

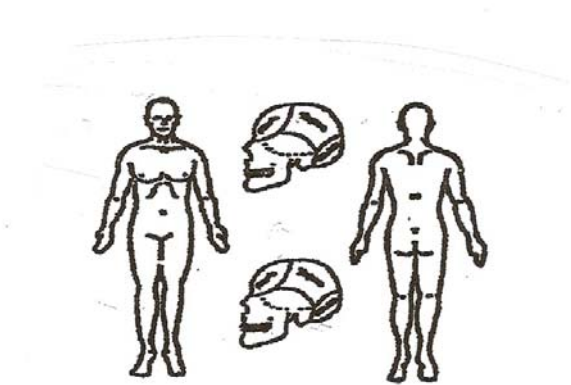
9. If yes, when?

10. Other doctors seen for this condition:

11. Please make a mark on the scale to indicate your present level of pain. If you are describing more than one symptom, indicate the level of pain for each.

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

12. Mark any areas of pain or discomfort on the figures below:



Reserved for Doctors Use

Patient: _____

Notes: _____

Signature of Reviewing Doctor

Date

Duke

SPINAL CENTERS

Past Health History

Patient: _____

1. Any known health conditions (high blood pressure, diabetes, etc.)

2. Previous surgeries

3. Are you pregnant? Yes _____ Due Date _____ No _____

4. Do you smoke? Yes _____ No _____

5. Have you ever been treated for alcohol or substance abuse? Yes _____ No _____

6. Have you ever been in an accident? Yes _____ No _____ If yes, please describe _____

7. Any other family members with spinal related problems? Yes _____ No _____

Present Complaint(s)

1. Please list the primary complaint(s) for which you are seeking treatment:

2. When did symptoms begin?

3. What caused this condition?

4. Type of pain (circle all that apply) Sharp Dull Throbbing Stiff Burning Tingling

5. Frequency of pain? Constant or Intermittent

6. What makes the pain better?

7. What makes it worse?

8. Have you ever had similar symptoms in the past? Yes _____ No _____