NeuroSpine
Get your life back™

PATIENT HEALTH HISTORY FORM
NEUROSURGERY

PATIENT INFORMATION

Primary Reason For Your Visit? _____

Name: _____ DOB: _____ Occupation: _____

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic

Referring Doctor: _____ Primary Doctor: _____

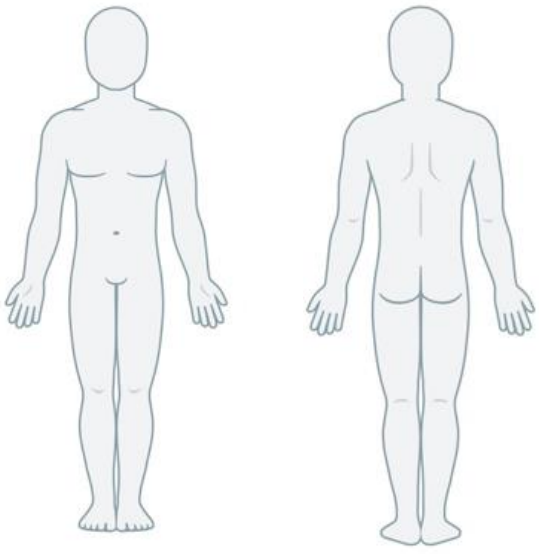
Primary Insurance: _____ Pharmacy: _____

SYMPTOMS Describe your symptoms. Please fill out and use the diagram below to assist you in your description.

Mark on the drawings according to where you hurt. Please indicate on the drawing where you feel any of the following symptoms by placing the marks shown here on the DIAGRAM KEY.

DIAGRAM KEY

*Numbness=**N** Ache=**A** Weakness=**W***
*Burning=**B** Stabbing=**S** Pins & Needles=**P***



_____

FOR OFFICE USE ONLY

Height: _____

Weight: _____

Blood Pressure: _____

Pulse: _____

O2 Sat (%) _____

How Long Have You Had These Symptoms? _____

Pain Score on your **WORST** day (0=no pain to 10=worst)? _____

Do you have any weakness? ☐Yes ☐No

Where: _____

Do you have numbness/tingling? ☐Yes ☐No

Where: _____

What Makes Your Pain Better?

☐Laying ☐Sitting ☐Standing ☐Walking ☐Rest ☐Heat

☐Ice ☐Position Change ☐NSAIDs (Ibuprofen, Celebrex, etc.)

☐Narcotics (name): _____

What Makes Your Pain Worse?

☐Laying ☐Sitting ☐Standing ☐Walking ☐Twisting ☐Lifting

☐Pushing/Pulling ☐Sit to stand ☐Getting out of bed ☐Carrying

Previously Tried Treatment(s):

***Physical Therapy** ☐No ☐ Yes (When?) _____ Was it helpful? _____

Provider name and office: _____

What area were you being treated for? _____

***Steroid Injections** ☐No ☐ Yes (When?) _____ Was it helpful? _____

Provider name and office: _____

Location of Injection: _____

***Stimulator** ☐No ☐ Yes (When?) _____ Was it helpful? _____

Type: ☐Spinal ☐Peripheral

Provider name and office: _____

***Opioid Pain Pump** ☐No ☐ Yes (When?) _____ Was it helpful? _____

Provider name and office: _____

Other Therapies:

☐Chiropractic ☐Massage ☐At Home Exercises ☐Aquatic ☐Acupuncture