

**NEW HAMPSHIRE NEUROSPINE INSTITUTE  
INITIAL NECK & BACK EVALUATION**

Today's Date: \_\_\_\_\_ Medical Records #: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.  
 Primary Care Physician (PCP): \_\_\_\_\_ Physician Specialists: \_\_\_\_\_  
 Referred by: \_\_\_\_\_

**History:**  
 Date of injury or when pain began: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Describe how injury occurred or how the symptoms began: \_\_\_\_\_

Did this happen at work? Yes  No

**Answer the following questions if this is a work related injury:**

Name of employer where injury occurred: \_\_\_\_\_  
 Job title at time of injury: \_\_\_\_\_  
 What is your current work status: Out of work   
 Working with restrictions  \_\_\_\_\_ hrs/day \_\_\_\_\_ days/wk \_\_\_\_\_ lbs. max  
 Fully Duty  Other  \_\_\_\_\_  
 How long had you worked at this job before the injury occurred: \_\_\_\_\_  
 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   
 Chiropractor  \_\_\_\_\_ wks Physical Therapy  \_\_\_\_\_ wks Pain Center  \_\_\_\_\_ wks  
 Spinal Injections  \_\_\_\_\_ wks Oral Steroids  \_\_\_\_\_ wks PCP  \_\_\_\_\_ wks

If you have had physical therapy, please fill in what you have tried:  
 Massage  Ultrasound  Heat  Ice  Electrical Stimulation  Pool therapy  Treadmill   
 Exercise bike  Stairmaster  Stretching  Myofascial release  Weights  Nautilus   
 Home exercise program  Work hardening

What diagnostic tests (related to your neck or back) have you had: (fill in approximate dates {month/year})  
 MRI  \_\_\_\_/\_\_\_\_/\_\_\_\_ CT Scan  \_\_\_\_/\_\_\_\_/\_\_\_\_ Myelogram  \_\_\_\_/\_\_\_\_/\_\_\_\_ Bone Density  \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Discogram  \_\_\_\_/\_\_\_\_/\_\_\_\_ Bone Scan  \_\_\_\_/\_\_\_\_/\_\_\_\_ EMG's  \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had neck / back symptoms before this episode:  
 No  One episode  Multiple episodes  Most recent date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Complete the following if you have had neck or back surgery:**

Describe type of surgery, date, surgeon:

|           |                    |         |
|-----------|--------------------|---------|
| _____     | ____ / ____ / ____ | _____   |
| procedure | date               | surgeon |
| _____     | ____ / ____ / ____ | _____   |
| procedure | date               | surgeon |
| _____     | ____ / ____ / ____ | _____   |
| procedure | date               | surgeon |

Have you had an infection related to neck / back surgery: No  Yes   
 Were you able to return to work after the most recent surgery:  
 No  Yes, with limits  Yes, no limits  Homemaker  Student  Retired

**Present Neck Status:**

Describe your pain in relation to how much is neck pain and how much is arm pain:

- All neck pain  Mostly neck pain / some arm pain  Equal neck and arm pain   
Mostly arm pain / some neck pain  All arm pain   
Quality of Pain: Aching  Burning  Sharp  Dull

**Answer the following questions regarding your arm symptoms:**

- I don't have arm symptoms
- Do you have **arm pain**:  
{Choose one} Constantly  It comes and goes   
{Choose one} Left arm  Right arm  Both arms
- Do you have **arm numbness/tingling**:  
{Choose one} Constantly  It comes and goes   
{Choose one} Left arm  Right arm  Both arms
- Do you have **arm weakness**:  
{Choose one} Constantly  It comes and goes   
{Choose one} Left arm  Right arm  Both arms

What makes your pain worse:

- Lifting  Coughing  Sneezing  Driving  Flexing neck  Extending neck   
Turning head to left  Turning head to right

What relieves your pain:

- Lowering arm  Raising arm overhead  Flexing neck  Extending neck   
Changing positions  Nothing

Describe your pain (neck and/or arm) 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  Tens Unit  Neck brace   
Other  \_\_\_\_\_

**Present Back Status:**

Describe your pain in relation to how much is back pain and how much is leg pain:

- All back pain  Mostly back pain / some leg pain  Equal back and leg pain   
Mostly leg pain / some back pain  All leg pain   
Quality of Pain: Aching  Burning  Sharp  Dull

**Answer the following questions regarding your leg symptoms:**

- I don't have leg symptoms
- Do you have **leg pain**:  
{Choose one} Constantly  It comes and goes   
{Choose one} Left leg  Right leg  Both legs
- Do you have **leg numbness/tingling**:  
{Choose one} Constantly  It comes and goes   
{Choose one} Left leg  Right leg  Both legs
- Do you have **leg weakness**:  
{Choose one} Constantly  It comes and goes   
{Choose one} Left leg  Right leg  Both legs

What makes your pain worse:

- Lifting  Bending  Twisting  Sitting  Driving  Standing  Walking   
Coughing  Sneezing  Getting up from a chair

What relieves your pain:

- Lying on back  Lying on side  Lying on stomach  Bending knees  Sitting   
Standing  Walking  Changing positions  Nothing

Describe your pain (back and/or leg) 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:

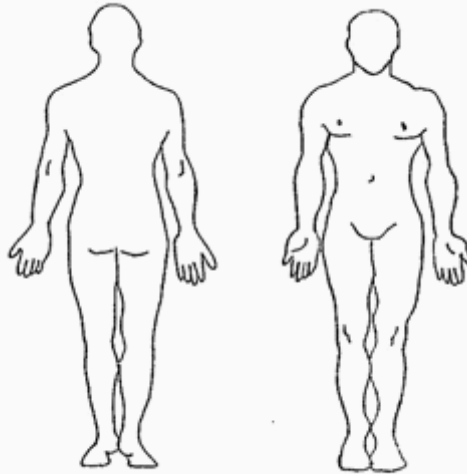
- No  Cane(s)  Crutches  Wheelchairs  Tens Unit  Back brace   
Other

**SHOW US WHERE YOUR PAIN IS LOCATED**

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

P = PAIN

N = NUMBNESS (Numbness is the loss of sensation or the feeling of being "asleep" - it is not painful.)



**Medical History:** (check all that apply) Do you have or have you had any of the following?

No medical conditions

Diabetes  Heart Disease  Stroke  Asthma  Depression  Hepatitis  High Blood Pressure

Lung Disease  Alcohol Abuse  Ulcer Disease  Vascular Disease  Thyroid Disease  Osteoporosis

Tuberculosis  Arthritis  High Cholesterol  Anxiety  ADD/ADHD  GERD

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: \_\_\_\_\_

**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/ethnicity?: \_\_\_\_\_

What is your language preference? (If other than English): \_\_\_\_\_

**Family History:**

Do any of these diseases run in your immediate family (parents, brothers and 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  Arthritis   
 Chronic Pain   
 Cancer  (type: \_\_\_\_\_) Other: \_\_\_\_\_

**Work History:** (Skip this section if already answered on page 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 neck/back  Permanently disabled / retired for other health reasons   
 Retired not due to health

**Exercise Habits:**

Do you routinely exercise? If so, how often?:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Functional Status:**

Which of these functions are you presently able to perform:

- Personal hygiene  Cooking  Light house cleaning (sweeping/dusting)  Laundry   
 Heavy housework (vacuuming)  Yardwork  Driving \_\_\_ min.  Sitting \_\_\_ min.   
 Walking \_\_\_ min.  Standing \_\_\_ min.  Lifting \_\_\_ lbs.

**Review of Systems:** Please check any condition you are currently experiencing.

- |  |  |   |  |
|--|--|---|--|
| Recent nausea or vomiting <input type="checkbox"/> | Loss of hearing <input type="checkbox"/>   | Frequent headaches <input type="checkbox"/>   | Incontinence of bowel <input type="checkbox"/>   |
| Hot or cold spells <input type="checkbox"/>        | Nosebleeds <input type="checkbox"/>        | Blackouts <input type="checkbox"/>            | Incontinence of bladder <input type="checkbox"/> |
| Swollen ankles <input type="checkbox"/>            | Stomach pain <input type="checkbox"/>      | Seizures <input type="checkbox"/>             |  |
| Difficulty swallowing <input type="checkbox"/>     | Ulcers <input type="checkbox"/>            | Recent weight change <input type="checkbox"/> |  |
| Morning cough <input type="checkbox"/>             | Fever or chills <input type="checkbox"/>   | Nervous exhaustion <input type="checkbox"/>   |  |
| Shortness of breath <input type="checkbox"/>       | Constipation <input type="checkbox"/>      | Claustrophobia <input type="checkbox"/>       |  |
| Heart or chest pain <input type="checkbox"/>       | Poor appetite <input type="checkbox"/>     | Pacemaker <input type="checkbox"/>            |  |
| Abnormal heartbeat <input type="checkbox"/>        | Burning urination <input type="checkbox"/> | Metal in eye <input type="checkbox"/>         | R or L <input type="checkbox"/>                  |
| Calf cramps w/ walking <input type="checkbox"/>    | Recent diarrhea <input type="checkbox"/>   |   |  |

If you checked any of the above, have you discussed the problem(s) with your primary doctor? Yes  No

**MD USE ONLY**

**RX:**

**Vital signs:**

**MD Notes:**

**Who is accompanying a minor?**



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## **Prescriptions and Medication Refills**

**Name:**

**Acct #:**

**Prescriptions and prescription refills are issued during regular business hours only. Our on-call physicians will not provide prescription refills or prescribe medications at night or on weekends.**

- 1) You need to contact the office Monday- Friday 8am- 4pm. If you need a prescription refilled, please call the office and leave a message on our medication refill line by choosing option 4. Leave a detailed message and you will be contacted by one of our staff within 4 hours.
- 2) If you lose your prescription it will not be refilled until it was due for a refill.
- 3) You will need to take the medication as prescribed as it will not be refilled early in the event you decided to take more medication.
- 4) We will not automatically take over a narcotic prescription that has been prescribed by another provider.
- 5) Narcotics will not be prescribed on a long term basis and it is expected that medications will be weaned over time. In the event you are involved in our pain management program, you will be required to sign a "Pain Treatment Agreement" which will outline our policies and procedures for managing your pain.

I, the undersigned, acknowledge that I have read and understand the NHNSI prescription policy and procedure.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_