Donald S. Corenman, MD
New Patient Cervical Spine History

Date: ☐☐ / ☐☐ / ☐☐☐☐

Please PRINT and fill out completely.

Shade circles like this: ●

Med record # ☐☐☐☐☐☐

Name _____ **Age** _____ yrs. **D.O.B.** _____

Height ☐ ft ☐☐ in **Weight** ☐☐☐ lbs **Sex** ○ Male ○ Female **Are you or could you be pregnant?** ○ Yes ○ No

Your Occupation _____ **Employer** _____

Who referred you to this office? If more than one, please note.
○ Dr. _____ ○ PA/NP _____
○ Friend/Word of Mouth _____ ○ Physical Therapist _____
○ Family Member _____ ○ Other _____

HISTORY OF CARE

Who is your primary care physician? _____ **Location:** _____

Address: _____ **Phone:** _____

Please list any other doctors, clinics, or hospitals you have seen for your current spinal problems:

Name	*City*	*Date of First Visit*	*Currently Continuing?*

HISTORY OF CURRENT SPINAL PROBLEMS

List your chief complaints or main problems with the most severe first:

1. _____
2. _____
3. _____

Describe all details of any accident, incident or the way these problems began:

_____
_____
_____
_____

CURRENT SYMPTOMS

What time of day is your pain at its worst? ○ Morning ○ Afternoon ○ Evening ○ Night ○ Not Applicable

Does the pain wake you up at night? ○ Yes ○ No

In the past six months have you experienced: ○ Fever ○ Weight Loss _____ lbs ○ Chills ○ Night Sweats

How would you describe your pain? ○ Constant ○ Constant, but worse with activity ○ Intermittent (comes and goes) ○ Intermittent, but worse with activity

Do you have full control of your bladder? ○ Yes ○ No

Do you have full control of your bowels? ○ Yes ○ No

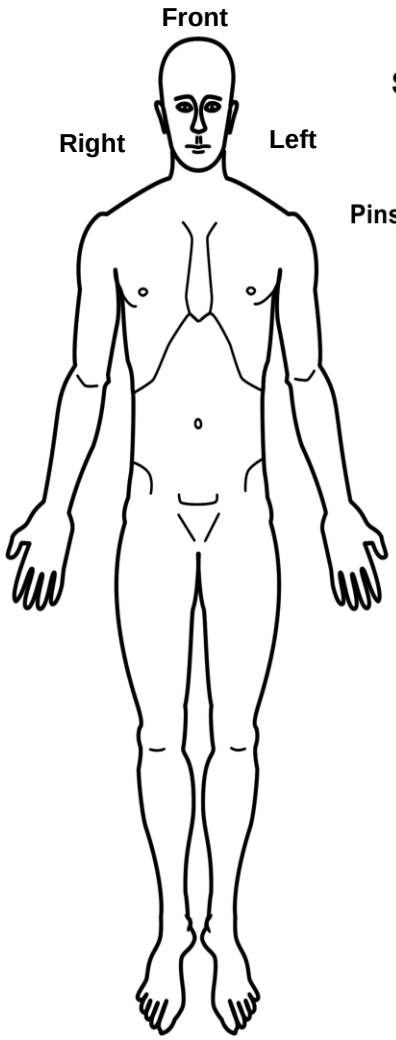
PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, include all affected areas.

For Doctor Use Only

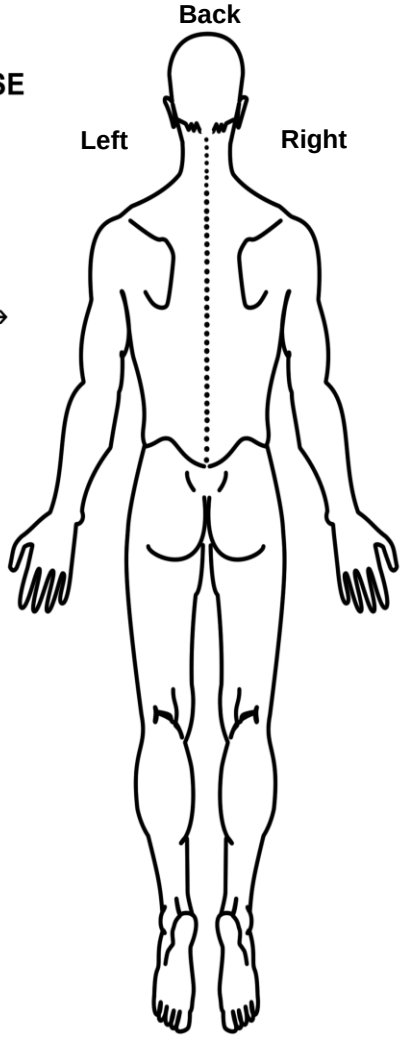
	R			L			Both/axial		
Head									
Neck									
Trap									
Scap									
Scp/ Arm									
Arm									
LB									
LB/SI									
SI									
Bt/Leg									
M Bk									
Groin									

Complex ○ Positional ○



SYMBOLS TO USE

Aching: △△△
Numbness: =====
Pins & Needles: OOO
Burning: XXX
Stabbing: ///
Radiates: →→→



For Dr. Use Only

For each area of your body, please mark where your symptoms (pain, numbness, weakness, etc.) exist on "average" (most of the time) and at their "worst."

