Mohawk Valley Orthopaedics, PC
Spine Center
New Patient Form

Today's Date _____ Birth Date _____

First Name _____ Last Name _____

Your Email Address

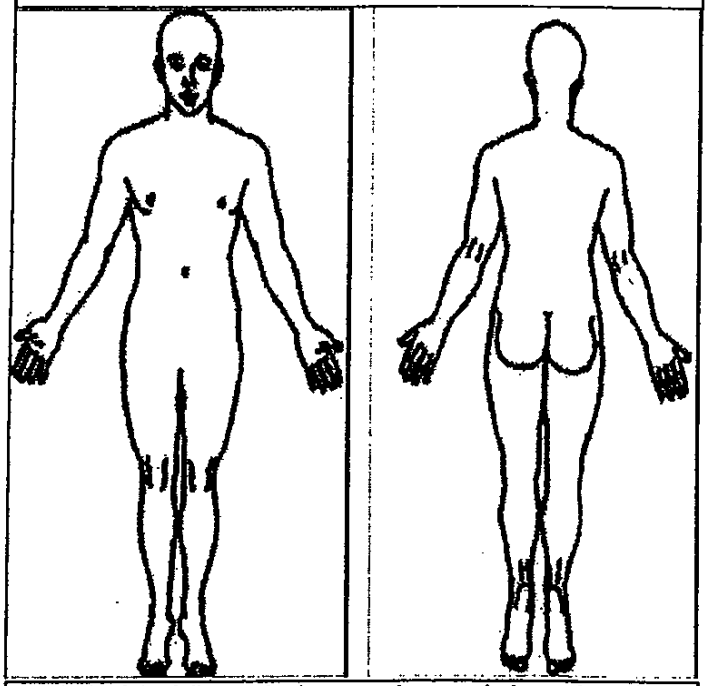
1. Referring Physician and contact information:

2. Primary Care Physician and contact information:

MD Notes:

3. Please describe why you are here today, and specify any changes that have occurred since your last visit.

4. Please mark any areas where you feel pain on the drawings below.
- Mark burning pain XXXX
- Mark deep aching pain OOOO
- Mark pins and needles pain ////
- Mark stabbing pain ZZZZ



5. Which of the following bothers you the most (select only one)?

☐ Back pain
☐ Leg or buttock pain
☐ Neck pain
☐ Arm or shoulder pain

6. How long have you had your symptoms?

☐ Less than 1 month
☐ Between 1 and 3 months
☐ Between 3 and 6 months
☐ Between 6 months and 1 year
☐ More than 1 year

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7. Did your pain start because of an accident?
- ☐ Yes
- ☐ No

8. Changing degree of pain (please select one):
- ☐ My pain is getting rapidly better
- ☐ My pain changes, but overall is getting better
- ☐ My pain seems to be getting better, but improvement is slow
- ☐ My pain is neither getting better nor worse
- ☐ My pain is getting rapidly better
- ☐ My pain is rapidly worsening

9. Are you involved in physical activities?
- ☐ Never, my disability prevents it
- ☐ Never
- ☐ An average of once per week
- ☐ An average of 2-3 times per week
- ☐ An average of 4 or more times per week

10. If you are involved in physical activities, please list the activities in which you participate:

11. How does each of the following affect your symptoms?

Sitting	☐ Better	☐ Worse	☐ No Change
Standing	☐ Better	☐ Worse	☐ No Change
Walking	☐ Better	☐ Worse	☐ No Change
Bed Rest	☐ Better	☐ Worse	☐ No Change
Bending Forward	☐ Better	☐ Worse	☐ No Change
Bending Backward	☐ Better	☐ Worse	☐ No Change

12. How much relief did you receive from each of the following parts of your overall treatment (on a scale from 0% to 100%, with 0% being no relief and 100% being complete relief)? (Mark only one answer in each row. "N/A" if it does not apply.)

	0%-30%	31%-60%	61%-100%	N/A
Medication	☐	☐	☐	☐
Bracing	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐
Injections/Blocks	☐	☐	☐	☐
Surgery	☐	☐	☐	☐
Physical Modalities (heat, ultrasound, massage, electrical stimulation)	☐	☐	☐	☐
Pain Management	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐
Bed Rest	☐	☐	☐	☐

13. Indicate what medications you take for your back, and how frequently. (Mark one choice in each group.)

	Never	Once or Less per Week	More Than Once per Week	Daily
Over the counter (e.g., Tylenol, aspirin, Excedrin)	☐	☐	☐	☐
Non-steroidal anti-inflammatories (e.g, ibuprofen, anaprox, Motrin, Feldene, Vioxx, Celebrex, Naprosyn, Arthrotec, Cataflam, Mobic)	☐	☐	☐	☐
Muscle relaxers (e.g., Flexeril, Robaxin, Soma)	☐	☐	☐	☐
Narcotics (e.g., Vicodin, Lortab, MS Contin, Percodan, Percocet)	☐	☐	☐	☐
Anti-depressants (e.g., Elavil, Paxil, Prozac, Wellbutrin)	☐	☐	☐	☐
Neuroleptics (agents to calm nerves e.g., Neurontin, Klonopin, Tegretol)	☐	☐	☐	☐
Recreational drugs	☐	☐	☐	☐

14. Have you had spine surgery (neck or back) before?
- ☐ No
- ☐ Yes

If yes, please indicate the approximate date

☐☐ Month ☐☐ Year

If yes, what type of surgery and on what levels?

