SHASTA ORTHOPAEDICS

New Patient History

ShastaOrtho SPINE Institute
Complete Neck & Back Care

Name ______________________ DOB ____________ Date ____________

Height ____________ Weight ________ Dominant Hand: Right Left Ambidextrous

What is the primary reason for your visit today? ______________________

What is the cause of your pain? ______________________

Is this pain due to an injury? ☐Yes ☐ No If yes, how did the injury occur? ____________

When did your symptoms begin? Month ____________ Year ____________

Do you feel your pain is getting better worse unchanged

Which of the following activities makes your pain worse? (circle all that apply)

walking standing sitting all physical activities other ____________

Which of the following makes your pain feel better?

walking standing sitting all physical activities medication other ____________

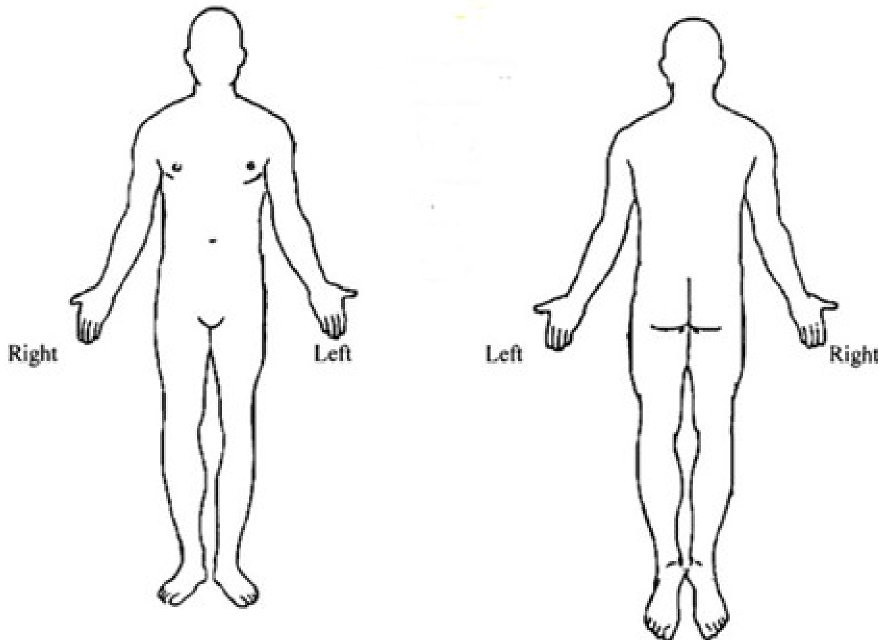
Conservative Treatment	Beneficial		Name of Facility	Date of last visit
Physical Therapy	☐ Yes	☐ No		
Injections	☐ Yes	☐ No		
Chiropractic	☐ Yes	☐ No		
Medications	☐ Yes	☐ No		
Other	☐ Yes	☐ No		

Pain Description

If you feel any of the following symptoms please indicate where you feel them by placing the appropriate letters on the diagram.

numbness = **n** tingling = **t** aching = **a** stabbing = **s** burning = **b** weakness = **w**

In addition, place an **X** on the part of the body where your pain is worse now



Alleviating/Aggravating Factors

What makes your pain feel better?

What makes your pain feel worse?

Rate your daily average pain:

1 2 3 4 5 6 7 8 9 10

Describe your pain:

Circle the appropriate number below showing how bad your pain is now:

No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Who is your primary care provider? ______________________

Medication History

Which local pharmacy do you use? ______________________

Do you take any blood thinners? ☐ Yes ☐ No

Do you use home oxygen? ☐ Yes ☐ No

Pain medications tried: ______________________

Muscle relaxers tried: ______________________

Please list the prescribed ***and*** over-the-counter medications you are currently taking:

☐ I am currently not prescribed any medications ☐ I currently do not take over-the-counter medications

Medication	Strength/Dose	How often taken	Prescribed by

Allergen History ☐ **No Known Allergies**

List any medication and non-medication allergies. Non-medication allergies include iodine, latex, adhesive, dyes, etc.

Medication or Allergen Name	Allergic Reaction

Patient Health History ☐ **No diseases or medical conditions listed below**

Check any of the following diseases or medical conditions:

☐ Pacemaker
☐ Artificial Joints
☐ Bleeding Disorder
☐ Heart Disease
☐ Heart Attack
☐ Heart Surgery
☐ Congenital Heart Defect
☐ Artificial Valves
☐ Peripheral Vascular Disease

☐ Diabetes Type I
Type I Controlled ☐ Yes ☐ No
☐ Diabetes Type II
Type II Controlled ☐ Yes ☐ No
☐ High Blood Pressure
☐ High Cholesterol
☐ Liver Disease
☐ Cancer
☐ Migraine Headaches

☐ Unusual Childhood Disease(s)
☐ Suicide Attempts/Ideation
☐ AIDS/HIV
☐ Hepatitis C
☐ Immune System Disorder
☐ Multiple Sclerosis
☐ Pulmonary Embolism
☐ Thyroid Problems
☐ Tropical Disease(s)

