CARDINAL NEUROSURGERY & SPINE, INC.

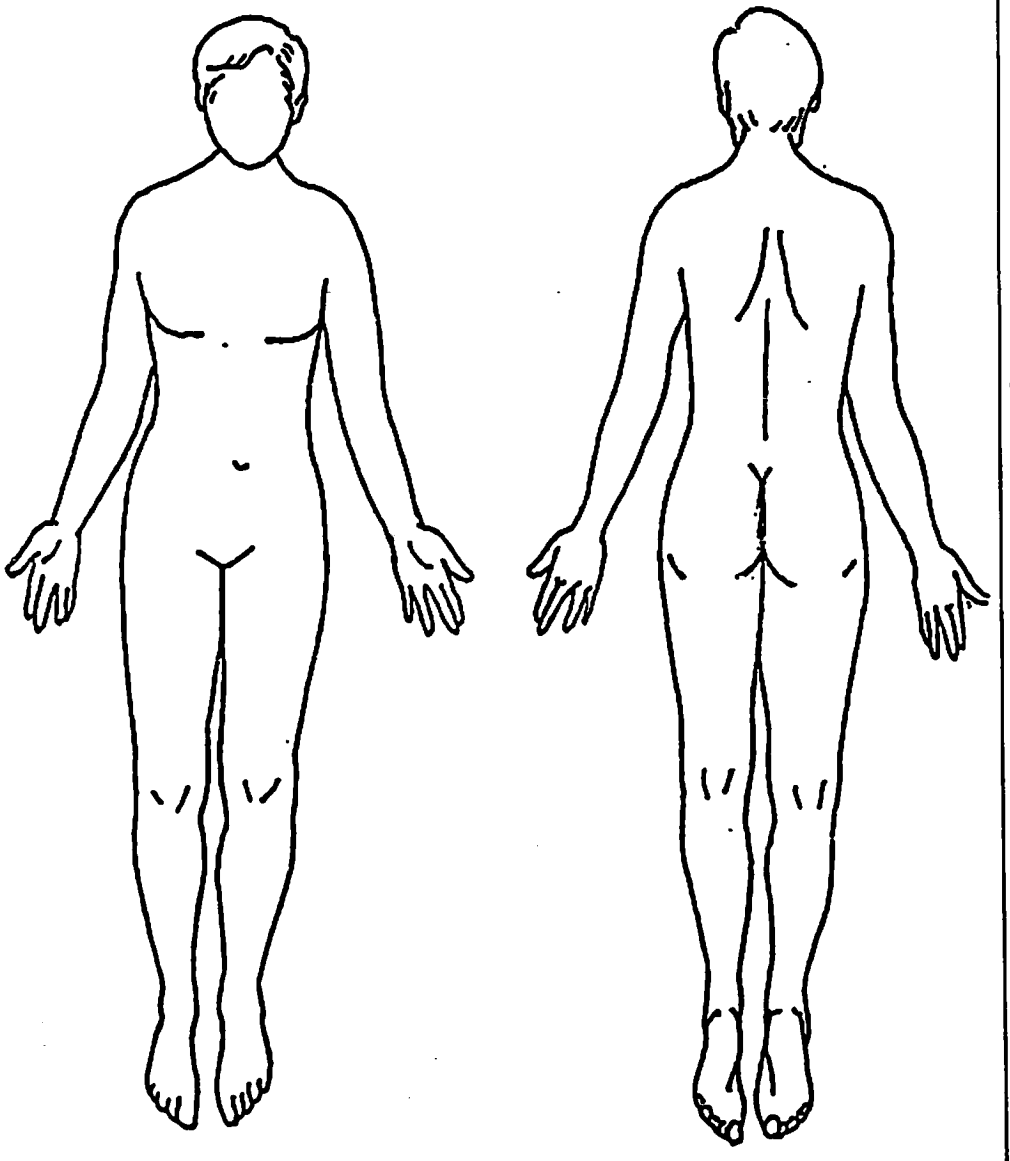
Patient Information Sheet

Name: _____ Date: _____

Please shade in the location of your pain. Complete applicable areas. If needed, use the symbols below

TYPE OF PAIN

XXXX	Burning	====	Pins & Needles
////	Stabbing	0000	Numbness



▲Right Left▲
ANTERIOR - FRONT VIEW

▲Left Right▲
POSTERIOR - BACK VIEW

AREA (Check all that Apply)

