Name _____

Date of Birth _____

ORTHOPAEDIC ASSOCIATES
of AUGUSTA, P.A.

Established Patient Spine Worksheet

Referring Physician: _____ **Height:** _____ **Weight:** _____

Reason for today's visit:

☐ Update on symptoms
☐ Review test results (MRI, CT, Nerve Study)
☐ Discuss surgery
☐ Follow-up after Spinal injection - performed by Dr. _____
☐ Follow-up after Surgery

Since your last visit, your symptoms are: (circle answer)

_____ % Better / Worse or the Same

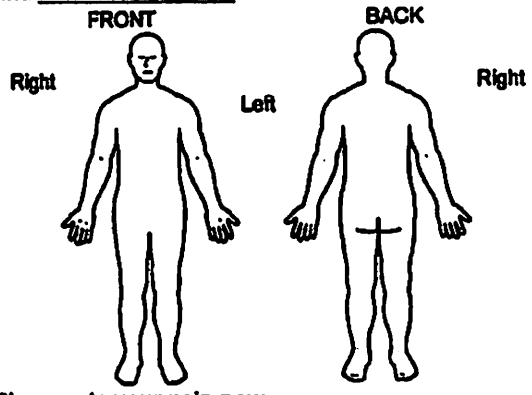
How would you describe your pain now?

☐ Constant ☐ Burning ☐ Dull
☐ Intermittent ☐ Sharp ☐ Throbbing
☐ Stinging ☐ Aching

Pain is:

☐ Equal on both sides
☐ Only or worse on the right side
☐ Only or worse on the left side

Mark areas below where you are having pain with an X, and numbness/tingling with an O.



Please rate your pain now.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Ever

Please rate your pain at its worst.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Ever

What makes your pain worse?

☐ All Activity ☐ Lifting ☐ Coughing
☐ Sitting ☐ Bending ☐ Sneezing
☐ Standing ☐ Twisting ☐ Lying Down
☐ Walking ☐ Nothing
☐ The pain wakes you from sleep
☐ Other _____

What makes your pain better?

☐ Nothing ☐ Activity ☐ Walking
☐ Lying Down ☐ Exercise ☐ Twisting
☐ Ice ☐ Sitting ☐ Bending forward
☐ Heat ☐ Standing ☐ Bending backward
☐ Other _____

Review of Systems

Have you had:

☐ Inability to urinate ☐ Loss of balance while walking
☐ Arm or leg weakness ☐ Falls

What is your current work status?

☐ Out of Work ☐ Light Duties ☐ Full Duties ☐ Retired

Since your last visit, have you tried any of the following?

☐ Chiropractor ☐ Physical Therapy
☐ Accupuncture ☐ Massage Therapy

Are you still smoking?

☐ Yes ☐ No ☐ N/A

List the medications you have tried since your last visit.
Circle refill requests.

☐ Neurontin / Amitriptyline / Lyrica
☐ Anti-inflammatory (list name): _____
☐ Pain killer (list name): _____
☐ Muscle relaxer (list name): _____
☐ Other: _____

Provider Notes:

Patient Signature: _____ **Date:** _____

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