_____

_____

15. Have you ever had, or been told you had, any of the following medical conditions: (Mark all that apply.)
- ☐ Anemia or other blood disease
- ☐ Chronic anti-inflammatory medication use
- ☐ Depression/anxiety/memory loss/confusion
- ☐ Heart disease
- ☐ History of cancer
- ☐ Leg pain
- ☐ Long term steroid use
- ☐ Lupus/rheumatoid arthritis/ankylosing spondylitis
- ☐ Osteoarthritis/degenerative arthritis
- ☐ Recent unexplained weight loss/gain
- ☐ Back pain
- ☐ Circulatory disorder
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Leg pain when walking
- ☐ Lung disease/asthma
- ☐ Nervous system disorder
- ☐ Osteoporosis
- ☐ Stroke

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16. Please list ANY prior surgeries or hospitalizations, and the approximate date of each:

17. Please list ANY allergies you have:

18. If you take pain medication, does it upset your stomach?
- ☐ Yes
- ☐ No
- ☐ I don't take pain medication

19. If you take anti-inflammatories, do they upset your stomach?
- ☐ Yes
- ☐ No
- ☐ I don't take anti-inflammatories

20. Does pain affect your ability to work?
- ☐ Yes
- ☐ No

21. What is your current work status?
- ☐ Working (including homemaker and self-employed)
- ☐ On PAID leave due to current back/neck condition
- ☐ On UNPAID leave due to current back/neck condition
- ☐ Unemployed or student
- ☐ Retired NOT due to back/neck problem
- ☐ Retired due to back/neck problem

22. What does your current occupation involve (including any work/housework you do at home)?
- ☐ Heavy physical labor
- ☐ Moderate physical labor
- ☐ Minimal physical labor
- ☐ No physical labor (desk job)
- ☐ Not working now

23. What is your normal occupation (including homemaker)?

24. Are you receiving Workers' Compensation for your neck/back problems?
☐ Yes ☐ No

25. If disabled, retired, or on Workers' Compensation for your back condition, how long has it been since you last worked?
- ☐ Less than 6 months
- ☐ Between 6 months to 1 year
- ☐ Between 1 and 2 years
- ☐ More than 2 years

26. Are you currently, or were you in the past, involved in a lawsuit because of neck/back problems?
☐ Yes ☐ No

27. Do you currently smoke or use tobacco products?
- ☐ Yes
- ☐ No
- ☐ Quit tobacco use within the last 3 months
- ☐ Using nicotine patches or other nicotine products

28. How often do you drink alcoholic beverages?
- ☐ Never
- ☐ Selcom
- ☐ Occasionally
- ☐ Frequently

26. Do you currently have any of these symptoms? (Check all that apply.)

Constitutional Symptoms
- ☐ Fever
- ☐ Night sweats
- ☐ Generalized weakness or fatigue
- ☐ Weight gain
- ☐ Weight loss

Cardiovascular
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Palpitations

Respiratory
- ☐ Coughing up blood
- ☐ Chronic cough
- ☐ Wheezing

Gastrointestinal
- ☐ Blood in stool
- ☐ Black or discolored stool
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal distention
- ☐ Abdominal mass or lumps

Genito-Urinary
- ☐ Burning with urination
- ☐ Dark or discolored urine
- ☐ Difficulty starting/ending urine stream
- ☐ Poor bladder control
- ☐ Loss of genital sensation
- ☐ Any sexual dysfunction

Skin/Breast
- ☐ Dry skin
- ☐ Body rash/hives
- ☐ Nipple discharge
- ☐ Breast lump
- ☐ Problems with wound bleeding
- ☐ Change in a mole
- ☐ Dimpling of skin
- ☐ Change in color/temperature of skin

Hematologic/Lymphatic
- ☐ Easily bruise/bleed
- ☐ Nose bleeds

Musculoskeletal
- ☐ Masses/lumps
- ☐ Swelling
- ☐ Inability to feel hot/cold
- ☐ Poor coordination
- ☐ Loss of control of arms or legs
- ☐ Loss of muscle mass
- ☐ Abnormal arm/leg sensations
- ☐ Neck pain
- ☐ Back pain
- ☐ Numbness
- ☐ Tingling
- ☐ Back pain

Neurologic
- ☐ Poor vision
- ☐ Blurry vision
- ☐ Double vision
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Numbness in face
- ☐ Loss of sense of smell
- ☐ Loss of sense of taste
- ☐ Droopy face/eye
- ☐ Hoarseness
- ☐ Difficulty speaking
- ☐ Difficulty swallowing
- ☐ Slurred speech
- ☐ Headache
- ☐ Dizziness
- ☐ Seizures
- ☐ Unsteady gait

Endocrine
- ☐ Poor appetite
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Loss of body hair

Psychosocial
- ☐ Depression
- ☐ Hallucinations
- ☐ Anxiety
- ☐ Mood swings