Dear Patient:

Enclosed you will find a back history packet. In order to treat your problem efficiently, we request that these forms be filled out completely prior to your appointment. Thank you for your cooperation.

You will need to obtain **ALL** prior spine x-rays, myelograms, CT scans, MRIs and a copy of all reports. Please bring these together with any MEDICAL RECORDS (EMGs, office notes, test results, etc.) with you the day of your appointment.

Thank you

OrthoMichigan
Name: ___________________________ Date: ___________________________ 

OCCUPATION: __________________ REferred BY: ___________________________ 

CHIEF COMPLAINT: Part(s) of body injured or painful: ________________________________
________________________________________________________________________________________
________________________________________________________________________________________

HISTORY OF INJURY:
Exact date of injury/painful event: __________________________________________________________
City/State where injury occurred: __________________________________________________________
Work related injury? YES/NO: __________________________________________________________________________
Employer’s Name/Location on injury date: __________________________________________________________
Describe in detail how injury occurred:
Describe your pain/problems IMMEDIATELY (48 hours) following injury: __________________________
________________________________________________________________________________________
________________________________________________________________________________________
Describe the INITIAL treatment you received (dates and physician’s names, medications, physical therapy, etc.):
________________________________________________________________________________________
________________________________________________________________________________________

HISTORY OF CHRONIC PAIN/PROBLEMS:
Date when you first noticed pain/problem: ______________________________________________________
Describe the progression of pain/problem (dates of changes in your status, surgeries, other events): __________________________
________________________________________________________________________________________
Has there been any pain free intervals with physical therapy or after surgery?: __________________________
________________________________________________________________________________________

CURRENT TREATMENTS (therapy, medication, braces, etc.):
Physical therapy (type/location): ____________________________________________________________
Anti-inflammatory: __________________________________________________________________________
Pain killers: ________________________________________________________________________________
Muscle relaxers: _____________________________________________________________________________
Sleeping pills: ______________________________________________________________________________
List all special tests and results prior to this evaluation (include dates, location, and any hospitalizations):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Names/Locations of physicians who have evaluated/treated you: ________________________________
________________________________________________________________________________________
________________________________________________________________________________________

WORK STATUS: Have you missed time from work because of INJURY/PAIN/ PROBLEM? List dates: __________________________
Have you returned to modified work or changed jobs? Explain: ________________________________
Have you had previous injuries or treatment to any part(s) of your body for which you now seek our help? YES/NO
Please explain: ____________________________________________________________________________
Have you had any subsequent injuries or exacerbations of pain since you initial claim? Explain: __________________________
________________________________________________________________________________________
DO YOU HAVE AN ATTORNEY INVOLVED WITH YOUR CASE?  YES / NO  (Their name and address)

__________________________________________________

REVIEW OF OUTSIDE MEDICAL RECORDS: (For doctor use only)

__________________________________________________

CURRENT SYMPTOMS:
Describe in DETAIL your PRESENT complaints and symptoms:

__________________________________________________

Number of hours you can sit: ____________, stand: ____________, walk: ____________
How far can you walk? ____________ # blocks/miles ____________
Is your pain exactly like it was during initial weeks/months from injury? ____________
Has there been a pain free interval with rest, physical therapy, and/or surgery? ____________
Where do you hurt the MOST? ____________

My pain is: (please circle) { dull / sharp / achy / cramping } { stabbing / throbbing / burning }
Other: ____________
Do you have: { numbness / tingling } Where? ____________
Does the pain/numbness travel? YES / NO Where? ____________

MY PAIN is:

<table>
<thead>
<tr>
<th>Activity</th>
<th>BETTER</th>
<th>WORSE</th>
<th>SAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>With cough/sneeze/straining</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing</td>
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<td></td>
<td></td>
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<tr>
<td>Walking</td>
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<td></td>
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<tr>
<td>Lifting</td>
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<td></td>
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<tr>
<td>Bending Forward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bending Backward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking up/down stairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I get up in morning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle of the night</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying flat on back</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying on stomach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying on side with knees bent</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Since the injury/time I noticed the problem, my pain has become (worse / better / remained the same)
Please comment: ____________
Do you have problems with sleep?
Are there recent changes in bowel / bladder habits?
Are you experiencing any sexual difficulties?
Headaches / vision changes / hearing changes / balance problems?
PAST MEDICAL HISTORY:
Circle if you now have or have previously suffered from (please list dates and explain):
High blood pressure / Heart attack / Lung problems / Thyroid condition / Liver disease / Ulcers /
Diabetes / Seizures / Strokes / Blood clots / Mental illness / Arthritis / Blood transfusion /
Other: _______________________
_____________________________________________________________________
Last menstrual period: _______________________________________________________________________________
Previous surgeries (type of operations and dates/name of physician): _____________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
Any other hospitalizations (reason and dates): ______________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
Allergies (medicines, foods, pollens, etc.): Please list and describe effects on you: _______________________________
_______________________________________________________________________________________________
Medications (and their dose) other than those previously listed: _____________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

REVIEW OF SYSTEMS: (Please check if applicable)

NEUROLOGICAL:
_______ loss of consciousness
_______ paralysis
_______ changes in taste/smell
_______ tremors
_______ gait disturbances
_______ headaches

MUSCULOSKELETAL:
_______ backache
_______ neckache
_______ stiffness
_______ fractures
_______ joint swelling
_______ muscle weakness
_______ muscle cramps
_______ leg pain with walking

GASTROINTESTINAL:
_______ swallowing difficulty
_______ heartburn
_______ nausea / vomiting
_______ abdominal pain
_______ ulcer
_______ jaundice / hepatitis
_______ blood in stool
_______ weight loss / gain

GENITOURINARY:
_______ urinary frequency / urgency
_______ inability to urinate
_______ dribbling
_______ increased amount of urine
_______ stones
_______ discharge / venereal disease
_______ pelvis pain
_______ painful intercourse

FAMILY HISTORY: 

<table>
<thead>
<tr>
<th></th>
<th>LIVING</th>
<th>DECEASED</th>
<th>CAUSE OF DEATH</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>______</td>
<td>______</td>
<td>__________________</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>______</td>
<td>______</td>
<td>__________________</td>
<td></td>
</tr>
<tr>
<td>Brother(s)</td>
<td>______</td>
<td>______</td>
<td>__________________</td>
<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td>______</td>
<td>______</td>
<td>__________________</td>
<td></td>
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</table>
Please mark the following found in family:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mother</th>
<th>Father</th>
<th>Sister</th>
<th>Brother</th>
<th>Child</th>
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</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
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<tr>
<td>Tuberculosis</td>
<td>______</td>
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<td>Heart Disease</td>
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<td>______</td>
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<tr>
<td>Epilepsy</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>Cancer</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
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<tr>
<td>Allergies</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

SOCIAL HISTORY:

Occupation: ____________________________________________  Currently working?  YES / NO
Date you last worked: ____________________________________
Activity limitations: ____________________________________

Marital Status:  Married / Single / Divorced / Widowed
Number of children: ______ Ages: ______________________  Number living at home: _______

Education completed (years):  9  10  11  12  13  14  15  16  16+

Alcohol use: ____________ beers/drinks per day / week (circle)
Tobacco use: ____________ packs per day for ___________ years

Name and address of your family physician: _____________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

AN IMPORTANT REMINDER:

You will need to obtain ALL prior spine x-rays, myelograms, CAT scans, spine MRI scans, and a copy of their reports by the radiologist. PLEASE BRING THESE together with any MEDICAL RECORDS of pertinent examinations (i.e. EMG, prior physician evaluations) with you the day of your appointment.

On the day of your examination you will undergo a complete orthopedic spine evaluation by the primary physician and members of his staff. The assessment along with your x-rays and other tests will be compiled into a detailed report for your insurance carrier. We feel your spine problems deserve this careful attention to obtain an accurate diagnosis and help initiate the appropriate treatment. Your cooperation with our procedures will help to ensure our continued medical intervention towards you spinal condition.

_______________________________________________________________
Signature
PATIENT PAIN DRAWING

Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas where sensations travel, if any. Include ALL affected areas.

<table>
<thead>
<tr>
<th>ACHÉ</th>
<th>NUMBNESS</th>
<th>PINÁS &amp; NEEDLÉS</th>
<th>BURNING</th>
<th>STABBING</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;&gt;&gt;&gt;&gt;&gt;</td>
<td>===========</td>
<td>00000</td>
<td>xxxxx</td>
<td>//////////</td>
</tr>
<tr>
<td>&gt;&gt;&gt;&gt;&gt;&gt;</td>
<td>===========</td>
<td>00000</td>
<td>xxxxx</td>
<td>//////////</td>
</tr>
</tbody>
</table>

Pain in arms(s) compared to neck
- Worse than:
- Same as:
- Less than: