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**Johnson County Spine**  
Providing Excellence in Spinal Care

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Primary care Doctor \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_-\_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone \_\_\_\_-\_\_\_\_\_

**Symptoms:**

What are your symptoms? \_\_\_\_\_

Is the pain mostly in the back, neck, or elsewhere? \_\_\_\_\_

How long ago did these symptoms begin? \_\_\_\_\_

How did they begin? \_\_\_\_\_

Is the pain constant, or does it come and go? \_\_\_\_\_

What make the pain better? (position, rest, ice/heat, pills)? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

Does the pain radiate into your arm or leg? **Y N** Describe \_\_\_\_\_

Do you have weakness, numbness, tingling in your arm or leg? **Y N** Describe \_\_\_\_\_

Have you lost control of your bowel or bladder function? **Y N** Describe \_\_\_\_\_

How long can you... Sit \_\_\_\_\_ Stand \_\_\_\_\_ Walk \_\_\_\_\_ Sleep \_\_\_\_\_

Is your pain the result of a... (Fall) (Car Accident) (Injury on the job) Other \_\_\_\_\_

Which of the following describes you presently? (Working) (Not working because of a back or neck problem) (Not working because of another health problem) (homemaker, retired or unemployed)

How long have you been at your job? \_\_\_\_\_ What is your occupation? \_\_\_\_\_

Does your job require bending, lifting, standing? \_\_\_\_\_

Employer at time of injury? \_\_\_\_\_ Is there a lawsuit pending or a problem? \_\_\_\_\_

**Previous Treatments/ tests**

Who first treated you for this problem? \_\_\_\_\_ City \_\_\_\_\_

What treatments did you have then? \_\_\_\_\_

What tests have you had done? CT scan \_\_\_\_\_ MRI \_\_\_\_\_

X-rays \_\_\_\_\_ EMG \_\_\_\_\_ Other \_\_\_\_\_

Please circle any of the other treatments you have had. Physical Therapy (Did/Did Not Help)

Injections (Did/Did Not Help) Special back/neck exercises (Did/Did Not Help) Other \_\_\_\_\_

List all **surgeries/ hospitalizations/ serious illnesses** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List all of your **current medications** (include prescriptions, over-the-counter, and herbal medicines and supplements) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Allergies** (drugs, food, seasonal and include type of reaction) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you **allergic** to shellfish \_\_\_\_\_ iodine \_\_\_\_\_ x-ray dye \_\_\_\_\_ latex \_\_\_\_\_?

Are you taking any **blood thinners** (aspirin, ibuprofen, coumadin, lovonox, vitamin E)? Please list drug(s) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had **complications** from surgery or anaesthesia? Please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please indicate any **family history** (parents, siblings, children) of **medical conditions** such as heart disease, diabetes, cancer, stroke, etc.

\_\_\_\_\_  
\_\_\_\_\_

Marital status \_\_\_\_\_ Number of children \_\_\_\_\_

Hobbies \_\_\_\_\_ Exercise/recreation \_\_\_\_\_

Tobacco (type/amount per day) \_\_\_\_\_ If former tobacco use, quit date \_\_\_\_\_

Caffeine intake (type/amount per day) \_\_\_\_\_ Alcohol intake (type/amount per week) \_\_\_\_\_

Height \_\_\_\_\_ Usual weight \_\_\_\_\_ Ideal weight \_\_\_\_\_

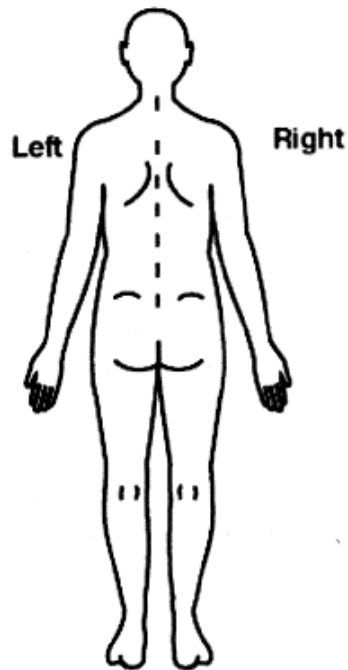
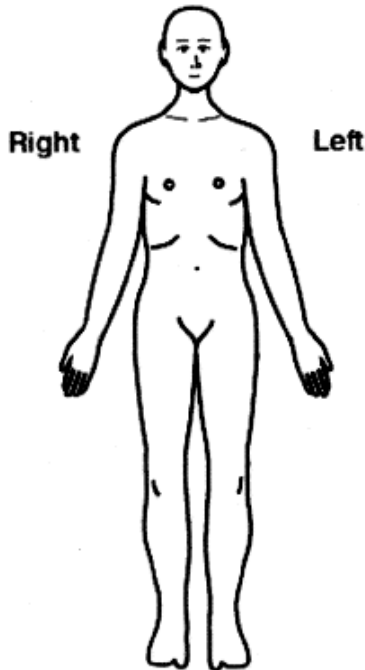
**To the best of my knowledge, the questions on this form have been answered correctly. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary healthcare services I may need.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's signature Date Physician's/Examiner's signature Date

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



Stabbing pain /////  
 Burning pain 0000  
 Aching pain xxxxx  
 Numbness =====  
 Pins & needles v v v



Circle your **current pain** on the graph

0	1	2	3	4	5	6	7	8	9	10	
No pain											Severe pain

Circle your **worst pain** on the graph

0	1	2	3	4	5	6	7	8	9	10	
No pain											Severe pain

Circle your **least pain** on the graph

0	1	2	3	4	5	6	7	8	9	10	
No pain											Severe pain

**Medical history**

Do you have a history of or do you currently have any of the following health problems?

	Yes	No		Yes	No
Heart disease	_____	_____	Diabetes	_____	_____
High blood pressure	_____	_____	Bleeding disorder	_____	_____
Stroke	_____	_____	Hepatitis	_____	_____
Blood clots	_____	_____	Stomach ulcers	_____	_____
Anemia	_____	_____	Thyroid disease	_____	_____
Lung disease	_____	_____	Kidney disease	_____	_____
Asthma/bronchitis	_____	_____	Liver disease	_____	_____
Emphysema/COPD	_____	_____	Skin disease	_____	_____
Tuberculosis	_____	_____	Infections	_____	_____
HIV/AIDS	_____	_____	Seizures	_____	_____
Arthritis	_____	_____	Cancer	_____	_____
Obesity	_____	_____	Depression/Anxiety	_____	_____
Rheumatic fever	_____	_____	Psychiatric problems	_____	_____
Heart murmur	_____	_____	Sickle cell anemia	_____	_____
Irregular heart beat	_____	_____	Prior blood transfusion	_____	_____
Chest pain	_____	_____	Dizziness/fainting	_____	_____
Heart attack	_____	_____	Polio	_____	_____
Recent cold/flu	_____	_____	Illicit drug use	_____	_____
Steroid medication	_____	_____	Other	_____	_____