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**BACK/NECK INFORMATION FORM**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

1. DOMINANCE:  RIGHT  LEFT  AMBIDEXTROUS

PRESENT HISTORY: CHECK CORRECT ITEM OR FILL IN THE BLANKS

2. My present problem is with my:  BACK  LEG  NECK  ARM

3. When did the present problem start? \_\_\_\_\_

4. When did present problem worsen? \_\_\_\_\_

5. The problem began:  GRADUALLY  SUDDENLY

6. The problem began: AT HOME: \_\_\_\_\_

AT WORK: \_\_\_\_\_

WITH AN ACCIDENT: \_\_\_\_\_

7. The problem began:  DURING OR AFTER LIFTING/BENDING

WHEN I FELL

AT THE TIME OF THE ACCIDENT

FOR NO APPARENT REASON

OTHER EXPLAIN \_\_\_\_\_

8. Accident/Injury Data:

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

Location: \_\_\_\_\_

Specifics: \_\_\_\_\_

Medical Attention: \_\_\_\_\_

Auto Accident: Seat belt / Harness belt  On  Off

Air bag deployment  Yes  No

## DESCRIPTION OF PRESENT PAIN

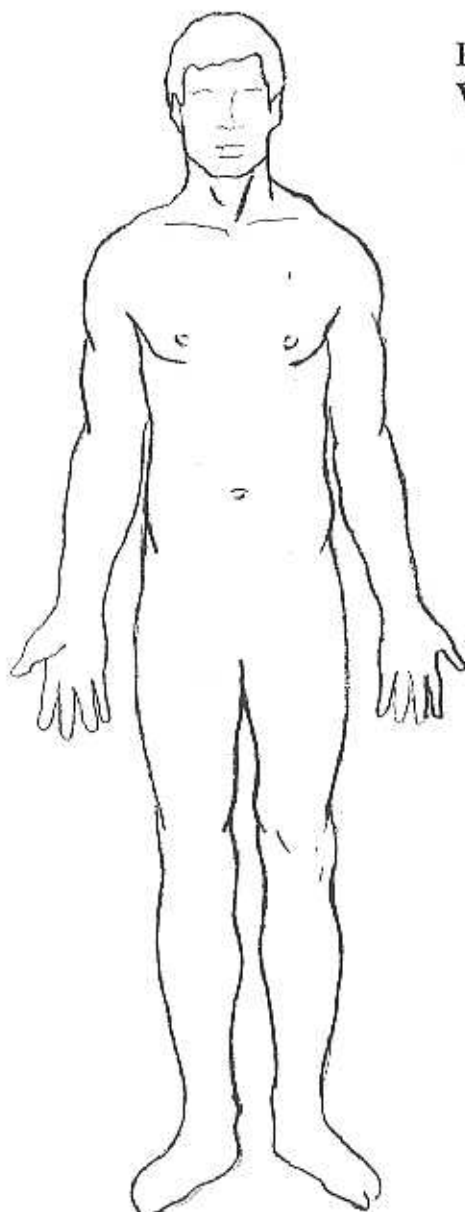
9. My present pain is in my:       BACK     LEG     R     L

