

South Texas Orthopaedic & Spinal Surgery Associates, P.A.
Patient History Form

ACCT#: _____ DATE: _____

Patient's Legal Name: _____

Age: _____ Date of Birth: _____ Education (Highest level attained): _____

Primary Care Physician: _____

Referring Physician: _____

REASON FOR VISIT: My area of pain or complaint(s) is/are:

Part of your body experiencing the GREATEST pain:

Pain Location: _____ Date of Onset _____ Rated at (0=none, 10=unbearable): _____

Pain Location: _____ Date of Onset _____ Rated at (0=none, 10=unbearable): _____

Pain Location: _____ Date of Onset _____ Rated at (0=none, 10=unbearable): _____

The pain was: gradual sudden following an injury on: _____

Please indicate: no prior low back pain no prior neck pain

MID TO LOW BACK: Numbness and/or Tingling: part of lower body: _____ right left both sides

Pain quality: aching sharp burning cramping stabbing

Pain location: middle of lower back left side right side both sides across buttock/back

NECK: Numbness and/or Tingling: part of upper body: _____ right left both sides

Pain quality: aching sharp burning cramping stabbing

Pain location: middle of lower back left side right side both sides across buttock/back

DOMINANT HAND: L R

TREATMENT HISTORY FOR CURRENT PROBLEM

Medications Taken for Current Symptoms: *Steroidal Anti-inflammatories:* Medrol Dosepak Other: _____

Nonsteroidal Anti-inflammatories: Aleve Aspirin Motrin Celebrex Mobic Other: _____

Pain Relievers: Tylenol Darvocet Tramadol Ultram Norco Vicodin Other: _____

Muscle Relaxers: Flexeril Skelaxin Soma Other: _____

Have you had physical therapy for this problem? No Yes- Duration: _____ Date of Last Session: _____

Please check any injection treatment(s) received for this problem: Epidural steroid Facet Trigger Point Hardware
 Nerve root block Other: _____

PAST MEDICAL HISTORY:

Medication allergies: _____

Medications you currently take: _____

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Patient Pain Diagram

ACCT#: _____ DATE: _____

Patient's Name: _____

INSTRUCTIONS: Use the appropriate symbol(s) below (as many as needed) and rate each

Pain Severity Scale: MILD -- 1 2 3 4 5 6 7 8 9 10 -- INTOLERABLE

NUMBNESS (SYMBOL: *)
How would you rate this pain: _____

PINS & NEEDLES (SYMBOL: O)
How would you rate this pain: _____

BURNING (SYMBOL: X)
How would you rate this pain: _____

DEEP ACHE OR PAIN (SYMBOL: A)
How would you rate this pain: _____

STABBING (SYMBOL: /)
How would you rate this pain: _____

