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# MEDICAL REHABILITATION SPINE CLINIC

## H & P FORM

Patient Name: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Name \_\_\_\_\_

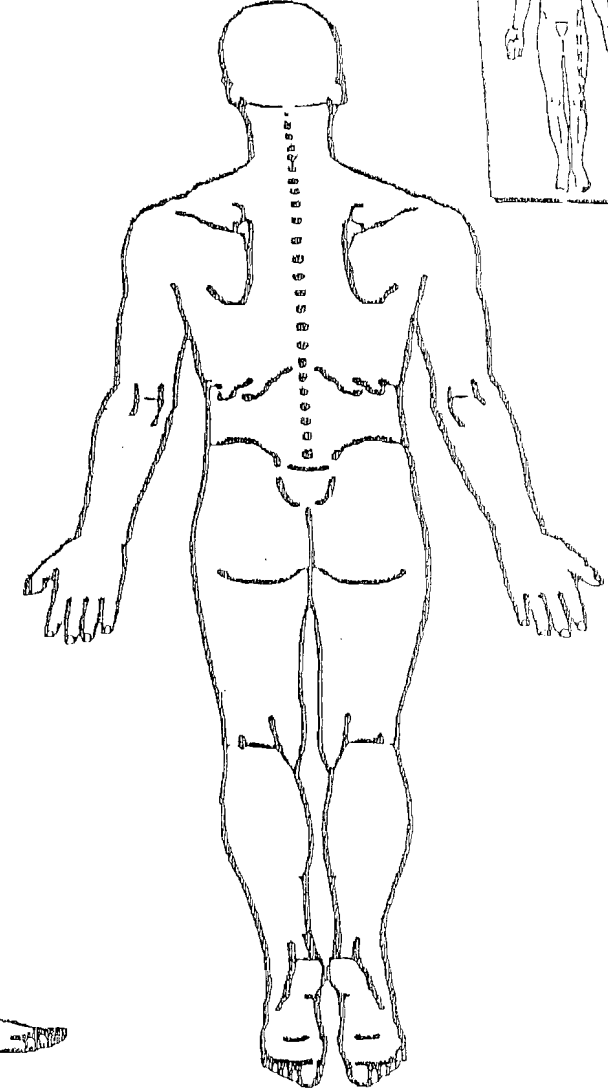
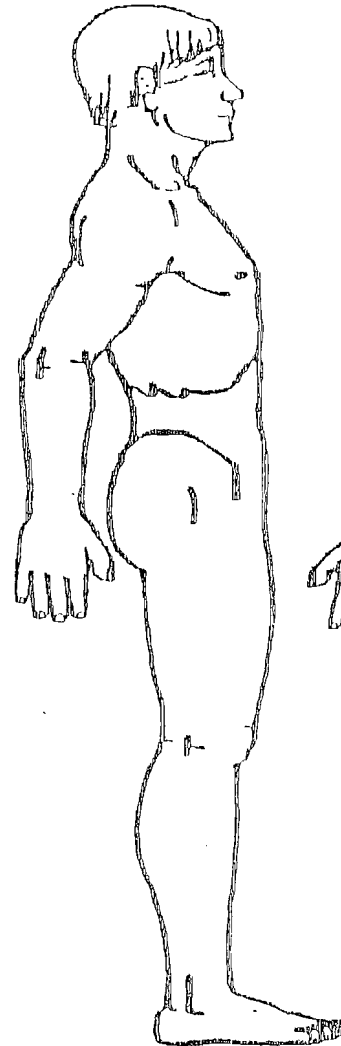
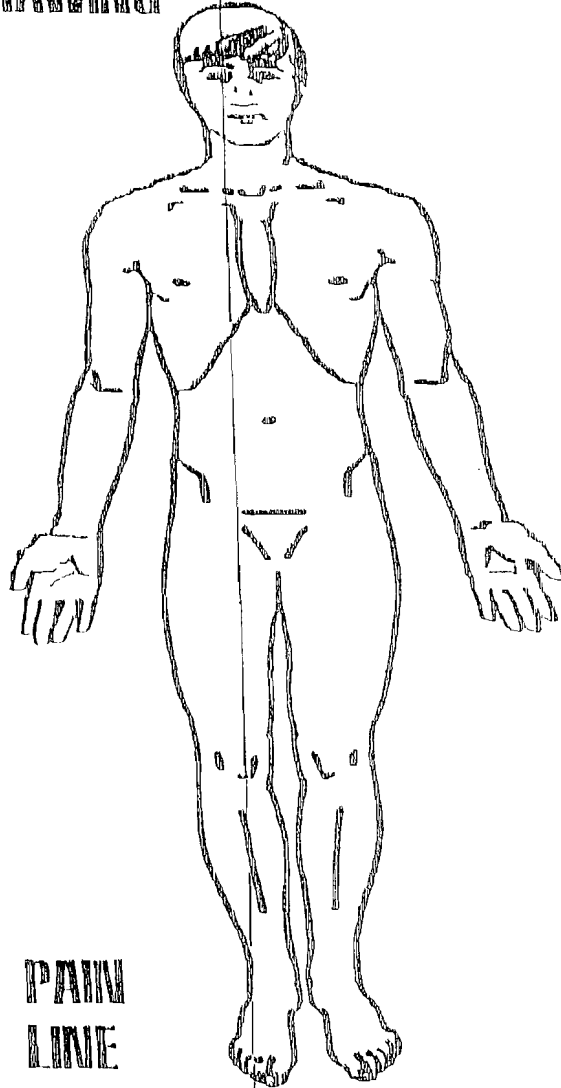
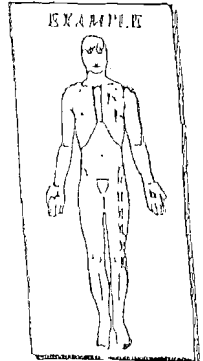
Date \_\_\_\_\_