10. My present pain is in my       NECK     ARM     R     L

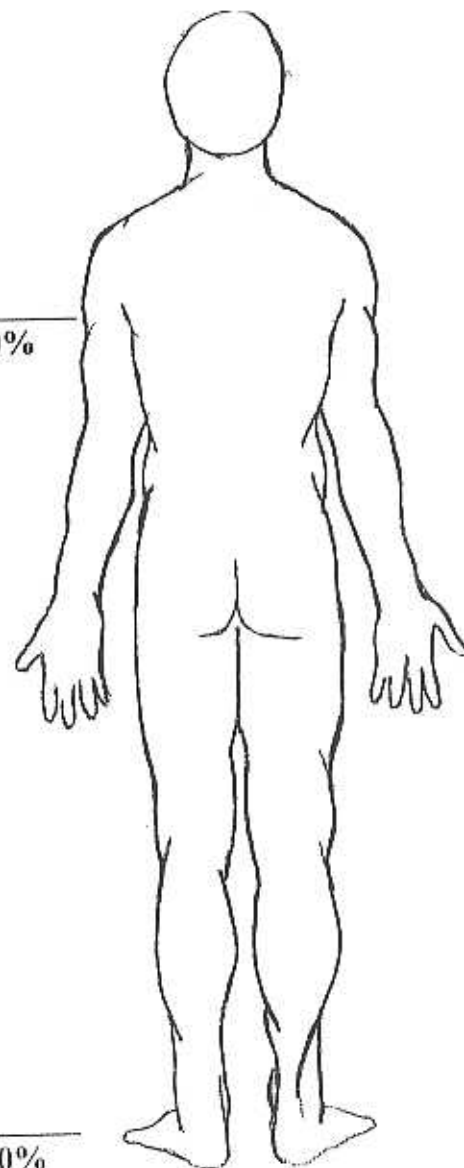
11. **PAIN DRAWING:** Using the symbols given below, mark the areas on your body where you feel the described sensation. Include all affected areas.

ACHING	NUMBNESS	TINGLING	BURNING	STABBING	WEAKNESS
□□□□	◆◆◆◆	○○○○	××××	////	●●●●

**FRONT**



**BACK**



**PAIN IN ARM(S) COMPARED WITH NECK:**

- WORSE THAN
- SAME AS
- LESS THAN

% OF PAIN IN NECK: \_\_\_\_\_

% OF PAIN IN ARM R / L: \_\_\_\_\_

Total = 100%

**PAIN IN LEG(S) COMPARED WITH BACK:**

- WORSE THAN
- SAME AS
- LESS THAN

% OF PAIN IN BACK: \_\_\_\_\_

% OF PAIN IN LEG R / L: \_\_\_\_\_

Total = 100%

## DESCRIPTION OF PRESENT PAIN

PAIN RATING SCALE: Use a number from 0 to 10 with 0 = NO PAIN and 10 = UNBEARABLE PAIN.

12. BACK PAIN \_\_\_\_\_ HIP/BUTTOCK PAIN \_\_\_\_\_ LEG PAIN \_\_\_\_\_  
NECK PAIN \_\_\_\_\_ ARM PAIN \_\_\_\_\_

13. My pain is: (check all that apply)

- Present intermittently
- Always present, but of variable intensity
- Improving
- Worsening in that it is:
  - present more often
  - more intense
  - Changing in location. Explain: \_\_\_\_\_

14. My neck/back pain is better: (check all that apply)

- with rest
- with heat
- with walking
- in the morning
- with cold
- with sitting
- after I'm up a while
- with lying down
- with activity
- with sleep

15. My neck/back pain is worse: (check all that apply)

- with sitting
- in the morning
- straining
- working at computer
- with standing
- by the end of the day
- coughing
- using phone
- with walking
- when I first lie down
- sneezing
- driving
- with bending
- at night
- with lifting
- sports
- with twisting
- reading/writing

16. If LEG PAIN, my pain is better (B) or worse (W) with: (circle all that apply)

Sitting:	B / W	Lying on effected side	B / W
Standing:	B / W	Driving	B / W
Walking:	B / W		

17. If ARM PAIN, my pain is worse (W) or better (B) with: (circle all that apply)

Arm overhead:	B / W	Lying on effected side	B / W
Arm hanging at side:	B / W	Driving	B / W
Arm against chest:	B / W		
With head tilted to opposite side:	B / W		

