NEW HAMPSHIRE NEUROSPINE INSTITUTE
INITIAL EVALUATION

Today's Date: Medical Records #:
Last Name: First Name:
Date of Birth: Age: Male Female
Height:_____ in. Weight: _____ lbs.
Primary Care Physician (PCP): Physician Specialists: _____
Referred by: Dominant Arm: Left ☐ Right ☐

History:

Date of injury or when pain began: _____ / _____ / _____
Describe how injury occurred or how the symptoms began: _____

Did this happen at work? Yes ☐ No ☐ Was this a Motor Vehicle Accident? Yes ☐ No ☐

Answer the following questions if this is a work related injury:
Name of employer where injury occured: _____
Job title at time of injury: _____
What is your current work status: Out of work ☐ Last day worked: ____/____/_____
Working with restrictions ☐ _____ hrs/day _____ days/wk _____lbs. max
Fully Duty ☐ Other ☐ _____
How long had you worked at this job before the injury occured: _____
Prior to this injury, were you working: Fully Duty ☐ Limited / Modified Duty ☐

Where did you first seek treatment: _____
What other treatments have you tried: (fill in number of weeks) None ☐
Physical Therapy ☐ _____ wks Braces/Orthotics ☐ explain: _____
Injections ☐ explain: _____ PCP ☐ _____ wks
Oral Medications ☐ List: _____
Other ☐ explain: _____
What diagnostic tests (related to your current symptoms) have you had: (fill in approximate dates {month/year}) None ☐
X-rays ☐ _____/_____ MRI ☐ _____/_____ CT Scan ☐ _____/_____ EMG's ☐ _____/_____
Arthrogram ☐ _____/_____
Have you had similar symptoms before this episode: No ☐
One episode ☐ Multiple episodes ☐ Most recent date: ____/____/____ (before this episode)

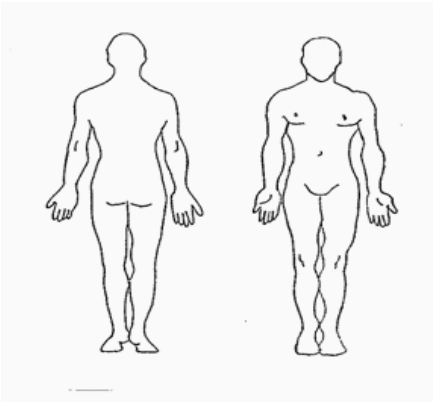
Present Status:

What makes your pain worse? _____
What relieves your pain? _____
Describe your pain on a scale of 0-10 (0 = no pain at all; 10 = the worst pain you can imagine):
At its worst: _____ Most of the time: _____ At its best: _____
Do you use any assistive devices:
No ☐ Cane(s) ☐ Crutches ☐ Wheelchairs ☐ Orthotic(s)/Brace(s) ☐ Walker ☐
Other ☐ _____
Does an attorney represent you (if this is an injury)? Yes ☐ No ☐

SHOW US WHERE YOUR PAIN IS LOCATED

Mark these drawings according to where you hurt (if the back of your shoulder hurts, mark the drawing on the back of the shoulder, etc.)

Use these symbols for PAIN: A = Aching, S = Stabbing, B = Burning
N = Numbness (is a loss of sensation or the feeling of being "asleep" -- it is not painful).
P = Pins and Needles



Medical History: (check all that apply)

No medical conditions ☐

Diabetes ☐ Heart Disease ☐ Stroke ☐ Asthma ☐ Depression ☐ Hepatitis ☐ (specify type: ____) Gout ☐

High blood pressure ☐ Lung Disease ☐ Alcohol Abuse ☐ Drug Abuse ☐ Ulcer Disease ☐ Vascular Disease ☐

Thyroid Disease ☐ Bleeding/Clotting problems ☐ Kidney Stones ☐ GERD (reflux/heartburn) ☐ Osteoarthritis ☐

Rheumatoid Arthritis ☐ Cancer ☐ (type: _____) Other: _____

Have you had any previous surgery: (add dates) None ☐

Tonsils ☐ _____ Appendectomy ☐ _____ Gallbladder ☐ _____

Hysterectomy ☐ _____ Heart ☐ _____ Blood vessels ☐ _____

Lung ☐ _____ Kidney ☐ _____ Stomach or intestinal ☐ _____

Other(s): ☐ _____ _____ _____ _____

List all of your current medications (Please include dosage and frequency): No medications ☐

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy: _____ Location: _____

Do you have any drug allergies: None ☐

Yes ☐ List & describe what happens: _____

_____

Social History:

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Do you have any children: No ☐ Yes ☐ (number: _____)

Living situation: Live with spouse ☐ Live with significant other ☐ Live alone ☐ Nursing home ☐

Live with parents ☐ Live with adult children ☐ Live with minor children ☐

Smoking: Never smoked ☐ Quit _____ months ago ☐ Quit _____ years ago ☐ Yes ☐ _____ pks per day x _____ yrs.

Do you drink alcohol: No ☐ Yes ☐ If yes, how much alcohol do you drink each day: _____ drinks/day.

Have you had any weight changes in the past year: No ☐ Yes, gained _____ lbs. ☐ Yes, lost _____ lbs. ☐

What is the last grade you completed:

_____ Grade ☐ GED ☐ High School Graduate ☐ 2-yr Associates Degree ☐ Technical School ☐

_____ yrs. College ☐ Bachelors Degree ☐ Post Graduate or Professional Degree ☐

What is your race?: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐

Native Hawaiian or Other Pacific Island ☐ Unknown/Decline to Answer ☐

What is your ethnicity?: Arab-American ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Decline to answer ☐

What is your language preference?: _____

Family History:

Do any of these diseases run in your immediate family (parents, brothers, sisters only):

No medical conditions ☐

Diabetes ☐ Heart Disease ☐ Stroke ☐ Asthma ☐ Depression ☐ Hepatitis B ☐ High Blood Pressure ☐

Lung Disease ☐ Alcohol Abuse ☐ Ulcer Disease ☐ Vascular Disease ☐ Thyroid Disease ☐

Cancer ☐ (type: _____) Other: _____

Work History: (Skip if you have already filled out in section one)

Present employer: _____

Primary occupation: _____

How long have you worked at your current job: _____ months _____ years

Current work situation:

Working ☐ Paid leave ☐ Unpaid leave ☐ Unemployed ☐ Homemaker ☐ Student ☐

Permanently disabled / retired due to health ☐ explain:_____ Retired not due to health ☐

MD USE ONLY

RX:

Vital signs:

MD Notes:
Who is accompanying a minor?