The Robotic Spine Institute of Silicon Valley

OrthoNorCal
Excellence in Orthopedics

PATIENT I.D.

RIGHT LEFT LEFT RIGHT

Where is your pain now?

Mark the areas on your body using the appropriate symbols to describe your symptoms.

TYPE OF PAIN	SYMBOL
Ache	<<<<<<<<<<<<<<<<
Numbness	0 0 0 0 0 0 0 0 0
Pins & Needles	■■■■■■■■■■■■■■■■■■■
Burning	xxxxxxxxxxxxxxxxx
Radiating Pain	//////////////////////////

How bad is your pain?

Neck Pain ________ %
Arm Pain ________ %
Total ___100___ %

Back Pain ________ %
Leg Pain ________ %
Total ___100___ %

How much pain in general can you tolerate?

How bad is your pain now?

THE DURATION OF PAIN

[ ] Continuous [ ] Positional [ ] Intermittent (On/Off) [ ] Unable to Rate

HAVE YOU TAKEN PAIN MEDICATION IN THE PAST 24 HOURS?

[ ] Yes [ ] No

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 ______________________

______________________ ______________________

______________________ ______________________

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

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.

Signature ______________________ Date ____________ Time ____________