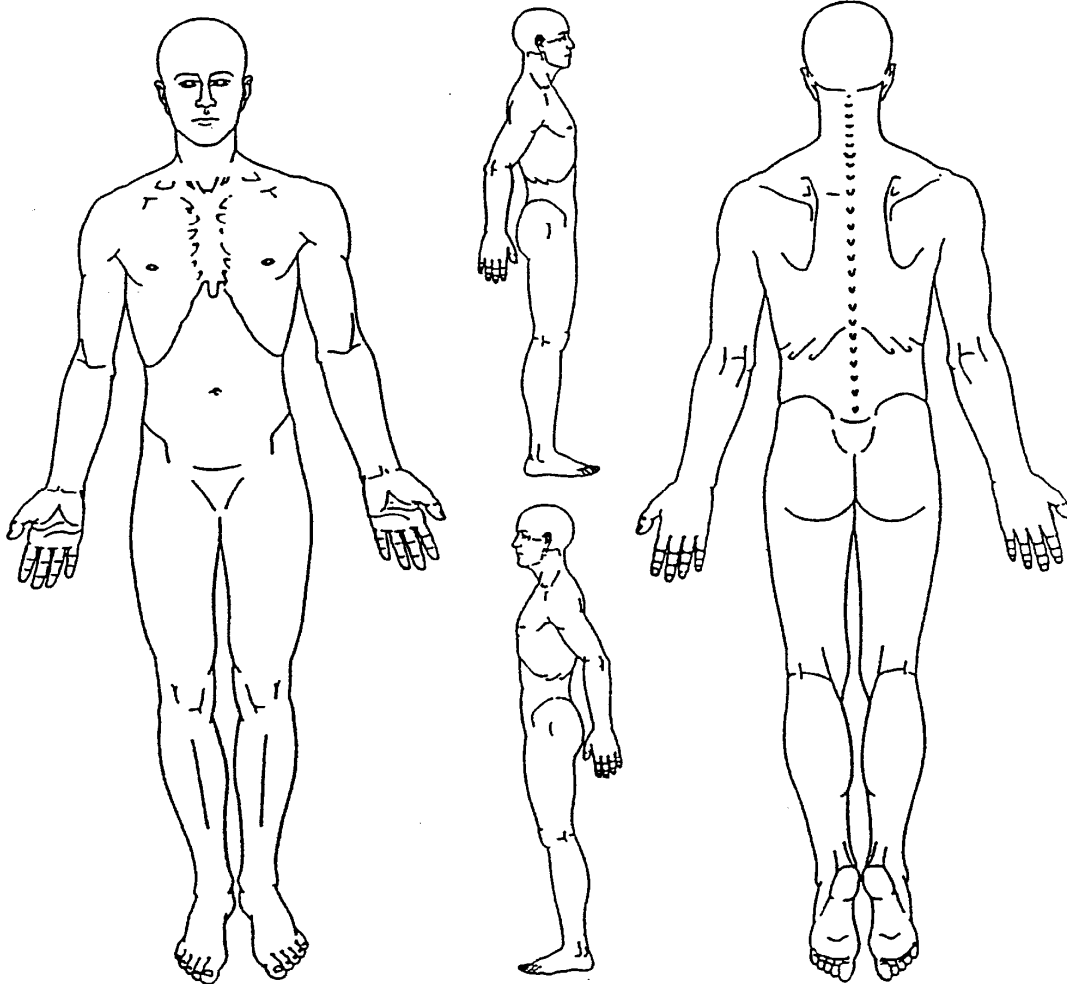


South Texas Brain & Spine Center

Name: _____

Date: _____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN		
A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER



I am right-handed

I am left-handed

1. My pain is in my: _____
2. My pain began (date and year): _____
3. Is this a recent injury? Yes No Possibly
Date of injury? _____ Is the injury work related? Yes No
4. How long have you been off from work since this episode began? _____
5. Explain how it happened: _____

I don't know how it happened My problem is chronic. It began at age: _____

6. I remember an injury. Describe injury: _____

Previous Treatment and Medication for This Condition: None

I have been treated by a physician. What is his or her name? _____

They prescribed:	With how much relief?		
<input type="checkbox"/> Medications:	None	A Little	A Lot
<input type="checkbox"/> Anti-inflammatories:			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscle relaxers:			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain medication:			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Others:			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Exercises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Manipulation			
Chiropractor's Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heat <input type="checkbox"/> Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I Have had surgery before for this same type of problem. How long ago? _____
 What type of surgery? _____

