

Huebert Sports & Spine

6464 SW Borland Rd, #D-2
Tualatin, OR 97062 (503) 885-8008

NAME: _____ AGE: ____ DOB: _____ Appointment Date _____

REFERRING DOCTOR: _____ PRIMARY DOCTOR: _____

How did you hear about us? (please mark appropriate choice) Your Doctor Insurance Co. Friend/Family Yellow Pages Television Other: _____ Internet

History of Present Illness

When (month/year) did your spine problem first begin? _____

Under what circumstances did your pain begin?

Accident at work	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Accident away from work	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Motor Vehicle Accident	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sports	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unknown Cause	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If your pain began from an injury at work, have you filed a Workers Compensation Claim? Yes No

If you were injured, did it involve:

Fall	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lifting object	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pushing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Struck by falling or moving object	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Repetitive activity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Did any of your present symptoms exist before your injury? Yes No

Please mark the sentence that best describes the effect of your condition/injury on your work:

- I have missed no work because of this condition.
- I have missed work, but I am now back at light duty.
- I have missed work, but I am now back without limitation.
- I have been off work since: (please give date) _____

Are your symptoms increasing decreasing staying the same

Is your pain: constant or intermittent

Do any of the following make your symptoms better?

<input type="checkbox"/> Lying down	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Walking
Other: _____			

Do any of the following make your symptoms worse?

<input type="checkbox"/> Lying down	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Walking
Other: _____			

Do you have any problems controlling your bowel and / or bladder? Yes No

Do you have any weakness? Yes No

if yes, label the pain diagram (page 3) where you are weak

If yes, is it increasing decreasing staying the same

Do you have any numbness Yes No

if yes, label the pain diagram page 3) where you are numb

if yes, is it increasing decreasing staying the same

MEDICATIONS

CURRENT **PAIN** MEDICATIONS

Medication	Dose	Number of pills in 24 hours	Prescribing Doctor

CURRENT **non pain** MEDICATIONS:

Medication	Amount	How often

Are you currently taking Aspirin, Motrin, Aleve, or any other anti-inflammatory? _____

Are you taking Coumadin Plavix Aggrenox

Unprescribed pain medications never tried

marijuana alcohol cocaine someone else's prescribed medication

other:

Please check / list all medications that you are allergic to: NONE

Medication	<u>Symptom</u>
1.	
2.	
3.	
4.	

Are you allergic to iodine Yes No

Are you allergic to tape Yes No

Do you have any skin reactions to jewelry or metals? Yes No

Huebert Sports & Spine

What is your current pain level on a scale from 0 to 10 scale (10 being the worst)? _____

What % of your pain is located in the: Back: _____ Hip: _____ Leg: _____ Foot: _____

Place a single vertical line across the line below to indicate your current pain level.



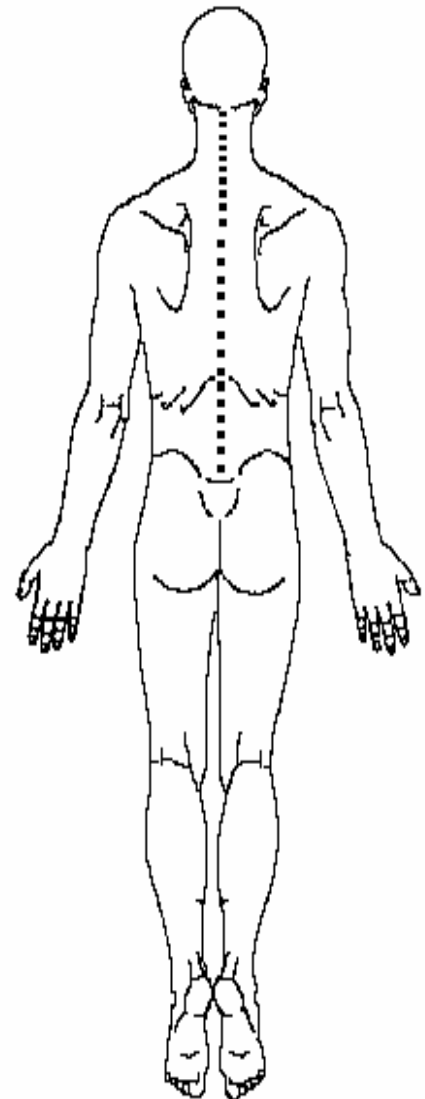
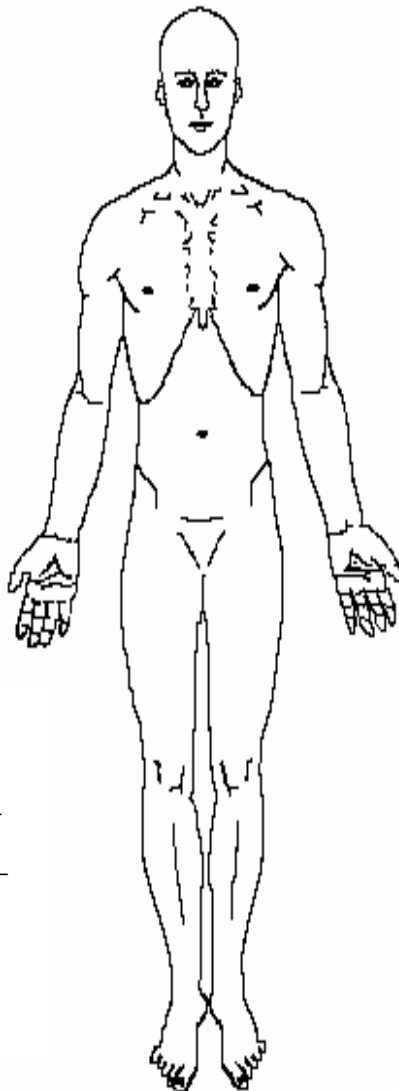
0 (no pain)

