SPINAL DECOMPRESSION PATIENT CASE HISTORY

Today's Date: _____/_____/_____

PATIENT INFORMATION:

Name: (First, MI, Last)____ **Preferred Name:** ____________

Address: ____

City:_______________________________ **State:**_________ **Zip:**______________

Date of Birth: _________/__________/__________ **Height:** _________ **Weight:** _____________

Gender: **Male** **Female** **Marital Status:** **Single** **Married**

Social Security#: __________-_________-__________

Home:______________________ **Mobile:**_____________________ **Work:**__________________

Email:____

Preferred Method of Contact: **Text** **Email** **Phone (Home, Mobile, or Work)**

Are you Currently Employed: **Yes** (Occupation) _____________________________ **No**

Referred By: _______________________________________

Family **Friend** **Co-Worker** **Doctor** **Other** (**social media, internet search**)

EMERGENCY CONTACT INFORMATION:

Name: (First, MI, Last) _______________________________________

Home: _______________________ **Mobile:**________________________

Relationship: **Child** **Parent** **Spouse** **Other**

Primary Care Physician: _______________________________ **Phone#:** ______________________

HISTORY OF PRESENT ILLNESS

1. **Please identify the conditions that brought you to this office and how they happened:**

____
____
____

2. **What is the level of your pain RIGHT now?**

No Pain (0/10)

Mild (1-2/10)

Mild-Moderate (3-4/10)

Moderate (5-6/10)

Moderate-Severe (7-8/10

Severe (9-10/10)

3. **Do you have any of the following:**

Neck pain

Neck Stiffness

Headaches

Numbness/Tingling

Grip Strength Issues

Low Back Pain

Sciatica

Neuropathy

Restless Leg

Weakness

4.
5. 4. **What relieves your symptoms?** ____
6. ____
7.
8. 5. **What makes your symptoms feel worse?** ____
9. ____

10.

11. 6. **Is your problem the result of ANY type of accident?** ______________________________________

12. ____

13.

14.

15.

16. PAST HISTORY

17.

1. **Have you ever been diagnosed with a bulging or herniated disc?**

18.

19. **Yes** **No**

20.

2. **Have you had a Lumbar MRI or Cervical MRI in the last 7 years?**

21. **Yes** **No**

22.

23. **If yes, when and where?** ____

24. ____

25.

3. **When and where was your last complete spinal examination including x-rays?**

26. ____
____
_

27.

4. **Have you suffered with this or a similar problem in the past?**

28. **Yes** **No**

29.

5. **Have you ever been treated by anyone for this in the past?**

30. **Yes** **No**

31.

6. **Have you had any spine of disc surgeries?**

32. **Yes** **No**

33. **If yes, when, what type of surgery, where was it done?**

____

34. ____

____

_

35.

7. **What other treatments have you sought out in the past for treatment of this condition?**

36. **Physical Therapy**

37. **Chiropractic**

38. **Pain Relievers**

39. **Epidural Steroid Injections**

40. **Surgery**