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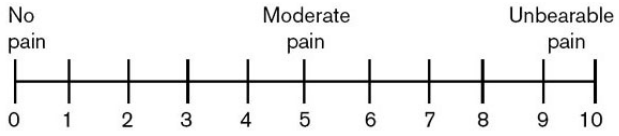
Spine History & Physical

Patient sticker

Physician who referred you:	**PCP:**
Describe the symptoms that you want help with in one sentence *(e.g., 'my low back and right leg hurt')*	
When did your symptoms start?	**How did the symptoms start?** *(e.g., 'fall,' 'accident', N/A)*

Circle a number from 0-10 that best describes how much pain you have had on average for the last week.



For a child or non-english speaking adult, use the FACES© pain rating scale below:

Since your symptoms started, have you had:

- ☐ Fever ☐ Chills ☐ Night sweats ☐ Unintentional weight loss
- ☐ New weakness (Where: _____)
- ☐ New numbness (including groin/genitals) (Where: _____)
- ☐ Difficulties with hand coordination
- ☐ Difficulties with balance
- ☐ Falls (When: _____ How: _____)
- ☐ **Losing control of bowel**
- ☐ **Losing control of bladder**

What makes your symptoms worse?

What makes your symptoms better?

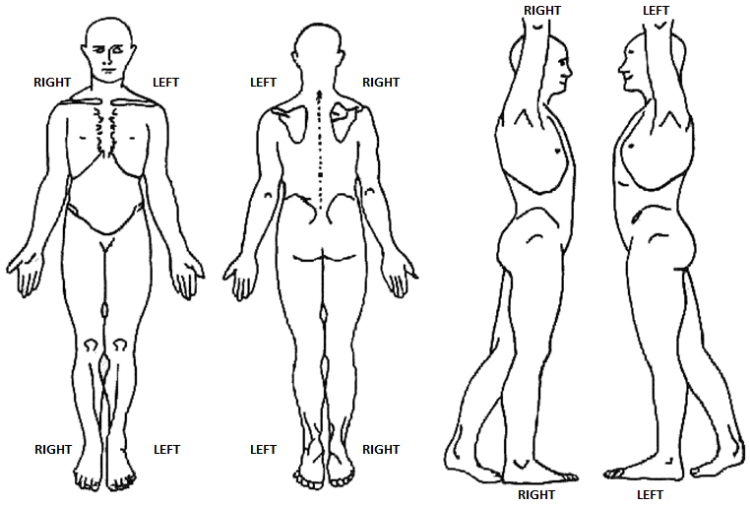
Do symptoms disrupt sleep?	Do symptoms disrupt mood?
☐ Y ☐ N	☐ Y ☐ N

Have you had any recent stressful event (e.g., job/ relationship change, family illness)? ☐ Y ☐ N If yes, please describe: _____	Occupation? _____ ☐ Retired	Are you able to continue your work? ☐ Y ☐ N, Disabled
What type of physical activities do you enjoy (e.g., sports, exercise)	Need assistive device to walk? ☐ Y ☐ N	Independent with self-care? ☐ Y ☐ N

Please mark any **area(s) of symptoms** on the adjacent drawings accordingly:

Pain
Use 'x' for pain

Sensory Changes
Use 'o' for numbness/tingling



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Have you seen any of the following professionals for your current symptoms?

☐ Primary care ☐ Physiatrist ☐ Chiropractor ☐ Neurologist ☐ Psychologist/ Psychiatrist
☐ Surgeon ☐ Pain Management ☐ Physical Therapist ☐ Other:_____

What **Medications** for pain have you tried? **Circle or write in ones tried.**	What was your response?
☐ **Anti-inflammatory medications** e.g., acetaminophen (Tylenol), ibuprofen (Advil, Motrin), naproxen (Aleve), Celebrex, meloxicam (Mobic) diclofenac, nabumetone (Relafen)	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Muscle relaxants** e.g., cyclobenzaprine (Flexeril), tizanidine (Zanaflex), carisoprodol (Soma), methocarbamol (Robaxin), metaxalone (Skelaxin), baclofen, clonazepam (Klonopin), diazepam (Valium)	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Opioid medications** e.g., tramadol (Ultram), codeine, hydrocodone (Vicodin, Norco), oxycodone (Percocet, Oxycontin), morphine, fentanyl, Dilaudid	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Nerve pain medications** e.g., gabapentin (Neurontin), pregabalin (Lyrica), nortriptyline, amitriptyline, duloxetine (Cymbalta), Topamax, mexiletine	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Anti-depressant pain medications** e.g., amitriptyline (Elavil), fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), citalopram (Celexa), duloxetine (Cymbalta), trazodone	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Oral steroids** e.g., methylprednisolone (Medrol), prednisone	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Other**	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
What **Therapies** have your tried?	What was your response?
☐ **Physical Therapy** | Weeks completed: _____ ☐ **Physical Modalities** – ultrasound, electric stimulation, TENS ☐ **Heat / Ice** ☐ **Chiropractic / Manipulations** ☐ **Massage** ☐ **Bracing** ☐ **Traction**	☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure
☐ **Spinal Injections. Circle or write in ones tried.** epidural steroid injections, facet joint injections, sacroiliac joint injections, medial branch blocks, radiofrequency lesioning **Dates:** _____	☐ Yes, it has helped ☐ No, it has not ☐ Not sure
☐ **Acupuncture** ☐ **Yoga** ☐ **Pilates** ☐ **Meditation** ☐ **Biofeedback** ☐ **Psychology / Cognitive Therapy**	☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure

What treatments might you be interested in at this time?