		None										Unbearable
Neck ○ Positional	Current **neck** pain											
	Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Sh ○ Positional	Current **shoulder** pain											
	Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Arm ○ Positional	Current **arm** pain											
	Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

PAST MEDICAL HISTORY

Check if you currently are being treated for or have been diagnosed with:

	When?		*When?*
○ High Blood Pressure		○ Osteoporosis	
○ Diabetes		○ Kidney Disease/Problem	
○ Liver Disease		○ Seizures	
○ Heart Disease or Attack		○ Arthritis	
○ Stroke		○ Thyroid	
○ Cancer _____		○ Tuberculosis	
○ High Lipids (cholesterol, etc.)		○ Psoriasis	
○ Ulcer Disease		○ Polio	
○ Gastritis		○ Rheumatic Fever	
○ Reflux Disease (GERD)		○ Gout	
○ Asthma		○ Herpes Simplex	
○ Depression		○ **Other**	
○ Bipolar Disease			
○ Other Psychiatric			

Have you ever had a history of blood clots or pulmonary embolus? ○ Yes ○ No

SURGERIES

Please list all ***spine* surgeries you have had in the past:**

Type of Surgery	*Date*	*Surgeon*

Please list all ***other* surgeries you have had in the past:**

Type of Surgery	*Date*	*Surgeon*

MEDICATIONS

Please list ALL medications you are ***currently* taking, including prescription and over the counter:**

Medication	*Dosage*	*Frequency (how many pills in a 24 hours)*

ALLERGIES

Please list any ***allergies or adverse reactions* you have to medications:**

Medication	*What Happened?*

FAMILY HISTORY

Is your father alive? ○ Yes ○ No **IF YES, age and any major medical problems?** _____

IF NO, age at time of death? _____ **What major medical problems did he have?** _____

Is your mother alive? ○ Yes ○ No **IF YES, age and any major medical problems?** _____

IF NO, age at time of death? _____ **What major medical problems did she have?** _____

Any siblings? ○ Yes ○ No **How many?**

SOCIAL HISTORY

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Living with other

Education level achieved: ○ Grade School ○ Jr. High ○ High School ○ College ○ Post. Graduate

***DO* you currently smoke cigarettes?** ○ Yes ○ No **Number of Years Smoked:** ☐☐ **For Dr. Use Only** p yrs ☐☐☐

Packs per Day: *(Please choose the closest)* ○ < 1/2 ○ 1/2 ○ 1 ○ 2 ○ > 2

***DID* you smoke cigarettes in the past?** ○ Yes ○ No **Number of Years Smoked:** ☐☐ **Quit Date:** ☐☐ / ☐☐ / ☐☐☐☐

Packs per Day: *(Please choose the closest)* ○ < 1/2 ○ 1/2 ○ 1 ○ 2 ○ > 2

Do you use any other tobacco products? ○ Yes ○ No **What kind?** _____ **Quantity:** _____

Do you use any recreational drugs? ○ Yes ○ No **What kind?** _____

Do you drink alcohol? ○ Yes ○ No **Drinks per Day:** ☐☐ **Drinks per Week:** ☐☐ **Years:**

***DO YOU HAVE OR HAVE YOU HAD* an unhealthy relationship with alcohol?** ○ Yes ○ No

Type of alcohol consumption: ○ Beer ○ Wine ○ Mixed Drinks

WORK HISTORY

Are you currently: ○ employed ○ unemployed ○ retired ○ on sick leave ○ on disability ○ a stay at home parent

Has your job changed since your symptoms started? ○ Yes ○ No ○ Not Working

If you are at a different job or not working, did your symptoms play a role in your job change or decision not to work? ○ Yes ○ No

If you are working, are you on: ○ Normal duties ○ Light duties

If you are on light duty, did your current symptoms play a role? ○ Yes ○ No

Are you applying for disability? ○ Yes ○ No

Please describe your job _____

WORKMAN'S COMPENSATION HISTORY

IS THIS A WORKERS COMPENSATION CASE? ○ Yes ○ No

Have you had any PRIOR workers compensation injuries? ○ Yes ○ No **If yes, how many?** ☐☐

Please list any prior workers compensation cases/injuries:

Date	*Area Injured*	*Time off Work*	*Who Treated You?*

Were you at work when your symptoms began? ○ Yes ○ No

Did you have a specific accident or injury while at work to cause your symptoms? ○ Yes ○ No

What is the company name? _____

Prior to your WC injury, how long had you been employed by that company? ☐☐ **months OR** ☐☐ **years**

