Spine Care Specialists

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PATIENT STATUS REPORT

Patient Name:_____ DOB_____ Date: _____

Zip_____ Allergies_____ Has this changed from last visit?_____

Cell Phone:_____ Insurance being billed today_____Has this changed since last visit? _____

Email Address:_____Has this changed since last visit? _____

Family Doctor:_____ If BWC, POR_____Has this changed from last visit?_____

Are you currently working? Yes No If yes: Part Time Full Time Occupation: _____

PLEASE MARK OR CIRCLE ANSWERS AS NEEDED

Any new complaints: _____

Have you started any new medications since last visit?_____ If yes, which one(s)_____

Has the pain changed since your last visit? Yes/No If yes, please explain:_____

The current treatment, including medications (if prescribed) allow me to: □ take care of myself □ take care of others □ do house work □ go shopping □ work □ exercise □ Other_____

If you had a procedure at your last visit, by what percent did your pain decrease **in the area treated**? _____

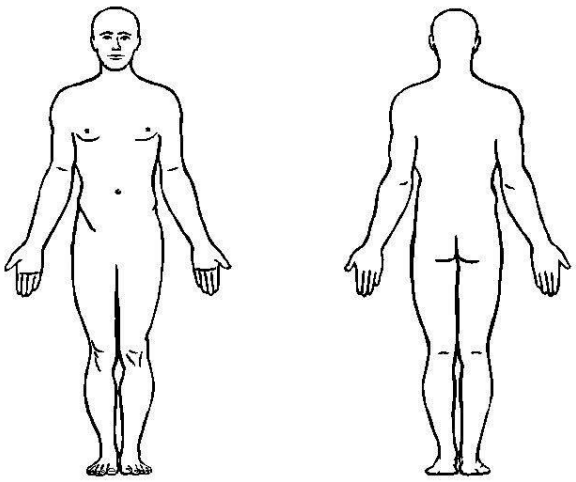
Activity Level: (**Use Activity Scale on Clipboard for your answers**) (use □ for activity with meds, ○ for activity without meds):

0 1 2 3 4 5 6 7 8 9 10

Current Pain Level: (**Use Pain Scale on Clipboard for your answers**) (use □ for pain with meds, ○ for pain without meds):

0 1 2 3 4 5 6 7 8 9 10

Please mark on the figure where the symptoms are located and describe the type of symptoms:



What makes the pain worse?

Activity	Lifting
Bending	Pulling
Climbing	Reaching
Driving	Stress
Heat	Stretching
Ice	Twisting
Inactivity	Weather Change
Laying Down	Walking

Other_____

What makes the pain better?

Activity	Massage
Acupuncture	Physical Therapy
Aquatherapy	Resting
Change Positions	Sitting
Chiropractic Care	Spinal Cord Simulation
Exercise	Standing
Ice	Stretching
Inactivity	TENS Unit
Heat	Walking
Laying Down	Yoga

□ Other_____

Are you currently exercising? Yes No If yes: At Home At Gym Physical Therapy

Please list typical daily activities:_____

Average number of hours of sleep each night: _____

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Review Of Systems

PATIENT'S NAME_____ DATE _____

Please circle or list problems in each body system.

Constitutional: fever, weight gain, weight loss, appetite change, night sweats, fatigue, chills

Eyes: blurry/double vision, vision loss, tearing, redness, pain/sensitivity to light, glaucoma

Ears, Nose, Mouth, Throat: hearing loss, ringing in ears, ear pain, nasal congestion, nasal drainage nosebleeds, mouth/throat irritation, tooth problem

Cardiovascular: chest pain/pressure, heart racing, palpitations, leg swelling, high/low blood pressure,

Pulmonary: cough, yellow/green sputum, blood in sputum, shortness of breath, wheezing

Gastrointestinal: nausea, vomiting, diarrhea, constipation, blood in stool, heartburn, difficulty swallow

Genitourinary: incontinence, abnormal bleeding, abnormal discharge, urinary frequency, urinary hesita painful urination, impotence, sexual problem, infection, urinary retention

Musculoskeletal: neck pain, joint stiffness, joint redness/warmth, back pain, limb pain, muscle wasting, sprain/fracture

Neuro: headache, weakness, dizziness, change in voice, change in taste, change in vision change/loss in hearing, loss/change in sensation, balance problem, coordination problem, speech problem

Endocrine: cold or heat intolerance, blood sugar problem, weight gain/loss, missed periods, hot flashes/sweats, change in body hair, change in libido, increased thirst, increased urination

Heme/Lymph: swelling, bleeding problem, anemia, bruising, enlarged lymph node(s)

Allergy/Immunologic: itchiness, post-nasal drip, watery/itchy eyes, nasal drainage, immunosuppressed

OTHER:_____

_____

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