10 (worst pain ever)

Mark the location of your symptoms on the diagram below

Using the symbols below, and please place them on the figure to the right that most accurately describes your current pain pattern and location.

- X - Sharp or Stabbing
- N - Numbness
- B - Burning



Height: _____ Weight: _____

BP: _____ Pulse: _____

Huebert Sports & Spine

Please Read: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but

Please just circle the one choice which closely describes your problem *right now*.

SECTION 1--Pain Intensity

- A. The pain comes and goes and is very mild.
- B1. The pain is mild and does not vary much.
- C2. The pain comes and goes and is moderate.
- D3. The pain is moderate and does not vary much.
- E4. The pain is severe but comes and goes.
- F5. The pain is severe and does not vary much.

SECTION 2--Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B1. I do not normally change my way of washing or dressing even though it causes some pain.
- C2. Washing and dressing increase the pain, but I manage not to change my way of doing it.
- D3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- E4. Because of the pain, I am unable to do any washing and dressing without help.
- F5. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting

- A. I can lift heavy weights without extra pain.
- B1. I can lift heavy weights, but it causes extra pain.
- C2. Pain prevents me from lifting heavy weights off floor.
- D3. Pain prevents me from lifting heavy weights off floor, but I can manage if they are conveniently positioned.
- E4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are convenient.
- F5. I can only lift very light weights, at the most.

SECTION 4 --Walking

- A. Pain does not prevent me from walking any distance.
- B1. Pain prevents me from walking more than one mile.
- C2. Pain prevents me from walking more than 1/2 mile.
- D3. Pain prevents me from walking more than 1/4 mile.
- E4. I can only walk while using a cane or on crutches.
- F5. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

- A. I can sit in any chair as long as I like without pain.
- B1. I can only sit in my favorite chair as long as I like.
- C2. Pain prevents me from sitting more than one hour.
- D3. Pain prevents me from sitting more than 1/2 hour.
- E4. Pain prevents me from sitting more than ten minutes.
- F5. Pain prevents me from sitting at all.

SECTION 6 -- Standing

- A. I can stand as long as I want without pain
- B1. I have some pain while standing, but it does not increase with time
- C2. I cannot stand for longer than one hour without increasing pain.
- D3 I cannot stand for longer than ½ hour without increasing pain.
- E4. I can't stand for more than 10 minutes without increasing pain.
- F5. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

- A. I get no pain in bed.
- B1. I get pain in bed, but it does not prevent me from sleeping.
- C2. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D3. Because of pain, my normal night's sleep is reduced by less than one-half.
- E4. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F5. Pain prevents me from sleeping at all.

SECTION 8--Social Life

- A. My social life is normal and gives me no pain.
- B1. My social life is normal, but increases the degree of my pain
- C2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D3. Pain has restricted my social life and I do not go out very often.
- E4. Pain has restricted my social life to my home.
- F5. Pain prevents me from sleeping at all.

SECTION 9--Traveling

- A. I get no pain while traveling.
- B1. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C2. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D3. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E4. Pain restricts all forms off travel.
- F5. Pain prevents all forms of travel except that done lying down

SECTION 10--Changing Degree of Pain

- A. My pain is rapidly getting better.
- B1. My pain fluctuates, but overall is definitely getting better.
- C2. My pain seems to be getting better, but improvement is slow at present.
- D3. My pain is neither getting better nor worse.
- E4. My pain is gradually worsening.
- F5. My pain is rapidly worsening.