[ ] **Back**
[ ] Hip [ ] Right [ ] Left
[ ] Leg [ ] Right [ ] Left
[ ] Foot [ ] Right [ ] Left
[ ] Toes:

[ ] **Neck**
[ ] Shoulder [ ] Right [ ] Left
[ ] Upper Arm [ ] Right [ ] Left
[ ] Forearm [ ] Right [ ] Left
[ ] Hand [ ] Right [ ] Left
[ ] Fingers:

[ ] Other:

INTENSITY

Rate pain on a numeric scale of 1 to 10. (Ten being the most severe pain that you have experienced.)

You may also describe your symptoms below:

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If you are having pain and seeking treatment for multiple body areas please list in order of treatment need, Most Urgent to Less Urgent Head, Cervical/Neck, Mid-Back, Lower Back Right or Left Arm, Hand, Leg, Foot

_____

The pain in my arms, legs, buttocks, hips currently is: [ ]Severe and incapacitating [ ]Moderately severe and troublesome [ ]Mild, mainly an annoyance [ ]I have no leg, hip or buttocks pain now

Since I have developed this problem I have had trouble urinating or loss of control of my bowel or bladder function [ ] NO [ ] YES _____

The pain wakes me from my sleep at night [ ] NO [ ] YES
When the pain wakes me, getting up and walking tends to relieve the pain? [ ] NO [ ] YES

My neck, back or leg pain seems to be

[ ] Present almost all of the time	[ ] Worse with coughing or sneezing	[ ] Worse with bending backwards
[ ] Tends to come and go	[ ] Worse with straining	[ ] Worse with prolonged sitting
[ ] Much worse with movement	[ ] Worse with bending forward	[ ] Worse with prolonged standing

I have weakness in my [ ] Neck [ ] R-Arm/Hand [ ] L-Arm/Hand [ ] Back [ ] R-Leg/Foot [ ] L-Leg/Foot
My leg gives out on me [ ] Always [ ] Frequently [ ] Occasionally [ ] Rarely [ ] Never
I have trouble grasping and holding onto object [ ] Frequently [ ] Occasionally [ ] Rarely [ ] Never

TREATMENTS (Check all that apply)

- [ ] Physical Therapy
  - [ ] Traction
  - [ ] Work Conditioning [ ] Work Hardening
  - [ ] Functional Capacity Evaluation
- [ ] Aqua Therapy
- [ ] TENS Unit
- [ ] Muscle Stimulator
- [ ] Back Brace
- [ ] Chiropractic Treatments
- [ ] Pain Management
  - [ ] Epidural Steroid Injection
    Number of Injections ____
  - [ ] Spinal Cord Stimulator

DIAGNOSTIC STUDIES (Check all that apply)

[ ] X-Rays	[ ] Discogram/CT	[ ] EMG/NCV
[ ] MRI	[ ] Bone Scan	[ ] Right Arm [ ] Left Arm
[ ] Myelogram/CT	[ ] Arteriogram/Venogram	[ ] Right Leg [ ] Left Leg
[ ] CT	[ ] Doppler/Vascular Studies	[ ] EEG [ ] Sleep Studies

MEDICATION/S you take for this condition • Pain Medications • Anti-Inflammatory • Muscle Relaxer • Steroids

_____

What modifications, if any, have you made to your activity?
Work: _____

_____

Home: _____

_____

Have you been hospitalized for your condition other than for surgery? _____

_____

Has your condition required surgery? _____

_____

Complete if you are seeking treatment for a HEAD INJURY (check all that apply)

[ ] Headache	[ ] Nervousness	[ ] Numbness or tingling	[ ] Difficulty concentrating
[ ] Nausea	[ ] Balance Problems	[ ] Feeling slowed down	[ ] Difficulty remembering
[ ] Vomiting	[ ] Drowsiness	[ ] Feeling like you are in a fog	[ ] Sleeping more than usual
[ ] Fatigue	[ ] Trouble Falling Asleep	[ ] Sensitivity to light/noise	[ ] Irritability/sadness, feelings of depression

Did you experience a loss of consciousness [ ] NO [ ] YES, for how long _____
Did you experience any short term memory loss (recent events) [ ] NO [ ] YES _____
Did you experience any long term memory loss (events of past) [ ] NO [ ] YES _____