



## PERSONAL INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Occupation: \_\_\_\_\_ ☐ Not working

## SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed  
Do you live alone: ☐ Yes ☐ No  
How many children do you have? \_\_\_\_\_  
Will you have a caregiver to assist you if surgery is needed? ☐ Yes ☐ No  
Are you currently working? ☐ Yes ☐ No  
Have you lost work due to your back problem? ☐ Yes ☐ No  
Do you have stairs in your home? ☐ Yes ☐ No  
Do you think you are at risk for a fall? ☐ Yes ☐ No

## CURRENT PROBLEMS

Date symptoms began: \_\_\_\_\_  
Chief complaint or reason for visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Cause of present problem (e.g. work related injury, auto accident, slip-and-fall, etc.): \_\_\_\_\_  
\_\_\_\_\_  
What favorite activities does your pain prevent?: \_\_\_\_\_  
\_\_\_\_\_  
Can you care for yourself (i.e. dressing, eating, toileting, standing up, etc.) \_\_\_\_\_  
\_\_\_\_\_  
Other difficult functions include: \_\_\_\_\_

## PAST HISTORY

Past or ongoing medical problems (e.g. high blood pressure, stroke, diabetes, heart condition, cancer, etc.):  
(If more space is needed, please attach on a separate sheet.)

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

### Previous Surgeries

Name of operation

Date

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### Other Information

Do you smoke? ☐ Yes ☐ No

Number of cigarettes per day \_\_\_\_\_

Do you drink alcohol? ☐ Yes ☐ No

Number of drinks per day \_\_\_\_\_

Have you had imaging in the last 3 months?

☐ Yes ☐ No ☐ MRI ☐ CT Scan ☐ X-rays

### Allergies

Please list all allergies and response such as rash, itching, difficulty breathing, or unknown:

Drug name

Reaction

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### Medications

Please list all current medications, over the counter drugs, vitamins and herbals.

Please give us the total number of "as needed" medication taken in a 24-hour period.

Name	Dosage / Amount	Time of day	Total taken in 24 hours.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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Signature

Date

Time

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