Kirshner Spine Institute Patient Information Form

Patient Name:______________________________ Age:__________ DOB: __________

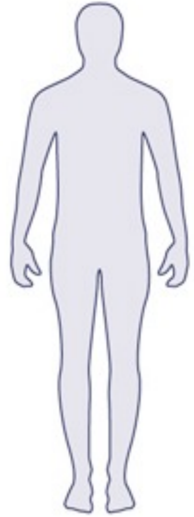
Work related injury? (Yes / No) Date: _______________ Auto accident? (Yes / No) Date________________

Reason for your visit:____

__ back pain __ leg pain (right/left) __ neck pain __ arm pain (right/left)

__ headache __ fracture __ other______________________________

Where is your pain?



What makes your pain worse? ____

What makes your pain better? ____

____

Have you had physical therapy? (yes / no) Where ? _________________________

Did it help ? (yes / no) For how long ? ________________________

Have you seen a chiropractor ? (yes/ no) Who? ____________________________

Did it help ? (yes / no) For how long ? ________________________

Have you had epidural or steroid injections? (yes / no)

Pain management Physician's name ? ____________________________

___ back ? If so – how many ? _______ Did it help ? (yes / no) For how long? ______

___ neck ? If so – how many ? _______ Did it help ? (yes / no) For how long? ______

Have you had surgery for your (back / neck) in the past? If so – what was the surgery and when?

____

Do you currently experience any of the following symptoms?

__ weakness of the (arm / leg) __ numbness of the (arm /leg) __ pins/ needles of the (arm /leg) __ bowel or bladder incontinence __ numbness of the groin __ black outs__ increase in pain w/ coughing, sneezing or bowel movements __ memory difficulties __ vision changes

Your past medical history:

__ high blood pressure __ diabetes __kidney problems __ liver problems __ asthma __ lung problems __sleep apnea __ CPAP

__ reflux __ thyroid problems __osteoporosis __arthritis __ stroke __ heart disease/heart attack __ stress test in the past

__ depression / anxiety __ psychiatric problem __ hepatitis __ bleeding/clotting disorder __ history of blood clot __ anemia

__ seizures _ cancer (type) ____________________________ Other____

Do you have problems/complaints of the following:

__ eyes / ears / nose / throat __ chest pain __ palpitations __ shortness of breath __ wheezing __ coughing __abdominal pain

__ constipation / diarrhea __ nausea / vomiting __ easy bruising __ recent unexplained weight loss __skin changes

List ALL medications including over the counter (OTC), vitamins and supplements and dosages that you are currently taking:

____

____

Allergies (medications and food): ____

Your **past surgical history**: (what type of surgery and the date)

__________________________ __________________________ __________________________ __________________________

__________________________ __________________________ __________________________ __________________________

Your **family history**: (what health issues/problems run in your family?)

__ aneurysm __ arthritis __asthma __ bleeding/clotting disorder __ cancer __ depression/anxiety__ heart disease__ heart attack __high blood pressure __ kidney problems __ liver problems __ lung problems__ osteoporosis__ psychiatric problems__ stroke__ thyroid problems__

________________________________ Other __________________________________

Employment: ________________________ **Job Title/position**: __________________ **How long** (employed / unemployed) ?____________

Are you collecting Disability? (yes / no) Social Security Disability? (yes / no) Worker's Comp disability? (yes / no)

Do you smoke? (yes / no) If so, how many packs per day? ___________ if quit – when? ___________

Do you drink alcohol? (yes / no) If so, how much/often? __ socially __often few times a week __ every day __ never

Do you use recreational drugs (marijuana, cocaine, IV drugs etc) (yes / no) if so – what_________________ Are you in recovery? (yes / no)

Do receive your pain meds from a physician? If so – who? ____________________________________ Do you have a pain contract? (yes / no)

__ Married __ Divorced __ Single __Widowed __Children/how many? ____________ Live alone or with?______________________
Family Physician name:_____________________________ Office phone #: _________________________

Pharmacy: Name ___________________________ Phone number _____________________________

Patient Signature: ____________________________ Date: _______________