I have had the following tests:
 Plain X-Rays CAT Scan MRI Mylogram Discogram EMG

I have seen other doctors for my condition: _____

The following make me feel:	Better	Worse		Better	Worse
Bed rest	<input type="checkbox"/>	<input type="checkbox"/>	Standing	<input type="checkbox"/>	<input type="checkbox"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>
Stretching/Popping	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>
Bending Backwards/Forwards	<input type="checkbox"/>	<input type="checkbox"/>	Heat	<input type="checkbox"/>	<input type="checkbox"/>
Bending to the left	<input type="checkbox"/>	<input type="checkbox"/>	Ice	<input type="checkbox"/>	<input type="checkbox"/>
Bending to the right	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing/Coughing	<input type="checkbox"/>	<input type="checkbox"/>
Straining to go to the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	Changing Positions	<input type="checkbox"/>	<input type="checkbox"/>

I also have the following problems:

- | | |
|--|---|
| <input type="checkbox"/> My pain awakens me from sleep
<input type="checkbox"/> My pain is worse at night
<input type="checkbox"/> Weakness in my arms
<input type="checkbox"/> Weakness in my hands
<input type="checkbox"/> I drop items after I pick them up
<input type="checkbox"/> I am off-balance when I walk
<input type="checkbox"/> I stumble/fall frequently or run into walls
<input type="checkbox"/> My arms/legs are weak because they hurt | <input type="checkbox"/> I awaken at night with my hands asleep
<input type="checkbox"/> My hands go to sleep while:
<input type="checkbox"/> Driving
<input type="checkbox"/> Using a computer mouse
<input type="checkbox"/> Using a telephone or blow dryer
<input type="checkbox"/> I have weakness in my:
<input type="checkbox"/> Right arm <input type="checkbox"/> Left arm
<input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
|--|---|

- My legs feel weak or hurt when I walk too far:
 - This is relieved by stopping and standing
 - This is relieved by sitting
- I have numbness/tingling in my:
 - Arms
 - Hands
 - Legs
 - Feet
- I can walk:
 - Less than a block
 - 1-2 blocks
 - More than 3 blocks
- I have trouble with my bladder control
 - Can't empty my bladder
 - Loss of control (accidents)
- Trouble with my bowels
 - Constipation
 - Loss of control (accidents)

My job is: _____

My job requirements are:

- Heavy - Lifting over 60 lbs frequent bending and stooping
- Medium - Lifting 30-50 lbs
- Light - Lifting 10-20 lbs
- Sedentary - Sit most of the time with very little lifting
- My job is highly stressful - it makes me tense

General Medical History:

Illness	Year	Illness	Year	Illness	Year
Heart		Hormone Imbalances		Joint Problems	
<input type="checkbox"/> Heart Trouble	_____	<input type="checkbox"/> Thyroid Disease	_____	<input type="checkbox"/> Osteoarthritis	_____
<input type="checkbox"/> Chest Pain	_____	<input type="checkbox"/> Diabetes:	_____	<input type="checkbox"/> Rheumatoid Arthritis	_____
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Insulin controlled	_____	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Heart Failure	_____	<input type="checkbox"/> Diet controlled	_____	<input type="checkbox"/> Hips	_____
<input type="checkbox"/> Heart Murmur	_____			<input type="checkbox"/> Knees	_____
<input type="checkbox"/> Valve Disease	_____	Liver		<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Irregular Heartbeat	_____	<input type="checkbox"/> Liver Disease	_____		
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Hepatitis A	_____	Blood Problems	
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Bad Heart Valve	_____	<input type="checkbox"/> Hepatitis C	_____	<input type="checkbox"/> Leukemia	_____
		<input type="checkbox"/> Cirrhosis	_____	<input type="checkbox"/> Abnormal Bleeding	_____
		<input type="checkbox"/> Other	_____		
Vessels		Kidney		Eye Problems	
<input type="checkbox"/> Bad Vessels	_____	<input type="checkbox"/> Kidney Disease	_____	<input type="checkbox"/> Eye Disease	_____
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Kidney Stones	_____	<input type="checkbox"/> Glaucoma	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Kidney Infections	_____	<input type="checkbox"/> Macular Degeneration	_____
<input type="checkbox"/> Peripheral Vascular Disease	_____	<input type="checkbox"/> Kidney Failure	_____		
				Nervous System	
Lungs		Stomach		<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Lung Disease	_____	<input type="checkbox"/> Ulcerative Colitis	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Emphysema	_____	<input type="checkbox"/> Crohn's Disease	_____	<input type="checkbox"/> Bipolar	_____
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Diverticulitis	_____	<input type="checkbox"/> Psychosis	_____
<input type="checkbox"/> Chronic Bronchitis	_____	<input type="checkbox"/> Heartburn/Reflux	_____	<input type="checkbox"/> Psych. Difficulties	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Irritable Bowel (IBS)	_____	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Frequent Pneumonia	_____			<input type="checkbox"/> Dementia	_____
				<input type="checkbox"/> Nerve Disease	_____
				<input type="checkbox"/> Pain Syndrome	_____

Cancer, describe: _____

No Major Illnesses

Social History:

1. Married Separated Divorced Widow/Widower Single
2. Number of children at home: _____ away: _____
3. I am Left handed Right handed
4. I work as a: _____
5. I am retired from: _____
6. I live with my children or other relatives.
Explain: _____
7. I drink: Beer Wine "Hard" Drinks None Daily Socially
8. I honestly consider myself to drink too much
9. I smoke: Cigars Pipe Cigarettes _____ Packs/day for _____ years
10. My recreational activities include: Jogging Bicycling
 Sports: _____
11. I was born in: City: _____ State: _____

Family Medical History:

- Mother Living at age: _____
 Healthy
 Suffers with: _____

- Father Living at age: _____
 Healthy
 Suffers with: _____

- Deceased at age: _____
Cause: _____
- Deceased at age: _____
Cause: _____
- I have _____ living brothers I have _____ living sisters
- My brothers and sisters suffer from the following:
 Stroke High blood pressure Heart disease Lung disease
 Arthritis Diabetes Back problems
 Cancer (type): _____
 Other: _____
 I don't know
 I am an only child
 I am adopted
- I have _____ deceased brothers I have _____ deceased sisters
- Causes of death: _____

Review of Systems:

Problems that bother you other than your neck or back

I feel my overall state of health is: Good Fair Poor

Height: _____

The most you have weighed as an adult: _____

Weight: _____

The least you have weighed as an adult: _____

- I have recently lost weight without dieting: _____ pounds over _____ months

- I have unusual skin moles, spots or sores
- I have no appetite
- I have an elevated fever
- I have chills
- I have night sweats
- I have problems with my eyes:
 - Blurred vision Double Vision
 - Pain when I look at the lights
 - Floaters Central loss of vision
 - Loss of vision: Right Left
- I have trouble with taste
- I have problems with my ears
 - Pain in ears: Right Left
 - Ringing in ears: Right Left
- I have problems with my nose
 - Nasal discharge
 - Nose bleeds
 - Post-nasal drip
- I have sinus pain
- I have hoarseness
- I have frequent headaches
 - Daily
 - On one side only
- I have frequent nausea
- I frequently vomit
- I have pain when I eat
- I have pain when I swallow
- I have frequent heartburn
- I have frequent reflux
- I throw up coffee ground material
- I cannot hold my urine
- I am frequently thirsty
- I have no energy
- I am nervous
- I am hyperactive

- I have chest pain
 - Daily After eating
 - Radiating down the arm
 - With activity
- My heart "races"
- I wake at night feeling like I am smothering
- I have a heart murmur
- I feel faint frequently
- I sleep on _____ pillows
- I frequently cannot catch my breath
- I get out of breath when I walk
- My legs swell
- I wheeze when I breath
- I cough frequently
- I cough up blood
- I have had blood clots in my legs
- I have been treated for Tuberculosis
- I have frequent pain in my stomach
- I have blood/black stools
- I have blood in my urine
- I have constipation
- I have diarrhea
- I have to urinate at night
- I have to urinate frequently
- I am frequently hungry
- I do not tolerate heat or cold
- I am pale (anemic)
- I bruise easily
- I bleed easily
- I have frequent infections
- I have lymph nodes that swell
- I have recently gained weight for an unknown reason: _____ pounds over _____ months