Atlantic Neurosurgical & Spine Specialists
Minimally invasive surgery to maximize your recovery.

Office Use
Arrival: _____
Checked In: _____
Roomed: _____

New Patient History Inventory

*****PLEASE USE BLACK INK*****

Patient Name: _____ Date of Birth: _____ Age: _____

What brings you to the office, and when was the date it started? _____

Did your pain begin gradually or suddenly? _____

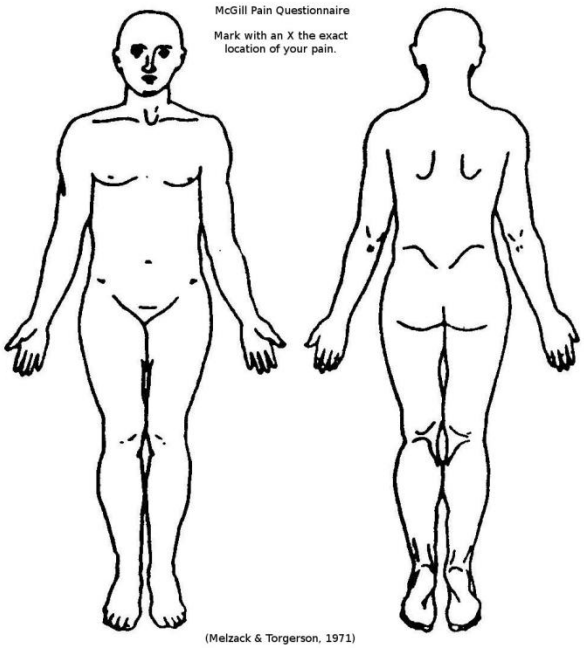
Was there any trauma or any other inciting event that caused the pain? _____

Is this a work related injury? (Required) Y N if yes, did you file a Worker's Comp Claim? Y N

Are you still working? Y N If no, when was your last day of work? _____

Are you on disability? Y N If yes, when did you go on disability?_____

How bad is your pain now? (Circle ONE)
0 1 2 3 4 5 6 7 8 9 10
No pain Excruciating pain



Please mark the body diagram where you feel:

Ache:
^^^^^^^^

Burning:
XXXXXXXX

Numbness:
0000000

Pins & Needles:
////////

Stabbing:
====

Is your pain constant or does it vary based on your activity or position? _____
How does the following affect your pain?

_____

_____

_____

	Increases	Decreases	No effect

Sitting	☐	☐	☐
Standing	☐	☐	☐
Lying down	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Walking	☐	☐	☐
Coughing/Sneezing	☐	☐	☐

Have you had treatment by the following for your neurosurgical problem (see below)?

	Yes	**No**	**When?**	**Result?**
Physical therapy	☐	☐		
Chiropractic	☐	☐		
Acupuncture	☐	☐		
Injections	☐	☐		
Other (specify)	☐	☐		

Do you have any weakness associated with your pain? Yes No Explain:_____

Does your pain wake you up at night? Yes No

Overall, would you say you are (circle one): improving worsening about the same

Medical History:

Do you have any of the following medical conditions?

Medical	**Y**	**N**	**Medical**	**Y**	**N**	**Medical**	**Y**	**N**
Asthma/ Emphysema	☐	☐	Hepatitis	☐	☐	Parkinson's disease	☐	☐
Tuberculosis	☐	☐	Pacemaker	☐	☐	Tremor	☐	☐
COPD	☐	☐	Heart Attack	☐	☐	Stroke	☐	☐
Cancer (list type):	☐	☐	Hypertension	☐	☐	Epilepsy/Seizures	☐	☐
			Atrial Fibrillation	☐	☐	Multiple Sclerosis (MS)	☐	☐
Depression	☐	☐	High Cholesterol	☐	☐	Peripheral Neuropathy	☐	☐
Diabetes	☐	☐	Congestive Heart Failure	☐	☐	Arthritis	☐	☐
Thyroid (Low/High)	☐	☐	Irregular Heart Beat	☐	☐	Osteo Arthritis	☐	☐
Osteoporosis	☐	☐	Murmur	☐	☐	Rheumatoid Arthritis	☐	☐
Kidney Problems	☐	☐	Scoliosis	☐	☐	Acid Reflux Disease	☐	☐
Stomach Ulcers	☐	☐	Carotid Disease	☐	☐	Saroidosis	☐	☐
Polio	☐	☐	Blood/Bleeding Disease	☐	☐	Fibromyalgia	☐	☐
HIV	☐	☐	Blood Clots/PE	☐	☐	Chronic Fatigue Syndrome	☐	☐

Previous Surgery (include dates)	
Previous Hospitalizations (include dates)	

Family History:

Family History	Age if	Age at	Present Condition or

	Living	Death	Cause of Death
Father			
Mother			
Brothers: Number:_____			
Sisters: Number:_____			
Children: Number:_____			