Huebert Sports & Spine

Please list any doctors that you have seen for this spine problem.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Physical Therapy never tried

yes Last appointment _____ Where _____

What treatment was performed?

exercises stretching TENS unit ultrasound massage

helpful not helpful

Spine Injections never tried

yes Last injection _____ Where _____

helpful not helpful

Acupuncture never tried

yes Last treatment _____ Where _____

helpful not helpful

Chiropractics never tried

yes Last treatment _____ Where _____

helpful not helpful

Naturopath never tried

yes Last treatment _____ Where _____

helpful not helpful

Huebert Sports & Spine

Please check / list all operations: none

spine surgery

Lumbar	Type of Surgery	Date	Surgeon	Helpful	SX
1				Yes No	
2				Yes No	
3				Yes No	
4				Yes No	
5				Yes No	

Cervical	Type of Surgery	Date	Surgeon	Helpful	SX
1					
2					
3					

- | | |
|--|---|
| <input type="checkbox"/> appendectomy when:
<input type="checkbox"/> tonsillectomy when
<input type="checkbox"/> gall bladder removal when:
<input type="checkbox"/> knee arthroscopy when:
<input type="checkbox"/> knee replacement when:
<input type="checkbox"/> hip replacement when:
<input type="checkbox"/> eye surgery when:
<input type="checkbox"/> when:
<input type="checkbox"/> when: | <input type="checkbox"/> heart surgery when:

<input type="checkbox"/> hysterectomy when:
<input type="checkbox"/> prostate surgery when:

<input type="checkbox"/> surgery for cancer
Type: |
|--|---|

Please check or add any medical illness that you have.

- | | | |
|---|---|--|
| <input type="checkbox"/> GERD
<input type="checkbox"/> heart failure
<input type="checkbox"/> asthma
<input type="checkbox"/> high blood pressure
<input type="checkbox"/> cancer

<input type="checkbox"/> other | <input type="checkbox"/> emphysema
<input type="checkbox"/> gout
<input type="checkbox"/> atrial fibrillation
<input type="checkbox"/> anemia
<input type="checkbox"/> diabetes | <input type="checkbox"/> lung disease
<input type="checkbox"/> fibromyalgia
<input type="checkbox"/> thyroid disease

<input type="checkbox"/> HIV |
|---|---|--|

Huebert Sports & Spine

Family History

Father Alive Deceased (at age _____) Sibling 3 Alive Deceased (at age _____)
Mother Alive Deceased (at age _____) Sibling 4 Alive Deceased (at age _____)
Sibling 1 Alive Deceased (at age _____) Sibling 5 Alive Deceased (at age _____)
Sibling 2 Alive Deceased (at age _____) Sibling 6 Alive Deceased (at age _____)

Please check the box if anyone in your immediate family has had any of the following conditions (Note relationship)

<input type="checkbox"/> Hypertension	father	mother	sister	brother	<input type="checkbox"/> Gout	father	mother	sister	brother
<input type="checkbox"/> Heart Attack	father	mother	sister	brother	<input type="checkbox"/> Kidney Disease	father	mother	sister	brother
<input type="checkbox"/> Diabetes	father	mother	sister	brother	<input type="checkbox"/> Thyroid Disease	father	mother	sister	brother
<input type="checkbox"/> Epilepsy	father	mother	sister	brother	<input type="checkbox"/> Asthma	father	mother	sister	brother
<input type="checkbox"/> Stroke	father	mother	sister	brother	<input type="checkbox"/> Rheum. Arthritis	father	mother	sister	brother
<input type="checkbox"/> Cancer	father	mother	sister	brother	<input type="checkbox"/> Blood Disorder	father	mother	sister	brother

Cancer Type: lung colon breast
 prostate skin
 other : _____

Does anyone in your family have a spine problem? yes no

IF YES:

Father mother sister brother

Neck Mid Back Low Back

Have they had surgery? yes no

Social History

Current Marital Status: Married Single Divorced Widowed N/A

Number of Children: _____ Ages of children _____

Living Status: alone with spouse with parents with roommate assisted living nursing home

Occupation: _____ How Long: _____ Previous Occupation: _____

Highest education level: Grade School Middle School High School College Post Graduate

Are you on any type of disability Yes No

Do you use tobacco now or in the past? Yes, use now Never used Previous user Quit _____ years ago

Cigarettes How many per day? _____ How many years? _____

Cigars How many per day? _____ How many years? _____

Smokeless How much per day? _____ How many years? _____

Nicotine patch gum

Do you drink alcoholic beverages? Yes, drink now Never drank Previous Quit _____ years ago

