



SPINAL AND ORTHOPAEDIC MEDICINE ASSOCIATES

DIAGNOSIS & TREATMENT OF SPINAL & ORTHOPAEDIC MEDICINE DISORDERS

New Patient Questionnaire

Name: _____ Date: _____
Age: _____ D.O.B: _____ Weight: _____
Employer: _____ Occupation: _____
Family Doctor: _____ Phone #: _____
Address of Family Doctor: _____
Referring Doctor: _____ Phone #: _____
Address of Referring Doctor: _____
Pain assessment Information Form: _____

Please complete the form and bring it to your appointment

Right handed Left handed Ambidextrous

Who referred you to Dr. Korby? Self Friend Another doctor Other:

Are you off from work because of your current problem/ Yes No

If yes, since what date have you been out of work/

Related to a: Motor Vehicle Accident Yes No

Date of injury: _____

(If yes, you will need a letter of protection from your attorney or a letter of waiver from your insurance company to be seen in our office)

Describe how the auto accident occurred:

Describe how injury occurred: *(if not related to auto accident)*

Date of injury: _____

Brief history of your current symptoms: Where the pain is:

SPINE: Cervical (neck) Thoracic (mid-back) Lumbar (lower back)

Extremity: UE R/L arm R/L elbow R/L wrist R/L hand

 LE R/L hip R/L knee R/L ankle R/L foot

Numbness: Yes No Where?

Pins and needles: Yes No Where?

Mark all that apply:

Dull Aching Sharp Pressure Cramping Cold



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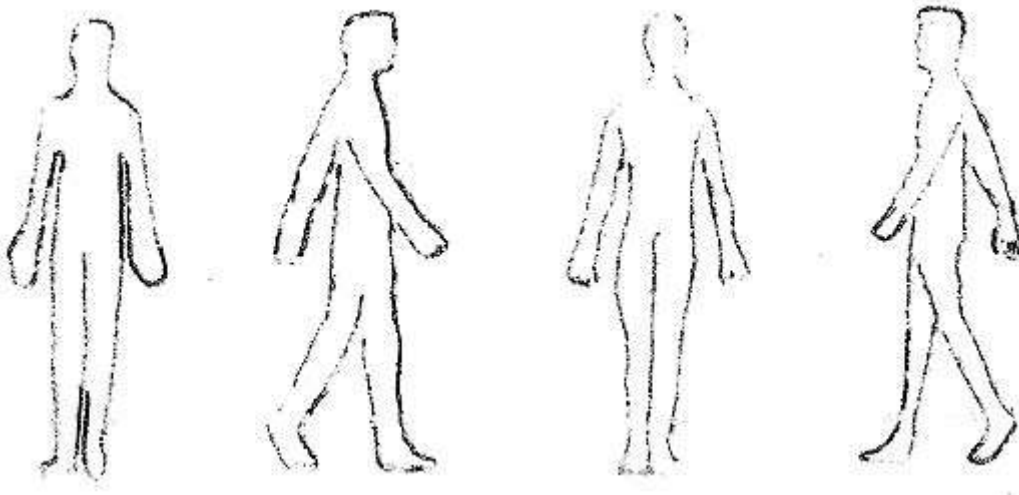
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Do you have weakness? Yes No Where?

Pain Assessment

Please mark the figure to locate your discomfort, pain or other complaint:

(X=Most intense pain/discomfort N=Numbness B=Burning P=Pain A=Ache)



Please rate your pain or discomfort, No pain is "0", the worst possible is "10".

Lowest Level of pain: 0 1 2 3 4 5 6 7 8 9 10

Today's Level of pain: 0 1 2 3 4 5 6 7 8 9 10

Worst Level of pain: 0 1 2 3 4 5 6 7 8 9 10

From your worst, do you think your pain or discomfort is getting better?

Better No change Worse

If you are better, how much improvement do you have? _____%

Date of last episode: _____ How many episodes in the past year?

Your symptoms are: Improving Unchanged Worsening

Constant symptoms affect which area(s)? Back Leg Neck Arms Hands

Other: _____

Intermittent symptoms affect which area(s)? Back Leg Neck Arms Hands

Other: _____

Your symptoms worse during: Bending forward Bending backward Sitting Rising

Walking Lying down AM PM As the day progresses



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Do your symptoms worsen: Coughing Sneezing Straining

Are your symptoms better during: Bending forward Bending backward Sitting Rising
 Walking Lying down AM PM As the day progresses

Are you having any bowel problem? Yes No Constipation Other:

Do you have any bladder problems? Yes No Incontinence Prostate Other:

FUNCTIONAL STATUS

Do you have any problem with sexual intercourse? Yes No Not applicable

Do you have problems with walking? Yes No Mild Moderate Severe N/A

Do you have problems with sleep? Yes No Mild Moderate Severe N/A

Do you have problems with dressing? Yes No Mild Moderate Severe N/A

Do you have problems with driving? Yes No Mild Moderate Severe N/A

Do you have problems with standing? Yes No Mild Moderate Severe N/A

Do you have problems with sitting? Yes No Mild Moderate Severe N/A

Do you have problems with riding in a car? Yes No Mild Moderate Severe N/A

Do you have problems in walking up & down stairs? Yes No Mild Moderate Severe N/A

Do you have problems in writing or using a phone? Yes No Mild Moderate Severe N/A

Sleep Position: Face up Face down Right side Left side

Which position causes pain? Face up Face down Right side Left side

Sleep Surface: Firm Soft Waterbed Other

What sleep surface makes the pain worse? Firm Soft Waterbed Other

Are you depressed for the pain? Yes No Sometimes

Have you had thoughts about or even attempted suicide? Yes No

HEADACHES OR FACIAL PAIN

Do you experience headaches or facial pain? All the time Sometimes Rarely Mild
 Medium Severe



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Would you rate your headaches or facial pain as Migraines? Yes No

Sinus type pain? Yes No

Head pain? Yes No where: _____
Describe the pain: _____

Do you have pain in the Jaw or teeth? Yes No

Do you have facial pain? Yes No where: _____ (Left/Right)
Describe the pain: _____

Is the pain in the back of the head? Yes No Ringing in the ears? Yes No

Is the pain in or near your eyes? Yes No

FOR THIS PAIN CONDITION, HAVE YOU HAD ANY OF THE FOLLOWING ITEMS DONE?

(If you have more than one type of pain please not what pain you are referring to)

Physiotherapy / neuromuscular retraining? Yes No

Surgery? Yes No If yes where: _____

TENS unit? Yes No When: _____

Are you still using the TENS unit? Yes No

Are you undergoing Psychotherapy? Yes No P.h.d M.D D.O

Other _____

Massage therapy? Yes No If yes: Infrequent frequently Biofeed back? Yes No

Trigger point injections? Yes No Taken Narcotics? Yes No If yes what? _____

Botox injections? Yes No Laser therapy? Yes No Neurotherapy? Yes No

Biomodulation electrotherapy? Yes No By Whom? _____ Date: _____

REGENERATIVE INJECTION THERAPY/ Prolotherapy: Yes No

Acupuncture? Yes No Electroacupuncture? Yes No

Aromatherapy? Yes No Magnets? Yes No

Pain management/Epidurals/Spinal Joint Injections? Yes No
If yes, Doctor's Name: _____ Town: _____ Phone: _____

Chiropractic treatments? Yes No Osteopathic Manipulation? Yes No
If yes, Doctor's Name: _____ Town: _____ Phone: _____

Have you had any of the following done?



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X-ray? Yes No Date: _____ Where: _____

CAT Scan? Yes No Date: _____ Where: _____

MRI? Yes No Date: _____ Where: _____

Please mark all the following treatments you have had performed:

VAX-D Disc Distraction Therapy Flexion Distraction Decompression Osteopathic
 Chiropracti Therapy Electrotherapy Ultrasound

List all the medications you are currently taking (or attach list):

List all medications you have tried for this condition in the past:

List all medication allergies:

Do you have an allergy to any of the following items? Latex IV Dye Iodine
 Other: _____

CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE/HAD:

Diabetes Heart Attack Heart Murmur High blood pressure Stroke Chest pain
 Heart failure Atrial fib Seizures Fainting spells Migraines Chronic cough
 Sleep apnca Asthma Trouble Breathing Drug abuse Alcoholism Hepatitis
 Bleeding disorder HIV positive TB Lyme disease STD's Jaundice Anxiety
 Depression Osteoarthritis Rheumatoid arthritis Lupus Trouble with anesthesia
 Kidney Disease Hiatal hernia/Heartburn Possible Pregnancy Thyroid Trouble
 Aspirin or inflammatory intolerance Keloidor scar badly Work Injury Motor vehicle accident
 Cancer Other _____

Heart bypass Heart valve replacement Blood transfusio Neck injury
 Joint surgery (if yes what join R/L) Carpel tunnel (if yes which hand R/L)

Tonsillectomy Hernia Appendectomy Gallbladder Removal of ovaries
Hysterectomy C-section Cataract Other

Are you unusually nervous about surgery or injections? Yes No

PLEASE CHECK ALL ILLNESSES THAT OTHER FAMILY MEMBERS HAVE HAD:

Diabetes Heart disease Stoke Cancer (what type)

Arthritis Trouble with Anesthesia Spinal problems Other

WORK HISTORY:

Are you: Working Temporarily disabled Permanent disability Retired

PLEASE DESCRIBE YOUR JOB:



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It is: Light duty Moderate duty Heavy duty Sedentary

PLEASE LIST OTHER JOBS YOU HAVE DONE:

DO YOU HAVE WORK RESTRICTIONS? Yes No

If yes, please describe your work restrictions:

DO YOU ENJOY WORK: Yes No Sometimes

SOCIAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

Married Divorced Single Do you have children? Yes No

Do you use: cigarettes cigars snuff chew How often?

Do you drink: beer liquor wine How often?

DO YOU USE RECREATIONAL DRUGS? Yes No How long?

HAVE YOU HAD A HISTORY OF ALCOHOLISM? Yes No How long?

HAVE YOU HAD A HISTORY OF DRUG ADDICTION OR DRUG ABUSE? Yes No

HAVE YOU EVER HAD TO GO THROUGH A DETOX PROGRAM? Yes No

Are you or have you ever been under the care of a Psychiatrist? Yes No

If answer is yes, please provide the name, address and phone number of the Psychiatrist:

Date of your last visit?

What is the last grade of education you completed? Jr.High High School

GED BS/BA Masters PhD Professional college: Degree:

