

**St. Louis Spine Care Alliance**

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**Patient History Health Questionnaire**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

What is your current complaint? \_\_\_\_\_

How did you get injured? \_\_\_\_\_

Date of Injury or Onset of Symptoms: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Is your condition job related? \_\_\_\_ Yes \_\_\_\_ No

Is there any possibility that you are pregnant? \_\_\_\_ Yes \_\_\_\_ No

Are you allergic to any medications? \_\_\_\_ Yes \_\_\_\_ No

If yes, list the medication and your reaction to the medication.

**Please list your current medications, including over the counter and herbal medications.**

Pharmacy Name: \_\_\_\_\_

Pharmacy telephone number: (\_\_\_\_) \_\_\_\_\_

Referred By: \_\_\_\_\_

Name of your medical doctor: \_\_\_\_\_

Telephone number for your medical doctor: (\_\_\_\_) \_\_\_\_\_

**Please continue on the next page**

**Medical History**

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Medical Test Already Done:

X-RAYS      MRI    CAT SCAN    BONE SCAN    MYELOGRAM    EMG/NCS

OTHER: \_\_\_\_\_

Back: Have you had back problems before this?     Yes     No

Neck: Have you had neck problems before this?     Yes     No

If so, have you seen any other doctors for this problem? (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What types of treatment have you received for your back or neck?

Injections       Physical Therapy       Massage       Medication

Other: \_\_\_\_\_

What makes your pain worse? (check all that apply)

During Exercise       Stress       Bending Forward

After Exercise       Sex       Bending Backwards

Sitting       Morning       Coughing

Standing       Night       Sneezing

Walking       Fatigue       Touching Skin

Damp Weather       Cold Weather       Work

Twisting

Other: \_\_\_\_\_

**Please continue on the next page**

What makes your pain less? (check all that apply)

<input type="checkbox"/> Lying Down	<input type="checkbox"/> Heat / Massage	<input type="checkbox"/> Injections
<input type="checkbox"/> Sitting	<input type="checkbox"/> Medications	<input type="checkbox"/> Exercise
<input type="checkbox"/> Standing	<input type="checkbox"/> Waling	<input type="checkbox"/> Ice
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Nothing
<input type="checkbox"/> Other: _____		

What can you do now? (check all that apply)

<input type="checkbox"/> Drive	<input type="checkbox"/> Housework	<input type="checkbox"/> Work at Job
<input type="checkbox"/> Walk	<input type="checkbox"/> Sit	<input type="checkbox"/> Stand
<input type="checkbox"/> Climb Stairs	<input type="checkbox"/> Yard Work	<input type="checkbox"/> Get Dressed

Do you now or have you ever had any problems related to the following?

<u>Constitutional</u>		<u>Respiratory</u>	
Fever (unexplained)	Y N	Pneumonia	Y N
Chills	Y N	Asthma	Y N
Night sweats	Y N	Emphysema	Y N
Weight loss (unexplained)	Y N	Bronchitis	Y N
		Tuberculosis	Y N
<u>Eyes</u>			
Visual changes	Y N	<u>Gastrointestinal</u>	
Glaucoma	Y N	Abdominal pain	Y N
		Blood in stool	Y N
		Nausea / Vomiting (not related to flu)	Y N
<u>ENT</u>		Indigestion / Heartburn	Y N
Loss of hearing	Y N	Stomach ulcers	Y N
Sinus problems	Y N	Irritable bowel syndrome	Y N
<u>Psychiatric</u>			
Depression	Y N	<u>Miscellaneous</u>	Y N
Sleeping disorder	Y N	History of Alcohol Abuse	Y N
		History of Drug Abuse	Y N
		Hepatitis	Y N
		Liver Disorders	Y N

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Cardiovascular

Heart Attack	Y	N
Mitral Valve Prolapse	Y	N
Abnormal heart rhythm	Y	N
High blood pressure	Y	N
Stroke / Mini-stroke	Y	N
Aneurysm	Y	N
Poor circulation in legs	Y	N
Reynaud's Disease	Y	N

Musculoskeletal

Back pain	Y	N
Osteoporosis	Y	N
Arthritis	Y	N

Integumentary / Breast

Skin Rash	Y	N
Sore that will not heal	Y	N
Breast lump / discharge	Y	N

Hematologic / Lymphatic

Anemia	Y	N
Bruise easily	Y	N
Sickle cell disorder	Y	N
Blood clots	Y	N
Aids or HIV	Y	N
Enlarged lymph nodes	Y	N
Lupus	Y	N

Genitourinary

Bladder problems	Y	N
Frequent urinary infections	Y	N
Blood in urine	Y	N
Kidney stones	Y	N
Kidney failure	Y	N

Neurological

Dizzy spells	Y	N
Seizures or convulsions	Y	N
Headaches	Y	N
Multiple sclerosis	Y	N

Endocrine

Diabetes (please circle)	Y	N
Adult onset		
Juvenile onset		
Insulin dependent		
Non-insulin dependent		
Thyroid dysfunction	Y	N
Gout	Y	N

History of Cancer

Type: _____	Y	N
_____		
_____		

Any other illness not listed above: \_\_\_\_\_

**Surgical History:**

Have you ever had an operation? If yes, list operations and year they were performed.

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**Social History:**

What is your occupation? \_\_\_\_\_

Specific Duties: \_\_\_\_\_

Are you working?    \_\_\_\_\_ Yes    \_\_\_\_\_ No

If no, what is the last date you worked?    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If yes, are you working with restrictions?    \_\_\_\_\_ Yes    \_\_\_\_\_ No

Does your employer have light duty available?    \_\_\_\_\_ Yes    \_\_\_\_\_ No    \_\_\_\_\_ Unknown

Have you ever been injured on the job before?    \_\_\_\_\_ Yes    \_\_\_\_\_ No

If so, for what reason? \_\_\_\_\_

Marital Status:    \_\_\_\_\_ Single    \_\_\_\_\_ Married    \_\_\_\_\_ Separated    \_\_\_\_\_ Divorced    \_\_\_\_\_ Widow/Widower

Use of alcohol:    \_\_\_\_\_ Never    \_\_\_\_\_ Rarely    \_\_\_\_\_ Moderate    \_\_\_\_\_ Daily

Use of tobacco:    \_\_\_\_\_ Never    \_\_\_\_\_ Previously, but quit    \_\_\_\_\_ Currently packs per day \_\_\_\_\_

Use of illegal / street drugs:    \_\_\_\_\_ Never    \_\_\_\_\_ Previously, but quit  
\_\_\_\_\_ Type / Frequency \_\_\_\_\_

Are you on any special diet? \_\_\_\_\_

Hobbies: \_\_\_\_\_

Sports: \_\_\_\_\_

Do you CURRENTLY exercise?    \_\_\_\_\_ Yes    \_\_\_\_\_ No    If so, what type of exercise and  
how many times per week? \_\_\_\_\_

**Family History:**

Who, if anyone, in your family has had any of the following:

Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Heart Disease \_\_\_\_\_ Cancer \_\_\_\_\_

Stroke \_\_\_\_\_

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