VALLEY Sports & Spine CLINIC

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NEW PATIENT INITIAL HISTORY EXAM

NAME _____ TODAY'S DATE _____/_____/_____

DATE OF APPOINTMENT _____/_____/_____

Please list the top three questions you would like answered during today's visit:

1. _____

2. _____

3. _____

1. How and when did your problem begin? (Mark each that applies):

☐ I don't know how it began.
☐ It comes and goes.
☐ I've had it a long time
☐ Injury (date of injury_____)
☐ work related injury
☐ injury related to a motor vehicle accident
☐ sports related injury
☐ unrelated to any particular incident

2. Please list previous back, neck, and/or joint problems:

_____

3. Have you or will you file a Workers' Compensation or No-Fault Insurance Claim? ☐ YES ☐ NO

4. At any point in time, have you had a Workers' Compensation or No-Fault Claim? ☐ YES ☐ NO
What of your body was/is involved: _____

5. What is your occupation? _____

6. Are you currently working? ☐ YES ☐ NO With? ☐ Regular Duty ☐ Modified/Light Duty

7. Date last worked: _____/_____/_____

8. Check which of the following activities change the nature of our pain, if applicable:

	Aggravates Pain	Relieves Pain		Aggravates Pain	Relieves Pain
Sitting	☐	☐	Lying on your back	☐	☐
Standing	☐	☐	Lying on your stomach	☐	☐
Walking	☐	☐	Driving	☐	☐
Rising from sitting	☐	☐	Coughing/Sneezing	☐	☐
Bending forward	☐	☐	Other _____	☐	☐

Patient Name: _____DOS:_____

9. List all physicians you have consulted for your present condition:

_____

10. Have you had any of the following studies? (Please check)

☐ Plain X-rays	Date:_____Where:_____	☐ Myelogram	Date:_____Where:_____
☐ CT scan	Date:_____Where:_____	☐ Discogram	Date:_____Where:_____
☐ MRI	Date:_____Where:_____	☐ Bone scan	Date:_____Where:_____
☐ EMG(nerve test)	Date:_____Where:_____	☐ Bone density (DEXA)	Date:_____Where:_____
☐ Other _____	Date:_____Where:_____		

11. Have you had any of the following for your current problem? If Yes, did it make your condition better or worse?

NSAID Therapy ☐ Better ☐ Worse; When(if within past 6months)?_____
List(Aleve, Motrin, Celebrex, etc)?_____
Physical Therapy ☐ Better ☐ Worse; When?_____Where?_____
Chiropractic Care ☐ Better ☐ Worse; When?_____Where?_____
Steroid Injection ☐ Better ☐ Worse; When?_____Where?_____
Other:_____ ☐ Better ☐ Worse; When?_____Where?_____

12. Have you had previous spine surgery for your current pain or problem?

Type of surgery_____Date_____Surgeon_____

Did it make your pain: ☐ Better ☐ Worse_____

13. Please check whether or not you have had the following problems:

YES	NO		YES	NO	
☐	☐	Stomach Ulcers	☐	☐	Seizure disorder
☐	☐	Cancer	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Hepatitis
☐	☐	Asthma	☐	☐	Thyroid Disease
☐	☐	Bronchitis/Emphysema	☐	☐	Kidney Stones
☐	☐	Heart disease or heart attack	☐	☐	Kidney Infections
☐	☐	Rheumatic disease, Arthritis	☐	☐	Prostatic problems
☐	☐	High blood pressure			

14. Please list any other medical problems not listed above: _____

_____

15. Are you taking medications for medical conditions? Please list or see attached: _____

_____

16. Are you allergic to any medications? ☐ YES ☐ NO (If Yes, please list)

_____

Have you ever had x-ray dye? ☐ YES ☐ NO
Are you allergic to x-ray dye? ☐ YES ☐ NO

Patient Name: _____ DOS: _____

17. List all previous non-spinal surgeries:

_____ Year: _____ _____ Year: _____
_____ Year: _____ _____ Year: _____
_____ Year: _____ _____ Year: _____

18. Please check whether or not you have had the following problems:

YES	NO			YES	NO	
☐	☐	Change in ability to pass urine	1	☐	☐	Dizziness
☐	☐	Difficulty with bowel movements	2	☐	☐	Fainting
☐	☐	Unexplained weight loss	3	☐	☐	Loss of consciousness
☐	☐	Night pain		☐	☐	Difficulty swallowing
☐	☐	Fever		☐	☐	Swelling of toe or finger joints
☐	☐	Difficulty falling asleep		☐	☐	Headaches
☐	☐	Difficulty staying asleep	4	☐	☐	Difficulty breathing 8
☐	☐	Feeling tired in the morning		☐	☐	Irregular heart beat or palpitations 9
☐	☐	Visual changes	5	☐	☐	Rashes or blisters 10
☐	☐	Weakness	6			
☐	☐	Numbness	7			
		Poor coordination:				
☐	☐	With gait				
☐	☐	With fine hand manipulations				

☐ All other systems negative

19. Are you currently: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

20. Do you smoke cigarettes? ☐ NO ☐ YES _____ packs per day x ____ years
Are you trying to quit smoking? ☐ NO ☐ YES

21. Do you drink alcoholic beverages? ☐ NO ☐ YES How much per week? _____

22. If your symptoms were better, what two physical activities would you like to do better or return to doing?

_____
_____

23. Currently (or before symptoms began), what regular exercises were you doing?
(examples: running, weight training)

1. _____ 2. _____
3. _____ 4. _____

Ethan Colliver, DO: _____

Holly P. Martin, PA-C: _____