☐ Sleep Apnea
☐ Asthma
☐ COPD
☐ Emphysema
☐ Ulcers/Colitis
☐ Polio
☐ Tuberculosis
☐ Kidney Disease
☐ Anemia

Surgical History ☐ **No previous surgeries**

Procedure	Date	Surgeon/Facility

Image History ☐ **No past images**

Body Part	Image Modality (x-ray, MRI, etc.)	Date	Imaging Facility

Have you ever had problems with anesthesia? ☐ Yes ☐ No

If yes, explain: ______________________________

Have you ever had a history of infections(s), other than lung/respiratory? ☐ Yes ☐ No

If yes, explain: ______________________________

Family Health History ☐ **Unknown** ☐ **Adopted**

Relationship	Health Condition	Alive	Deceased
Father			
Mother			
Runs in Family			

Smoking Status

Do you **currently** use tobacco? ☐ Yes ☐ No

If yes, how many packs per day? ____________

How many years have you smoked? ____________

Are you a former smoker? ☐ Yes ☐ No

What year did you quit? ____________

Fall Risk

Have you fallen once in the past 12 months? ☐ Yes ☐ No

Were you injured in the fall? ☐ Yes ☐ No

Have you fallen more than once in the past 12 months with or without injury? ☐ Yes ☐ No

Alcohol Use

Have you ever used alcohol? ☐ Yes ☐ No

Do you currently consume alcohol? ☐ Yes ☐ No

How many drinks per day? ____________

For how many years? ____________

If quit drinking, what year? ____________

Recreational Drug Use

Have you ever used recreational drugs? ☐ Yes ☐ No

Substance(s): ______________________________

How many years have you been using? ____________

Have you had a problem with addiction? ____________

If you used and quit, what year did you quit? ____________

Medical Marijuana Use

Do you currently use marijuana? ☐ Yes ☐ No

How much per day? ____________

Number of years? ____________

Does it effectively alleviate your pain? ☐ Yes ☐ No

Review of Systems Check those that apply to your current condition ☐ **No symptoms listed below**

GENERAL	**MUSCULOSKELETAL**	**EYES**	**EARS**
☐ Unexplained fevers	☐ Neck pain	☐ Visual disturbance	☐ Hearing loss
☐ Weight loss	☐ Joint pain/swelling	☐ Visual change	☐ Dizziness
☐ Weight gain	☐ Back pain	☐ Double vision	☐Ringing
☐ Excessive fatigue	☐ History of fractures	☐ Blurred vision	
☐ Appetite decrease	☐ Muscle pain	☐ Dry eyes	
☐ Sleep disturbance	☐ Muscle weakness		
	☐ Muscle cramps		

NOSE	**MOUTH**	**THROAT**	**RESPIRATORY**
☐ Nose bleeds	☐ Dry mouth	☐ Dry throat	☐ Wheezing
☐ Nasal Obstruction	☐ Dentures/partial	☐ Sore throat	☐ Persistent or unusual cough
☐ Nasal discharge	☐ Loose or broken teeth	☐ Voice changes	☐ Shortness of breath
	☐ Speech difficulty	☐ Hoarseness	☐ Sleep apnea
		☐ Difficulty swallowing	☐ Night sweats
			☐ Breathing difficulty

CARDIOVASCULAR	**GASTROINTESTINAL**	**GENITOURINARY**	**ENDOCRINE**
☐ Rapid/Irregular heart beat	☐ Abdominal pain	☐ Urinary Incontinence	☐ Intolerance to ☐ heat ☐cold
☐ Chest pain	☐ Nausea	☐ Urinary Retention	☐ Abnormal skin color change
☐ Chest pressure	☐ Vomiting	☐ Urinary Frequency	☐ Excessive thirst
	☐ Bowel habit changes	☐ Painful Urination	☐ Dryness of the ☐ hair ☐skin
	☐ Blood in stools		
	☐ Bowel incontinence		
	☐ Constipation		
	☐ Diarrhea		

PSYCHIATRIC	**BLOOD & LYMPH SYSTEM**	**NEUROLOGICAL**	**NEUROLOGICAL** cont.
☐ Depression	☐ Swollen lymph nodes	☐ Walking difficulty	☐ Seizure disorder
☐ Hallucinations	☐ Abnormal bleeding	☐ Pain going down arms	☐ Involuntary limb movement
	☐ Bleeding disorder	☐ Pain going down legs	☐ Disturbance of smell
	☐ Bruise easily	☐ Paralysis	☐ Facial numbness/weakness
	☐ Lower extremity swelling	☐ Headaches	☐ Disturbance of taste
WOMEN ONLY		☐ Prior head injury/skull fracture	☐ Loss of consciousness
☐ Currently pregnant		☐ Weakness Location	________________
☐ Currently in menopause		☐ Numbness Location	________________
		☐ Tingling Location	________________

Please sign and date this form as being true and correct:

Patient Signature Date

Reviewed and verified by office staff Date