The Spine and Orthopedic Center

COMPREHENSIVE INTERVAL HISTORY FORM

PATIENT____DOB _________________Today's Date___________
Last Name, First Name

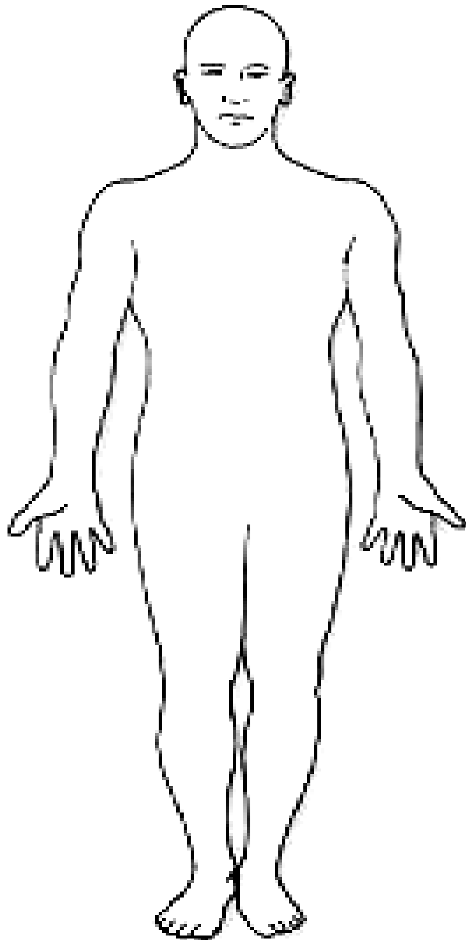
Mark these drawings using the symbols that best describe your pain:

(To mark, select the sticky note symbol and place on the body part.)

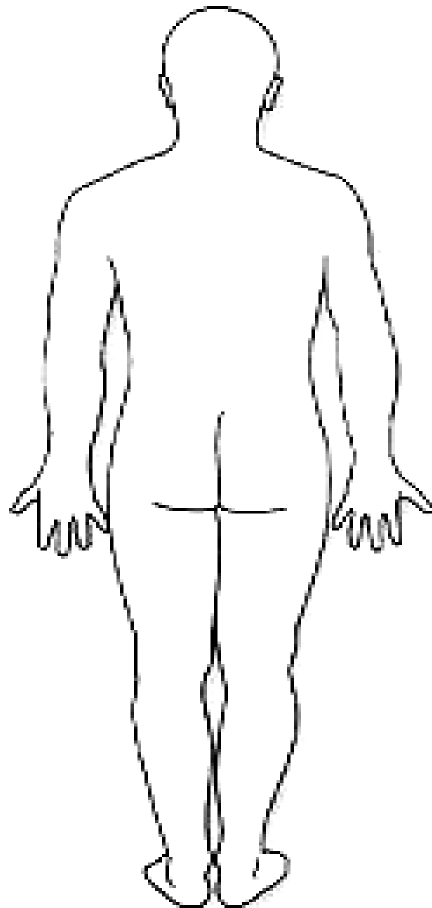
Numbness = = = = = = = Aching ^ ^ ^ ^ ^ ^ Pins and needles o o o o o o

Stabbing / / / / / / / / / / / / Burning x x x x x x Cramping ●●●●●●●

FRONT



BACK



Describe any symptom changes since your last visit:

____
____
____
____
____

What is the reason for your follow-up visit?

____
____
____
____
____

Select the number that best describes your current Pain with "10" being the most severe.

Back/Leg
Neck/Arm

Select what percent better or worse:

Are you working? Yes No

Full Duty ______ Modified Duty_______

When did you last work? ___________________

How long/far can you:

Sit___________Stand_________Walk_________

Are you affected by lack of sleep? Yes No

If so, how many hours do you sleep? _________

How does the lack of sleep affect you? ____

If you are using topical creams or lotions, please answer the questions in this box:

Which topical cream(s) or lotion(s) are you using – please list:

____
____
____

Does the topical cream or lotion help to decrease your pain level? Yes No

Does this help you to sleep better? Yes No

Does this allow you to take fewer oral medications (pills)? Yes No

Does this help your level of function (ability to do more things)? Yes No

Additional comments on how the cream helps you:

____
____
____
____
____
____
____
____
____

Please list any medications you are currently getting from The Spine and Orthopedic Center:

Medication #1:

Name: ___________________________Dose: _______________Frequency:___________

How does this medication help your pain? ____

____

If I take this medication, my pain level is _____________ on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is on a scale from 0 to 10, with 0 being less pain and 10 being more pain.

This medication helps me:

(Select one)

How does this medication help you with function? Please list all ways that this Medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.:

____

____

Please list any side effects you experience from this medication: __________________

____

Medication #2:

Name: ___________________________Dose: _______________Frequency:___________

How does this medication help your pain? ____

____

If I take this medication, my pain level is _____________ on a scale from 0 to 10, with 0 being less pain and 10 being more pain. If I don't take this medication, my pain level is on a scale from 0 to 10, with 0 being less pain and 10 being more pain.

This medication helps me:

(Select one)

How does this medication help you with function? Please list all ways that this Medication helps you function. Following are some *examples* of things that medication can help with: sleeping, walking longer, sitting longer, keep you working, etc.:

____

____

____

Please list any side effects you experience from this medication: ____________________

____

____

Do you have stomach pain? Yes No

Have you had any nausea or vomiting since your last visit? Yes No

If yes, what is the cause? Please explain: ______________________________

____

Have you had any recent weight loss, fever, chills, or night sweats? Yes No

Do you have any problems with your bowels/bladder? Yes No

If yes, please explain: ______________________________

____

Select all that apply since your last visit:

None apply	Frequency Diarrhea	Seizures	Frequent Constipation
Frequent Headaches	Swollen ankles or legs	Bleeding w/ Bowel Movement	
Thoughts of hurting myself or others		Other: ____________	

Are you receiving physical therapy or chiropractic treatment? Yes No

If so where:______________________How many days per week:______________________

What physical therapy or chiropractic treatments are you receiving?______________________

____

Have you had any acupuncture since your last visit? Yes No

Are you using any aids, such as : (select)

Have you had any medical tests since your last visit such as x-rays, MRI, blood tests, etc.? Yes No

What and Where?____

Have you seen any other doctors since your last visit? Yes No

What has been changed or treated? ____

Have you been treated at a hospital since your last visit? Yes No

Please explain: ____

Have you had any spinal injections since your last visit? Yes No

If yes, are you: Better □ Worse □ Same □

Any additional comments:____

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