## DESCRIPTION OF PRESENT PAIN

- When I wake up in the morning, my back is stiff/sore and I can hardly move, after I'm up for a while I loosen up and do better, but as the day goes on I begin to hurt worse so that by bedtime I'm very stiff and sore.
18. What reactions have you had to the pain? (check all that apply)
- |  |  |
|--|--|
| <input type="checkbox"/> I have none               | <input type="checkbox"/> I feel blue and no good |
| <input type="checkbox"/> I feel tired all the time | <input type="checkbox"/> I feel frustrated       |
19. Do you have problems with your bowels related to present problem? (check all that apply)
- |  |   |
|--|---|
| <input type="checkbox"/> none                        | <input type="checkbox"/> constipation       |
| <input type="checkbox"/> diarrhea                    | <input type="checkbox"/> pain with movement |
| <input type="checkbox"/> loss of feeling of movement | <input type="checkbox"/> loss of control    |
20. Do you have problems with your bladder related to present problem? (check all that apply)
- |   |  |
|---|--|
| <input type="checkbox"/> none                     | <input type="checkbox"/> more frequent urination |
| <input type="checkbox"/> loss of feeling of urine | <input type="checkbox"/> burning                 |
| <input type="checkbox"/> loss of urine control    | Explain _____                                    |
21. Do you have any sexual dysfunction? Explain \_\_\_\_\_
22. Do you have any limitation in the movement of your neck?:  Yes  No
23. Do you have any limitation in the movement of your back?:  Yes  No
24. Do you have any problem with balance or coordination?:  Yes  No
25. Do you have any problem with fine manipulation/dexterity with hands and fingers?:  Yes  No
26. My weight is:
- |  |  |                                 |
|--|--|---------------------------------|
| <input type="checkbox"/> increasing<br>____ lbs. | <input type="checkbox"/> decreasing<br>____ lbs. | <input type="checkbox"/> steady |
|--|--|---------------------------------|
27. How is pain now limiting your job and/or housework? (check ONE (1) only)
- Not limited in any way.
  - Pain is not bad enough to really limit me very much.
  - Able to work with pain all the time by modifying my activities.
  - Frequently unable to work for several or more days at a time.
  - Unable to work at all - totally disabled by pain.
28. How is pain now limiting your social, recreational and other leisure activities? (Check ONE (1) only).
- Not limited in any way.
  - Pain not bad enough to really limit me very much.
  - Able to do most things most of the time even with pain.
  - Must modify activities to control pain and not do most things.
  - Unable to engage in any of these activities whatsoever due to pain.
  - Activities/sports unable to perform: \_\_\_\_\_
29. How is pain affecting your sleep? (check ALL that apply)
- I have no problems falling asleep. I sleep a full night.
  - I have difficulty falling asleep because of my pain.
  - I wake up at night or in the early morning and can't go back to sleep because of my pain.
  - I wake up from a deep sleep with pain.

## PAST BACK AND NECK HISTORY

1. I have had trouble with my  BACK or  NECK in the past.

When was the FIRST time? \_\_\_\_\_

2. I have had prior injuries to my back or neck. Explain. \_\_\_\_\_  
\_\_\_\_\_

3. I have seen other doctors about my problem.  YES  NO

LIST THEIR NAMES,

SPECIALTY &

DATES OF EXAM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. I have had  BACK or  NECK surgery in the past.  YES  NO

5. LIST NECK OR BACK SURGERIES:

	DATE	SURGEON	WHAT WAS DONE	ANY COMPLICATIONS
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

6. Treatment I have had: DATE # OF TREATMENTS NAME OF PLACE OR DOCTOR

Physical Therapy: \_\_\_\_\_  
 Chiropractic Care: \_\_\_\_\_  
 Acupuncture: \_\_\_\_\_  
 Epidural steroids: \_\_\_\_\_  
 Brace or corset: \_\_\_\_\_  
 Other: \_\_\_\_\_

7. Tests I have had: DATE HOSPITAL DOCTOR'S NAME

MRI: \_\_\_\_\_  
 CT Scan: \_\_\_\_\_  
 Myelogram: \_\_\_\_\_  
 Bone scan: \_\_\_\_\_  
 EMG (nerve test) \_\_\_\_\_  
 Diskogram: \_\_\_\_\_

