NORTH ALABAMA SPINE AND REHAB

NEW PATIENT INFORMATION

For Office use only
Patient #

Date _____

Patient's First Name_____ Middle_____ Last_____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone_____

E-mail _____ Social Security # _____

Employer Name _____

Job Title _____ Work Phone # _____

Date of Birth _____ Age____ Gender ☐ Male ☐ Female Handedness? R L

Weight_____ Height _____ Marital Status S M W D

Spouse's Name_____ Spouse's Date of Birth _____

In case of an emergency who should we contact?_____

Phone #_____

PRESENT HEALTH

Please list any medications you are currently taking including **ALL** medications prescribed to you from this current injury? _____

_____

_____

Have you received any medical treatment for this (current) motor vehicle collision? Y or N

Name of Hospital you received treatment? (write N/A if you didn't go to the hospital)

_____

Date of Treatment at hospital? _____

Name of Doctor or Urgent Care Facility you received treatment? **(not including here)**

_____

Date of Treatment at Doctor or Urgent Care Facility? **(not including here)**_____

Name of Physical Therapy Facility you received treatment? **(not including here)**

_____

Date of Treatment at Physical Therapy Facility? **(not including here)**

Name of Orthopedist or Pain Management Facility you received treatment?

Date of Treatment at Orthopedist or Pain Management Facility?

List **ANY** surgeries you have had associated with this current collision and the dates?

PAST MEDICAL HISTORY

Have you ever been in a motor vehicle collision? **(not including the collision you are here today for)** Date? (please give year and approximate month) **Please include ALL history of Collisions**

Were you injured? Y or N What part(s) of your body was injured?

Where did you go for treatment for these injuries (Please include **ALL Treatment Facilities** or **names of Doctors?**

List **ALL** other injuries including falls and other traumas and when they occurred:

MEDICAL HISTORY QUESTIONNAIRE

TODAY'S DATE: _____

NAME: _____ Male/Female AGE: _____ DOB: _____

*****Since this is your medical history and it will be used in evaluating your health, it is extremely important that the questions be answered as accurately and completely as possible. All information is kept confidential. *****

Providers:

Primary Care Provider_____ Referring Physician: _____

Any Other Provider assisting in your care: _____

Past Medical History (Please check any medical problems that you have had in the past)

☐Abnormal pap smear
☐Alcoholism
☐Allergies
☐Anemia
☐Anxiety
☐Arthritis
☐Asthma
☐ Blood transfusion
☐Headaches
☐Heart murmur
☐HIV/AIDS
☐Substance abuse
☐Tuberculosis
☐Hypothyroidism
☐Congestive heart failure
☐COPD (lung disease)
☐Coronary artery disease
☐Depression
☐Diabetes mellitus
☐Diverticulitis
☐GERD (heartburn)
☐Glaucoma
☐Sickle cell anemia
☐Sleep apnea
☐Stroke
☐Colonic adenoma
☐Concussion
☐Ulcers
☐Irregular menses
☐Kidney disease
☐Liver disease
☐Menorrhagia
☐Myocardial infarction (heart attack)
☐Nerve/muscle disease
☐Osteoporosis
☐Seizures
☐Cancer
☐Cataracts
☐Clotting disorder
☐Hypertension (high blood pressure)
☐Hyperlipidemia (high cholesterol)
☐BPH (benign prostatic hyperplasia)

☐Other (list)

_____

Past Surgical History (Check any surgeries you have had and the date of surgery if you know it)

☐Appendectomy
☐Bariatric surgery
☐Brain surgery
☐Breast surgery
☐CABG (bypass)
☐Cesarean section
☐Joint replacement
☐Cholecystectomy (gall bladder removal)
☐Cosmetic surgery
☐Eye surgery
☐Fracture surgery
☐Hernia repair
☐Hysterectomy (ovaries removed)
☐Hysterectomy (ovaries remain)
☐Vasectomy
☐Prostate surgery
☐Small intestine surgery
☐Spine surgery
☐Tonsillectomy and Adenoidectomy
☐Tubal ligation (tubes tied
☐Valve replacement
☐Colon surgery
☐Other (list)_____

Additional Information:

_____

_____

Past and Present Medical Problems:

High blood pressure Yes/ No	Heart attack Yes/ No	High cholesterol Yes/ No
Stroke/TIA Yes/No	Heart Failure Yes/No	Atrial Fib/Arrhythmia Yes/No
PFO/ Hole in Heart Yes/No	Cancer Yes/No	Coagulopathy/Clotting disorder Yes/No
Diabetes Yes/ No	Kidney disease Yes No	Thyroid disease Yes/ No

Other Past Medical History not listed:_____

_____

Surgical History

Please list any surgeries that you have had in the past. Some of the more common ones are listed below

Please circle and date if relevant:

Amputation site_____ Date of surgery_____ Aneurysm repair/site_____Date of surgery_____

Bladder/Prostate repair/ Date of surgery_____ Carotid surgery/ Date of surgery_____