Check if any Relatives have had:

Diabetes…….. ☐	Tuberculosis…….. ☐	Mental Illness…….. ☐
Heart Trouble…….. ☐	Thyroid Trouble…….. ☐	Suicide…….. ☐
Heart Attack…….. ☐	Arthritis…….. ☐	Melanoma…….. ☐
High Blood Pressure…….. ☐	Obesity (Overweight)…….. ☐	Aneurysm…….. ☐
Stroke…….. ☐	Cancer…….. ☐	Cancer Type:_____

Social History:

Marital Status (Please Circle One): Single Married Divorced Widowed Separated

Occupation (Job): _____ Highest level of education completed: _____

Smoking/Tobacco Use:
Yes ☐ No ☐ Quit ☐
How many cig per day_____
Pipe ☐ Cigar ☐ Chew ☐
If quit, years stopped_____
How soon after you wake up do you smoke your first cigarette? _____

Drink Alcohol:
Yes ☐ ____per day____per week
(Circle) Beer / Wine / Liquor
No ☐

Do you drink more than 6 drinks in one day? Yes ☐ No ☐
Problem with Alcohol? Yes ☐ No ☐

Recreational Drugs:
Yes ☐ No ☐
If yes, list drugs:
_____
_____

Medications & Supplements:

	Name of Medications	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			

Allergies:

Do you have any allergies to medications? Yes ☐ No ☐ (no known allergies to medications)
If yes, Please list medication and reaction to the medication(s):

	Medication	Reaction
1.		
2.		
3.		

Please check ***YES OR NO*** for **symptoms** you have **RIGHT NOW:**

CONSTITUTIONAL	Yes	No	***RESPIRATORY***	Yes	No	***NEUROLOGICAL***	Yes	No

Weight Loss	☐	☐	Cough	☐	☐	Seizures	☐	☐
Fatigue	☐	☐	Coughing Blood	☐	☐	Weakness/Paralysis	☐	☐
Fever	☐	☐	Wheezing	☐	☐	Numbness	☐	☐
EYES			***GASTROINTESTINAL***			Tremors	☐	☐
Double Vision	☐	☐	Heartburn	☐	☐	Headache	☐	☐
Glaucoma	☐	☐	Nausea/Vomiting	☐	☐	Memory Loss	☐	☐
Cataracts	☐	☐	Constipation	☐	☐	Trouble Finding Words	☐	☐
EAR, NOSE, THROAT			Difficulty Swallowing	☐	☐	Balance Problems	☐	☐
Difficulty Hearing	☐	☐	Jaundice	☐	☐	***MUSCULOSKELETAL***		
Ringing in Ears	☐	☐	Abdominal Pain	☐	☐	Joint Pain/Swelling	☐	☐
Dizziness	☐	☐	Black Stools	☐	☐	Stiffness	☐	☐
Sinus Trouble	☐	☐	***GENITOURINARY***			Muscle Pain	☐	☐
CARDIOVASCULAR			Pain Urinating	☐	☐	Back Pain	☐	☐
Murmur	☐	☐	Urinary Frequency	☐	☐	Neck Pain	☐	☐
Chest Pain	☐	☐	Nighttime Urination	☐	☐	Shoulder Pain	☐	☐
Palpitations	☐	☐	Difficulty Urinating	☐	☐	***PSYCHIATRIC***		
Fainting Spells	☐	☐	History Kidney Stone	☐	☐	Anxiety/Depression	☐	☐
Shortness of Breath	☐	☐	History STD	☐	☐	Mood Swings	☐	☐
Difficulty Lying Flat	☐	☐	Abnormal Discharge	☐	☐	Difficult Sleep	☐	☐
Swelling Ankles/Other	☐	☐	Blood in Urine	☐	☐	***ALLERGIC/IMMUNOLOGIC***		
ENDOCRINE			***FEMALE ONLY***			Hay Fever/Asthma	☐	☐
Loss of Hair	☐	☐	Menopause	☐	☐	Hives/Eczema	☐	☐
Heat/Cold Intolerances	☐	☐	Are Your Periods Regular?	☐	☐	***SKIN***		
Change in Nails	☐	☐	***HEMATOLOGIC/LYMPH***			Rash	☐	☐
			Prolonged Bleeding	☐	☐	Lesions	☐	☐

How did you hear about us? (Circle all that apply):

1) Referral from my physician
2) Friend/relative
3) TV ad
4) Online ad
5) Online search
6) Other: _____

Patient Signature:_____

Provider Signature:_____

Oswestry Disability Index

Please mark the bubble next to the statement that applies to you:

Section 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 – Social Life

- My social life is normal and causes me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

Section 10 – Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys less than 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Patient name: _____
Today's date: _____