Do you currently have an attorney for this episode? ○ Yes ○ No

CAR ACCIDENTS

WERE YOUR SYMPTOMS CAUSED BY A CAR ACCIDENT? ○ Yes ○ No

Have you had any PRIOR car accidents? ○ Yes ○ No **If yes, how many?** ☐☐

Please list:

Date	*Area Injured*	*Time off Work*	*Who Treated You?*

Do you currently have an attorney for this episode? ○ Yes ○ No

REVIEW OF SYSTEMS

Check No or Yes in the following areas. If "Yes," please describe:

1. CONSTITUTIONAL

- **A. Recent weight change?** ○ Yes ○ No
- **B. Change or loss of appetite?** ○ Yes ○ No
- **C. Fevers?** ○ Yes ○ No
- **D. Chills?** ○ Yes ○ No
- **E. Night sweats?** ○ Yes ○ No
- **F. Weakness fatigue** ○ Yes ○ No

2. EYES

- **A. Vision change?** ○ Yes ○ No
- **B. Glasses/contacts?** ○ Yes ○ No
- **C. Glaucoma?** ○ Yes ○ No
- **D. Eye infections (iritis)?** ○ Yes ○ No
- **E. Loss of vision?** ○ Yes ○ No

3. EARS, NOSE, AND THROAT

- **A. Decrease or loss of hearing?** ○ Yes ○ No
- **B. Ear ache or infection?** ○ Yes ○ No
- **C. Tinnitus (ringing in ear)?** ○ Yes ○ No
- **D. Nasal stuffiness/discharge?** ○ Yes ○ No
- **E. Nosebleeds?** ○ Yes ○ No
- **F. Sore throat?** ○ Yes ○ No
- **G. Hoarseness?** ○ Yes ○ No
- **H. Dental problems?** ○ Yes ○ No
- **I. Dentures?** ○ Yes ○ No
- **J. Difficult swallowing?** ○ Yes ○ No

4. CARDIOVASCULAR

- **A. Chest pain?** ○ Yes ○ No
- **B. Shortness of breath?** ○ Yes ○ No
- **C. Palpitations?** ○ Yes ○ No
- **D. Swelling in the legs?** ○ Yes ○ No
- **E. PLEASE LIST MOST RECENT HEART TESTS WITH NAME OF FACILITY, DATE, AND CONTACT PHONE NUMBER**

5. RESPIRATORY

- **A. Cough?** ○ Yes ○ No
- **B. Wheezing/asthma?** ○ Yes ○ No
- **C. Pneumonia or bronchitis?** ○ Yes ○ No
- **D. Shortness of breath?** ○ Yes ○ No

6. GASTROINTESTINAL

A. Abdominal pain?	○ Yes	○ No	
B. Nausea or vomiting?	○ Yes	○ No	
C. Constipation?	○ Yes	○ No	
D. Diarrhea?	○ Yes	○ No	
E. Heartburn/acid reflux?	○ Yes	○ No	
F. Rectal bleeding or black, tarry stools?	○ Yes	○ No	

7. GENITOURINARY

A. Increase frequency of urination?	○ Yes	○ No	
B. Pain/burning when you urinate?	○ Yes	○ No	
C. Frequent infection of urine?	○ Yes	○ No	
D. Incontinence (loss of control)?	○ Yes	○ No	
E. Reduced force of urination?	○ Yes	○ No	

8. MUSCULOSKELETAL

A. Muscle aches?	○ Yes	○ No	
B. Joint pains/stiffness (arthritis)?	○ Yes	○ No	
C. Swelling of joints?	○ Yes	○ No	

9. SKIN

A. Rash?	○ Yes	○ No	
B. Lumps or sores?	○ Yes	○ No	
C. Changes in hair or nails?	○ Yes	○ No	
D. Dryness?	○ Yes	○ No	
E. Ulcers?	○ Yes	○ No	
F. Abnormal scars?	○ Yes	○ No	

10. NEUROLOGICAL

A. Headaches?	○ Yes	○ No	
B. Fainting/blackouts?	○ Yes	○ No	
C. Tremors/involuntary movements?	○ Yes	○ No	
D. Numbness, tingling?	○ Yes	○ No	
E. Dizziness?	○ Yes	○ No	
F. Muscle weakness?	○ Yes	○ No	

11. PSYCHIATRIC

A. Depression?	○ Yes	○ No	
B. Mood swings?	○ Yes	○ No	
C. Anger?	○ Yes	○ No	
D. Nervousness/anxiety?	○ Yes	○ No	

12. ENDOCRINE

A. Excessive thirst or hunger?	○ Yes	○ No	
B. Hot/cold intolerance?	○ Yes	○ No	
C. Hot flashes?	○ Yes	○ No	

13. HEMATOLOGICAL

A. Easy bruising or bleeding?	○ Yes	○ No	
B. Past blood transfusions?	○ Yes	○ No	