Beer How many per day? _____

Wine How many per day? _____

Other How much per day? _____

Have you ever felt the need to cut down on drinking? Yes No

Have you ever felt annoyed by criticism of your drinking? Yes No

Have you ever felt guilty about your drinking? Yes No

Have you ever felt the need for a morning eye-opener? Yes No

Have you ever had or been treated for a drug or alcohol dependency problem? Yes No

Huebert Sports & Spine

Review of Systems

Height:

Weight:

General

- | | | | |
|--------------------------------------|--------------------------------------|--|------------------------------------|
| <input type="checkbox"/> weight gain | <input type="checkbox"/> weight loss | <input type="checkbox"/> history of falls | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> fever | <input type="checkbox"/> sweats | <input type="checkbox"/> chills | |
| <input type="checkbox"/> insomnia | <input type="checkbox"/> snoring | <input type="checkbox"/> hypersomnia
(sleep all the time) | |

Skin

- | | | | |
|----------------------------------|--|----------------------------------|--|
| <input type="checkbox"/> rash | <input type="checkbox"/> change in mole | <input type="checkbox"/> lumps | |
| <input type="checkbox"/> itching | <input type="checkbox"/> change in nails | <input type="checkbox"/> dryness | <input type="checkbox"/> easy bruising |

Eyes

- | | | | |
|----------------------------------|--|-----------------------------------|------------------------------------|
| <input type="checkbox"/> glasses | <input type="checkbox"/> double vision | <input type="checkbox"/> glaucoma | <input type="checkbox"/> cataracts |
| <input type="checkbox"/> pain | <input type="checkbox"/> discharge | | |

Ears

- | | | | |
|---|---------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> pain | <input type="checkbox"/> hearing loss | <input type="checkbox"/> hearing aid | <input type="checkbox"/> deafness |
| <input type="checkbox"/> tinnitus (ringing) | <input type="checkbox"/> discharge | | |

Nose

- | | | | |
|-------------------------------------|------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> runny nose | <input type="checkbox"/> discharge | <input type="checkbox"/> nose bleeds | |
|-------------------------------------|------------------------------------|--------------------------------------|--|

Mouth / Throat

- | | | | |
|--|-------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> hoarseness | <input type="checkbox"/> dentures | <input type="checkbox"/> mouth sores |
| <input type="checkbox"/> dry mouth | <input type="checkbox"/> bleeding | | |

Breast

- | | | | |
|--------------------------------|-------------------------------|--|--|
| <input type="checkbox"/> lumps | <input type="checkbox"/> pain | | |
|--------------------------------|-------------------------------|--|--|

Respiratory

- | | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> dry cough | <input type="checkbox"/> productive cough | <input type="checkbox"/> bloody cough | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> pain with breathing | <input type="checkbox"/> wheezing | <input type="checkbox"/> pulmonary embolism |

Heart/ Blood Vessel

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> heart attack | <input type="checkbox"/> angina | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> murmur |
| <input type="checkbox"/> leg / foot sweating | <input type="checkbox"/> varicose veins | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> blood clots |

Gastrointestinal

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> change in appetite | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> indigestion | <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting | <input type="checkbox"/> constipation |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> change in bowel
movements | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> hepatitis |

Urology

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> painful urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> blood in urine | <input type="checkbox"/> night time urination |
| <input type="checkbox"/> urgency | <input type="checkbox"/> bladder infections | <input type="checkbox"/> genital / STD infection | |

MEN

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> difficulty with erection | <input type="checkbox"/> prostate cancer | <input type="checkbox"/> prostate hypertrophy | |
| | <input type="checkbox"/> vasectomy | | |

Gynecology

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> menstrual problems | <input type="checkbox"/> vaginal itching/discharge | <input type="checkbox"/> endometriosis | |
|---|--|--|--|

Hematologic

- | | | | |
|---------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> anemia | <input type="checkbox"/> bleeding problem | <input type="checkbox"/> transfusions | <input type="checkbox"/> transfusion reaction |
|---------------------------------|---|---------------------------------------|---|

Allergic / Endocrine

- | | | | |
|---|------------------------------------|--|--|
| <input type="checkbox"/> food allergies | <input type="checkbox"/> hay fever | | |
|---|------------------------------------|--|--|

Neurologic / Psychiatric

- | | | | |
|-------------------------------------|------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> tremors | <input type="checkbox"/> seizures | <input type="checkbox"/> memory problems | <input type="checkbox"/> TIA |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> headaches | | |
| <input type="checkbox"/> depression | <input type="checkbox"/> anxiety | <input type="checkbox"/> emotional problems | <input type="checkbox"/> ADD / ADHD |