Cataract/ Date of surgery_____ Heart stent/bypass/ Date of surgery_____

Laparoscopy (abdominal scope)/ Date of surgery_____ Lower extremity bypass/Date of surgery_____

Pacemaker / Date of implant_____ Prostate repair/Date of surgery_____

Orthopedic surgeries (Knee, shoulder/rotator cuff, hip replacement) Date of surgery_____

Other surgeries or procedures _____

Social History

(Circle all that apply)

Do you drink alcohol? Current everyday Current someday Former Never Unknown

Beer/Wine/Liquor How many per week? _____

Do you use recreational Drugs? Current everyday Current someday Former Never Unknown

Have you ever used tobacco? Current everyday Current someday Former Never Unknown

How many packs per day do you or did you smoke? Less than half Half One One and half Other_____

How many years did you or have you smoked? _____When did you quit?_____

Family History- Please list which family member was affected

Mother, Father, Brother, Sister, Grandmother (maternal/paternal)Grandfather (maternal/paternal)

Abdominal aortic aneurysm _____ Heart Disease_____

Bleeding Disorder _____ High Blood Pressure_____

Blood Clots_____ High Cholesterol_____

Cancer _____Type_____ Stroke_____

Diabetes _____

Current Medications and Allergies

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS?

Plavix/Clopidogrel: Dose/Frequency _____ Reason_____

Coumadin/Warfarin: Dose/Frequency _____ Reason_____

Aspirin Dose/Frequency _____ Reason_____

Please list the Provider that is monitoring any of the above medications: _____

Do you have any known Allergies to Medications? Please Mark Box if None: ☐

Iodine? Reaction _____Latex? ☐ Reaction _____

Others? Please list Medication and Reaction_____

_____

Please list all medications that you are currently taking (including insulin, over-the-counter medications, vitamins, diet supplements, herbal preparations, etc.).

Medication/Reason Dosage/Frequency Medication/Frequency

_____/_____/_____/_____

_____/_____/_____/_____

_____/_____/_____/_____

_____/_____/_____/_____

_____/_____/_____/_____

_____/_____/_____/_____

Exercise:

Do you exercise regularly? □ No □ Yes If yes, what kind of exercise?_____

How long (minutes)? _____ How often? _____

Sexual Relations Status? ☐ No Change ☐ Not applicable ☐ Painful/limited ☐ Unable due to pain
☐ Decreased desire ☐ Lack of Desire

Are you pregnant? ☐Yes How many weeks?_____ ☐ No

Patient's Signature:_____ Date:_____

SYMPTOMS

Patient's Name _____ Date of incident _____ Today's Date _____

CIRCLE ALL YOUR COMPLAINTS

1. DO YOU HAVE LACERATIONS, CUTS OR BRUISING? :
   a. Head or Face
   b. Neck
   c. Seat belt bruising
   d. Cuts or bruising on your chest
   e. Cuts or bruising on arms
   f. Cuts or bruising on legs
   g. Other: _____
2. HEAD INJURIES: (now or at the time of the accident)
   a. Were you knocked out or unconscious
   b. Headaches
   c. Face pain
   d. Pupils different sizes
   e. Dizziness
   f. Difficulty walking
   g. Balance problems
   h. Room spins
   i. Disoriented Confusion
   j. Day dreaming
   k. Attention problems
   l. Hearing problems
   m. Change in sense of smell or taste
   n. Difficulty speaking
   o. Memory problems
   p. Very tired or fatigued
   q. Appetite change
   r. Sleep difficulties
   s. Visual Disturbances, blurry or double vision
   t. Flashbacks to accident
   u. Problems to read or write
   v. Problems adding or subtracting
   w. Problems learning new things
   x. Problems understanding
   y. Problems remembering numbers
   z. Difficulty Concentrating
   aa. Difficulty remembering things
   bb. Difficulty making decisions
   cc. Change in Sexual Functioning
   dd. Nausea / Vomiting
   ee. Change of personality
   ff. Wanting to be alone
   gg. Mood swings
   hh. Sadness
   ii. Agitation
   jj. Anger
   kk. Helplessness
   ll. Reduce confidence
   mm. Apathy
   nn. Irritability
   oo. Sleepiness
   pp. Frustration
   qq. Impatience
   rr. Other head related issues

   _____
3. JAW PROBLEMS:
   a. Jaw pain
   b. Clicking
   c. Pain while chewing
   d. Pain while talking
   e. Pain while yawning
   f. Pain while moving jaw from side to side
4. NECK INJURIES:
   a. Neck pain
   b. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   c. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   d. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
   e. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
   f. Neck pain that causes headaches

Patient's Signature: _____

g. Neck spasms or shoulder spasms

h. Popping, clicking or clunking sound with neck movement

5. SHOULDER INJURIES
   a. Shoulder pain LEFT RIGHT BOTH
   b. Shoulder pain with movement L R BOTH
   c. Shoulder spasms LEFT RIGHT BOTH
   d. Sharp shoulder pain
   e. Dull shoulder pain
   f. Achy shoulder pain
   g. Pins and needles shoulder pain
   h. Shoulder pain that radiates or shoots pain into arm
   i. Other:

_____

6. UPPER ARM PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

7. ELBOW PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

8. FOREARM: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

9. WRIST PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

10. HAND PAIN: RIGHT LEFT BOTH
    a. Dull
    b. Ache
    c. Sharp
    d. Stabbing
    e. Other

_____

11. MID BACK PAIN OR UPPER BACK PAIN
    a. Upper or mid back pain

    b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand

    c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand

    d. Upper or mid back spasms

12. LOW BACK PAIN:
    a. Low back pain

    b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot

    c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot

    d. Low back spasms

13. PELVIC OR SACRAL PAIN
    a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot

    b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot

c. Sacral pain (tail bone)

d. Coccygeal or coccyx (tail bone) pain

14. HIP PAIN: RIGHT LEFT BOTH

a. Left hip pain

b. Left hip pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot

c. Right hip pain

d. Right hip pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot

15. UPPER LEG PAIN: RIGHT LEFT BOTH

a. Upper leg pain that radiates to knee

b. Upper leg spasms

16. KNEE PAIN: RIGHT LEFT BOTH

a. Knee pain that radiates to calf

b. Knee pain that radiates to calf and ankle

c. Knee pain that radiates to calf, ankle and foot

17. ANKLE PAIN: RIGHT LEFT BOTH

a. Ankle pain that radiates to foot

b. Ankle and foot pain

18. FOOT PAIN: RIGHT LEFT BOTH

19. CHEST PAIN

20. STOMACH PAIN

21. OTHER SYMPTOMS:

_____

Review of Symptoms

Patient Name: _____ Patient File #: _____ Today's Date: ____ / ____ / ____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
- ☐ None
- ☐ Chills
- ☐ Daytime Drowsiness
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Eyes/Vision:
- ☐ None
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Itching *(around the eyes)*
- ☐ Photophobia
- ☐ Tearing
- ☐ Wears Glasses or Contacts

Ears, Nose and Throat:
- ☐ None
- ☐ Bleeding
- ☐ Dental Implants
- ☐ Dentures
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dizziness
- ☐ Ear Drainage
- ☐ Ear Infection*(s)*
- ☐ Ear Pain
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injury *(history of)*
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Rhinorrhea *(runny nose)*
- ☐ Sinus Infections
- ☐ Snoring
- ☐ Sore Throats
- ☐ Tinnitus *(ringing in the ears)*
- ☐ TMJ Disorder

Cardiovascular:
- ☐ None
- ☐ Angina *(chest pain or discomfort)*
- ☐ Chest Pain
- ☐ Claudication *(leg pain or achiness)*
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Orthopnea *(difficulty breathing while lying)*
- ☐ Palpitations *(irregular or forceful heart beat)*
- ☐ Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- ☐ Shortness of Breath
- ☐ Swelling of Leg*(s)*
- ☐ Ulcers
- ☐ Varicose Veins

Gastrointestinal:
- ☐ None
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice *(yellowing of the skin)*
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber *(quality)*
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

Respiration:
- ☐ None
- ☐ Asthma
- ☐ Coughing up blood
- ☐ Shortness of Breath
- ☐ Sputum Production
- ☐ Wheezing

Endocrine:
- ☐ None
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Skin:
- ☐ None
- ☐ Changes in Nail Texture
- ☐ Changes in Skin Color
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia (numbness, prickling, or tingling)
- ☐ Rash
- ☐ History of Skin Disorders
- ☐ Skin Lesions or Ulcers
- ☐ Varicosities

Nervous System:
- ☐ None
- ☐ Dizziness
- ☐ Facial Weakness
- ☐ Headaches
- ☐ Limb Weakness
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors
- ☐ Unsteadiness of Gait

Allergy:
- ☐ None
- ☐ Anaphylaxis *(history of)*
- ☐ Food Intolerance
- ☐ Itching
- ☐ Nasal Congestion
- ☐ Sneezing

Hematology:
- ☐ None
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusion*(s)*
- ☐ Bruises easily
- ☐ Fatigue
- ☐ Lymph Node Swelling

Psychological:
- ☐ None
- ☐ Anhedonia *(inability to experience joy or enjoy life)*
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Change*(s)*
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Mood Change*(s)*

Female:
- ☐ None
- ☐ Birth Control Therapy
- ☐ Breast Lumps / Pain
- ☐ Burning Urination
- ☐ Cramps
- ☐ Frequent Urination
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Male:
- ☐ None
- ☐ Burning Urination
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy or Dribbling
- ☐ Prostate Problems
- ☐ Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: _____ Doctor Signature _____ Date

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travelling (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activity

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

_____ Patient's Signature

_____ Date

For Office Use Only:

Practitioner ID#: _____

Total Score _____ / 40

Clinical Diagnosis Codes:

Patient ID#: _____