8. Medications I take for my back/neck:

	NAME	DOSE	HOW OFTEN
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

# MEDICAL HISTORY

1. ALLERGIES: (food or medicine)  
(Include type of reaction)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

2. List any other Medications you take regularly and occasionally (except for neck and back):

NAME	DOSE	HOW OFTEN
------	------	-----------

- |          |       |       |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

3. List any Herbs you take occasionally and/or regularly:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

4. Do you use recreational drugs?  YES  NO If yes, Explain \_\_\_\_\_

5. Do you have any medical problems?  YES  NO (if yes)

- Heart  Lungs  Blood pressure  Stroke  Stomach  Intestines  Kidneys
- Hearing  Vision  Diabetes  Headaches  Cancer  Asthma
- Bowel/Bladder problems  Bleeding problems  Epilepsy  Dizziness
- Drug abuse or dependency problem  Alcoholism  Psychiatric problems

6. Did you have the usual childhood disease? (measles, mumps, chicken pox)  YES  NO

7. Any unusual diseases?  Mononucleosis  Hepatitis  Epstein Barr  Fibromyalgia  
 Lyme Disease  HIV/AIDS

8. Please list all surgeries you have had other than neck or back:

DATE	OPERATION	ANY COMPLICATIONS
------	-----------	-------------------

- |       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

9. Do you smoke?  YES  NO Number of packs/day? \_\_\_\_\_ for \_\_\_\_\_ years

10. Do you drink?  YES  NO How much? \_\_\_\_\_

11. OSTEOPOROSIS: Date of menopause \_\_\_\_\_ Age \_\_\_\_\_

Osteoporosis medication: \_\_\_\_\_

**11. FAMILY HISTORY:**

Are there any members of your immediate family with:

- High blood pressure       Bleeding problems       Anesthetic problems
- Heart disease               Cancer
- Diabetes      Explain \_\_\_\_\_

**EMPLOYMENT HISTORY**

1. Present employer: \_\_\_\_\_

How long? \_\_\_\_\_

2. Present job/occupation: \_\_\_\_\_

3. My present/last job involves(d): (check all that apply)

	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Lifting	_____ lbs.	_____ lbs.	_____ lbs.
Bending	_____	_____	_____
Twisting	_____	_____	_____
Sitting	_____ hrs.	_____ hrs.	_____ hrs.
Standing	_____ hrs.	_____ hrs.	_____ hrs.
Walking	_____ hrs.	_____ hrs.	_____ hrs.
Driving	_____ hrs.	_____ hrs.	_____ hrs.
Overhead work	_____ hrs.	_____ hrs.	_____ hrs.

4. IF UNEMPLOYED OR NOT CURRENTLY WORKING:

- Retired:             YES     NO
- On medical leave:  YES     NO      Since: \_\_\_\_\_
- Laid off:             YES     NO      Since: \_\_\_\_\_
- On total disability:  YES     NO      Since: \_\_\_\_\_
- SSD:                 YES     NO      Next review: \_\_\_\_\_

5. I last worked on: \_\_\_\_\_

6. My employer would allow me to return to work with restrictions:  YES     NO

7. Do you have an attorney who will be wanting a report about this examination?     YES     NO

If yes:    Name: \_\_\_\_\_

Address: \_\_\_\_\_

**FOR OFFICE USE ONLY**

**RADIOLOGY:**

**C Spine** \_\_\_\_ **L Spine** \_\_\_\_ **T Spine** \_\_\_\_

**Disk Desiccation:** \_\_\_\_\_

**DJD:** \_\_\_\_\_

**Spondylo: I** \_\_\_\_\_ **D** \_\_\_\_\_

**Alignment:** \_\_\_\_\_

**Bone Density:** \_\_\_\_\_

**Fracture:** \_\_\_\_\_