☐ Medications ☐ Physical Therapy ☐ Chiropractor ☐ Acupuncturist ☐ Psychology/ Psychiatry
☐ Injections ☐ Pain Management ☐ Surgery ☐ Other:_____

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Please list all prescription medications and the dose that you take or provide a list:	☐ None
Please list any ALLERGIES you have to medications or food/substances:	☐ None

Past Medical History:	☐ *NONE OF THE BELOW*	
☐ Anxiety	☐ Stomach or other GI ulcerations	☐ Heart disease
☐ Depression	☐ Osteoporosis	☐ Lung disease
☐ Arthritis	☐ Existing weakness or numbness	☐ Thyroid Disease
☐ Reactions to anesthesia	☐ Rheumatological disorder	☐ Diabetes
☐ Bleeding disorder	☐ Diagnosis of cancer	
Other medical problems:		

Past Surgical History:	Date	☐ *NONE OF THE BELOW*
☐ Back surgery		Other surgeries:
☐ Neck surgery		
☐ Shoulder surgery		
☐ Hand surgery		
☐ Hip surgery		
☐ Knee surgery		
Please describe in detail any prior surgery or other surgeries that you have had:		

Family History:

Have any close family members had any of the following:

☐ Scoliosis ☐ Back/Neck Surgery ☐ Ankylosing spondylitis

Please list any other pertinent family history and relationship to you:

Social History:

Do you smoke? ☐ Yes ☐ No ☐ Smokeless Tobacco	Alcohol Use: ☐ Yes ☐ No
Packs per day: _____	Drinks/Week: _____
Years of use: _____	Recreational Drugs: ☐ Yes ☐ No
Quit Date: _____	_____

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Review of Systems:	
Circle and explain if you have any of the following symptoms:	Comments
☐ Fever, chills, weight loss/ gain, malaise/ fatigue, sweats	_____
☐ Rash, itching	_____
☐ Hearing loss, ringing in ear, ear pain, ear discharge, nosebleeds, congestion, sinus pain, high pitched wheeze, sore throat	_____
☐ Blurred/ double vision, light sensitivity, eye pain/ discharge, eye redness	_____
☐ Chest pain, palpitations, short of breath when flat, poor circulation in legs, leg swelling, short of breath at night, vascular disease	_____
☐ Cough, coughing up blood, sputum, shortness of breath, wheezing	_____
☐ Heartburn, nausea, vomiting, abdominal pain, diarrhea, constipation, blood in stool, dark stool	_____
☐ Painful urination, urgency, frequent urination, blood in urine, flank pain	_____
☐ Muscle ache/ pain, neck pain, back pain, joint pain, falls	_____
☐ Easy bruising/ bleeding, allergies, excess thirst, diabetes, thyroid problems, endocrine problems	_____
☐ Dizziness, headaches, tingling, tremor, sensory change, speech change, focal weakness, general weakness, seizures, loss of consciousness	_____
☐ Depression, suicidal ideas, substance abuse, hallucinations, anxiety, difficulty sleeping, memory loss	_____

Thoughts and emotions have a powerful influence on pain. Many people have worrying thoughts about pain. Some common worries are that pain is never going to get better, movement is going to damage the spine, and that work and family life are going to be impacted. Emotions such as anxiety and depression are also common in patients with pain. These negative thoughts and emotion, with the stress that accompany them, make pain worse, no matter what is happening in the body.
Question: Do any of these apply to you? (select all that apply)
☐ Worries about work
☐ Impact on family
☐ Disruption to routine
☐ Fear of movement
☐ Uncertainty about pain
☐ Loss of identity

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UCSF Patient Assessment

Who do you live with?

☐ Alone ☐ Caregiver ☐ Child(ren) ☐ Family ☐ Friends ☐ Group Home
☐ Homeless ☐ Foster Care ☐ Legal Guardian ☐ Parent ☐ Roommate(s) ☐ Sr Housing
☐ Shelter ☐ Significant Other ☐ Skilled Nursing ☐ Spouse ☐ Other_____

Have you fallen since your last visit or within the last year? ☐ Yes ☐ No

If yes, did your fall result in an injury? ☐ Yes ☐ No

Please describe: _____

How do you (or your caregiver) learn best (check all that apply)?

☐ Listening ☐ Reading ☐ Demonstration ☐ Pictures/Video ☐ Declined

Do you (or your caregiver) have any barriers to learning (check all that apply)? ☐ **No barriers**

☐ Reading ☐ Language ☐ Cultural ☐ Visual ☐ Hearing
☐ Physical ☐ Emotional ☐ Cognitive ☐ Spiritual ☐ Financial

Do you (or your caregiver) have any cultural or religious practices or spiritual beliefs that we should be aware of?

☐ Yes ☐ No ☐ Declined

If yes, please describe: _____

In the last 12 months, have you been hurt or felt threatened by someone close to you? ☐ Yes ☐ No