Name: _____

Heidi M. Hullinger, MD

PAIN DIAGRAM

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

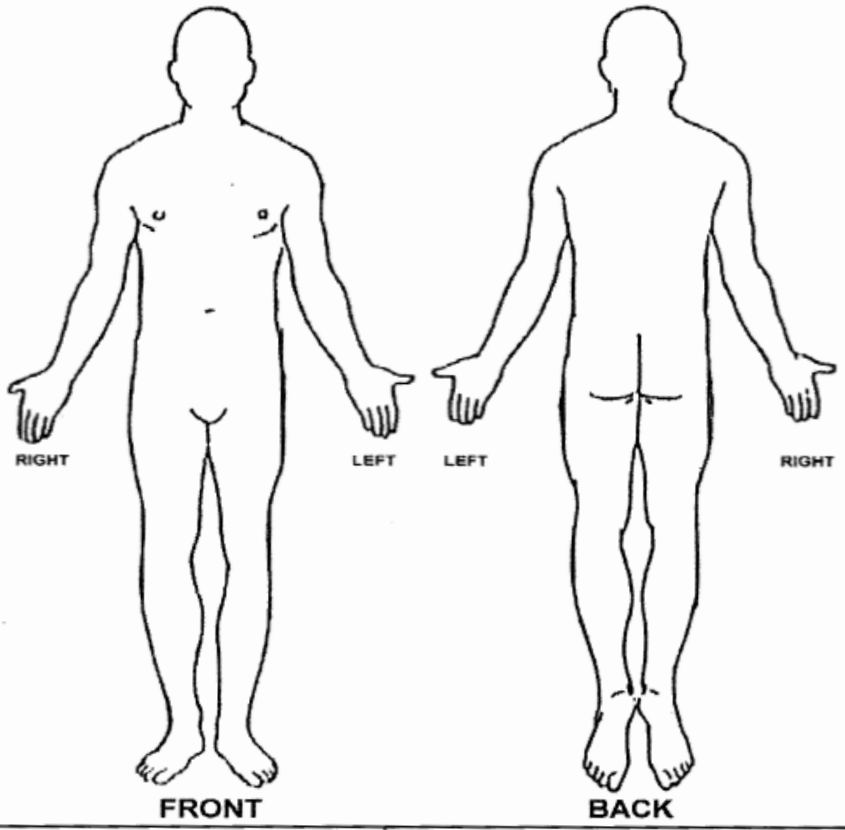
Ache
^^^^^
^^^^^
^^^^^

Numbness
OOOO
OOOO
OOOO

Pins & Needles
= = = =
= = = =
= = = =

Burning
XXXX
XXXX
XXXX

Stabbing
/////
/////
/////



How bad is your pain? Circle the number on each of the lines below to indicate your pain.

How bad is your **neck** pain?
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **arm** pain?
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **middle back** pain?
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **low back** pain?
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **leg** pain?
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

Please identify which one of the following ratios best describes the amount of pain you feel:

- ☐ 100% Spine pain to 0% Extremity pain
- ☐ 90% Spine pain to 10% Extremity pain
- ☐ 80% Spine pain to 20% Extremity pain
- ☐ 70% Spine pain to 30% Extremity pain
- ☐ 60% Spine pain to 40% Extremity pain
- ☐ 50% Spine pain to 50% Extremity pain
- ☐ 40% Spine pain to 60% Extremity pain
- ☐ 30% Spine pain to 70% Extremity pain
- ☐ 20% Spine pain to 80% Extremity pain
- ☐ 10% Spine pain to 90% Extremity pain
- ☐ 0% Spine pain to 100% Extremity pain

Initials: _____ Date: _____

Name: _____

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How did your problem begin?
(Check all that apply)

___ Came on gradually, no known cause

___ I've had it a long time: ___ years

___ It comes and goes

___ It came on suddenly: Date _____

___ It happened after an injury/accident

___ It happened at work
___ Are you still working?

___ Are you in litigation with regards to your spinal problem?

Further details about the reason you came in today:

_____

_____

_____

_____

_____

_____

Have you noticed arm/leg weakness? Explain:

_____

_____

What have you tried for your symptoms?

___ Physical Therapy?	___ Better	___ Worse	___ No change	
___ Anti-Inflammatories?	___ Better	___ Worse	___ No change	
___ Chiropractic Care?	___ Better	___ Worse	___ No change	
___ Injections?	___ Better	___ Worse	___ No change	
___ Narcotics?	___ Better	___ Worse	___ No change	
___ Other? _____	___ Better	___ Worse	___ No change	

Is your pain worse at night? __ yes __no

Does it awaken you from sleep? __ yes __no

Have you had any fevers/chills? __ yes __no

Have you had any weight loss/gain? __ yes __no

Any loss of bowel/bladder control? __ yes __ no
Details: _____

Difficulty emptying bladder? __ yes __ no

Initials: _____ Date: _____

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BACK

How do these activities affect your back/leg pain?

Walking? ___ Better ___ Worse ___ No Change
How far can you walk before needing to stop? _____
Better if you lean/bend forward? ___ Yes ___ No

Standing? ___ Better ___ Worse ___ No Change

Sitting? ___ Better ___ Worse ___ No Change
How long can you sit before needing to change positions? _____

Lying Down? ___ Better ___ Worse ___ No Change

What is your "Best Position"? _____

What activity (-ies) would you like to do that you can't currently do?

_____

_____

NECK

Do you have problems with the following?
Check all that apply

____ Buttoning shirts or clasping jewelry?

____ Picking up coins or other small objects?

____ Problems with balance?
____ Do you fall down?

____ Feeling that your hands are "clumsy"?

____ Tingling/burning in all fingers?

Initials: _____ Date: _____

Name: _____

Heidi M. Hullinger, MD

What tests have you had done for your spinal issues?
When were they done? (Approximately)

___ Xray _____ Date

___ MRI _____ Date

___ CT _____ Date

___ Myelogram _____ Date

___ EMG/NCV (nerve test) _____ Date

What would you like to happen as a result of this visit?

_____

_____

_____

_____

_____

_____

_____

Have you seen any other doctors for this problem?

Name of Doctor: _____
Date of Evaluation: _____

Name of Doctor: _____
Date of Evaluation: _____

Have you had surgery on your neck/back?

Type of Surgery:_____
Date: _____ Surgeon: _____
Did it help? _____

Type of Surgery:_____
Date: _____ Surgeon: _____
Did it help? _____

Type of Surgery:_____
Date: _____ Surgeon: _____
Did it help? _____

Additional Details:

_____

_____

_____

Any other neck/back or other spinal issues not related to this visit?

_____

_____

_____

_____

Initials: _____ Date: _____

Name: _____

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Past Medical History

Please circle if you have any of the following medical problems:

Hypertension/High Blood Pressure

Cancer

Diabetes

Heart Disease

Stomach Ulcers

Peripheral Vascular Disease/Problems with Circulation

Sleep Apnea

Tendency of easily bleeding/bruising

Previous problems with Anesthesia

Hepatitis

Blood clots

Any other medical problems not listed above: _____

_____

_____

Please list medications or provide a copy of a list of medications:

_____

_____

_____

_____

Medication Allergies:

_____

_____

Prior non-spine surgeries (list surgeon and date, if known)

_____

_____

_____

Initials: _____ Date: _____

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Social History:

What type of work do you do? _____

What is your status? ____ Single ____ Married ____ Divorced ____ Other

Do you have any children? ___ Y ____ N How many? _____

Do you drink alcohol? ____ Y ____ N If so, how many drinks in a week? _____

Do you smoke or use other tobacco products? ____ Y ____ N

What type? _____ How much do you use? _____

Relevant family medical history? ____ Cancer ____ Bleeding problems ____ Blood clots

____ Heart disease ____ Spinal deformity ____ Arthritis ____ Other (details below)

Please provide details below (member of family, any other relevant information)

_____

_____

_____

Review of Systems- Have you recently had any of the following symptoms or problems?

Weight loss	Anxiety	Sexual difficulty
Joint pain	Depression	Constipation
Nosebleeds	Osteoporosis	Diarrhea
Chest pain	Skin rash	Nausea or Vomiting
Shortness of breath	Varicose veins	
Stomach pain	Menstrual problems	

Other _____

Please provide additional details for any section above for which you did not have enough room:

Initials: _____ Date: _____