CEDARS-SINAI®

SPINE CENTER

Personal information

Last Name: _____ First Name: _____

Age: _____ Date of birth: _____ Occupation: _____ ❑ Not working

Social History

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

Do you live alone: ❑ Yes ❑ No

How many children do you have? _____ ❑ None

Will you have a caregiver to assist you if surgery is needed? ❑ Yes ❑ No

Are you currently working? ❑ Yes ❑ No

Have you lost work due to your back problem? ❑ Yes ❑ No

Do you have stairs in your home? ❑ Yes ❑ No

Do you think you are at risk for a fall? ❑ Yes ❑ No

Date symptoms began: _____

Current Problems

Chief complaint or reason for visit: _____

_____

_____

_____

Cause of present problem *(e.g. work related injury, auto accident, slip-and-fall, etc.)*:

_____

What favorite activities does your pain prevent?: _____

_____

_____

Can you care for yourself *(i.e. dressing, eating, toileting, standing up, etc.)* _____

_____

Other difficult functions include: _____

Past History

Past or ongoing medical problems (e.g. high blood pressure, stroke, diabetes, heart condition, cancer, etc.):

(If more space is needed, please attach on a separate sheet.)

_____

_____

_____

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Previous Surgeries

Name of operation: Date:

_____ _____

_____ _____

_____ _____

Other Information

Do you smoke? ❑ No ❑ Yes Number of cigarettes per day _____

Do you drink alcohol? ❑ No ❑ Yes Number of drinks per day _____

Have you had imaging in the last 3 months?

❑ No ❑ Yes ❑ MRI ❑ CT scan ❑ X-rays

Allergies

Please list all allergies and response such as rash, itching, difficulty breathing, or unknown:

Drug name Reaction

_____ _____

_____ _____

_____ _____

Medications

Please list all current medications, over the counter drugs, vitamins and herbals.

Please give us the total number of "as needed" medication taken in a 24-hour period.

Name	Dosage / Amount	Time of day	Total taken in 24 hours.

Signature	Date	Time

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PHYSICIAN INFORMATION

PATIENT I.D.

Please provide your current Physician's information. Write down as much information you can provide (i.e., Name & City), so that we may keep them informed of your progress.

REFERRING PHYSICIAN

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

INTERNIST / PRIMARY CARE PHYSICIAN

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

WORKMANS COMPENSATION *(IF APPLIES)*

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

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PHYSICIAN INFORMATION

PATIENT I.D.

Please provide your current Physician's information. Write down as much information you can provide (i.e., Name & City), so that we may keep them informed of your progress.

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

____
(City, State, Zip Code)

Phone: (_____) ____________________ Fax: (_____) ____________________

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

____
(City, State, Zip Code)

Phone: (_____) ____________________ Fax: (_____) ____________________

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

____
(City, State, Zip Code)

Phone: (_____) ____________________ Fax: (_____) ____________________

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

____
(City, State, Zip Code)

Phone: (_____) ____________________ Fax: (_____) ____________________

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PAIN DRAWING

PATIENT I.D.

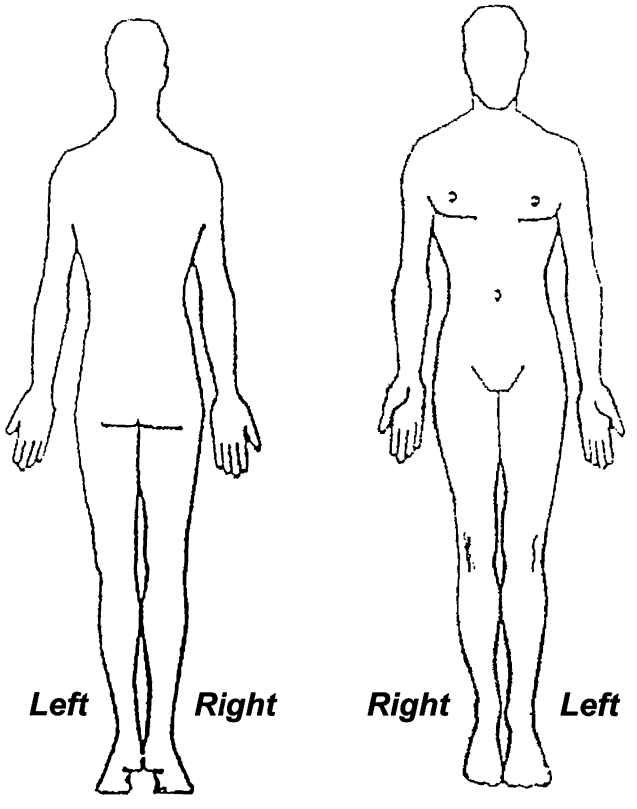
1. How much pain in general can you tolerate?

0 1 2 3 4 5 6 7 8 9 10

No Pain — **Worst pain Imaginable**

2. Where is your pain now?

Mark the areas on your body using the appropriate symbols to describe your symptoms.



TYPE OF PAIN	SYMBOL
Ache	<<<<< <<<<<
Numbness	○○○○○ ○○○○○
Pins & Needles	■■■ ■■■
Burning	XXXXXX XXXXXX
Radiating Pain	////////// //////////

3. How bad is your pain?

Neck pain _____ %

Arm pain _____ %

Total 100%

Back pain _____ %

Leg pain _____ %

Total 100%

4. How bad is your pain now?

0 1 2 3 4 5 6 7 8 9 10

No Pain — **Worst pain Imaginable**

5. The duration of pain:

❑ Continuous ❑ Positional ❑ Intermittent (On/Off) ❑ Unable to Rate

6. Have you taken pain medication in the past 24 hours?

❑ YES ❑ NO