# PENN SPINE CENTER - PAIN ASSESSMENT FORM

## PAIN DRAWING

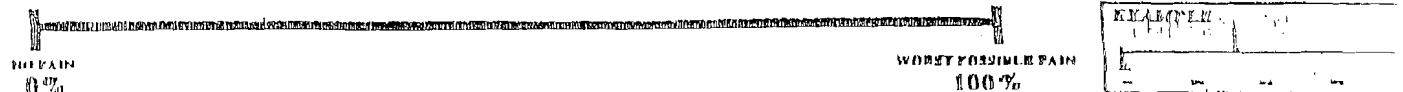
Draw the location of your pain on the body outlines & mark how severe it is on the pain line at the bottom of the page

Aching	Burning	Numbness	Pins & Needles	Stabbing	Other
AAAAA	→→→	00000	⊙ ⊙ ⊙ ⊙ ⊙		XXX
AAAAA	→→→	00000	⊙ ⊙ ⊙ ⊙ ⊙		XXX



## PAIN LINE

Draw a perpendicular line or arrow to indicate your usual level of pain



EXAMINER	DATE

- 1) Full name and age: \_\_\_\_\_
- 2) Which pain does your referring physician want me to evaluate today?  
 neck pain    mid back    low back    Right arm pain    Right leg pain  
 headaches    Left arm pain    Left leg pain    other: \_\_\_\_\_
- 3) Please provide me the year your pain started? \_\_\_\_\_
- 4) When did you first notice the pain?  
 after a motor vehicle accident    during work    when you woke up out of bed  
 other: \_\_\_\_\_

- 6) How would describe your pain ratio?  
 100% back pain and 0% leg pain    100% neck pain and 0% arm pain  
 75% back pain and 25% leg pain    75% neck pain and 25% arm pain  
 50% back pain and 50% leg pain    50% neck pain and 50% arm pain  
 25% back pain and 75% leg pain    25% neck pain and 75% arm pain
- 7) Describe the quality of your pain?  
 sharp    dull    ache    throb    other: \_\_\_\_\_
- 8) Instructions: Please place a “|” mark along the line for each of the following questions. Remember 0 means no pain and 10 means the worst possible pain. Only 1 “|” per question.

- a) If you have neck pain how severe is it?  
|-----|  
0   1   2   3   4   5   6   7   8   9   10
- b) If you have mid back pain how severe is it?  
|-----|  
0   1   2   3   4   5   6   7   8   9   10
- c) If you have low back pain how severe is it?  
|-----|  
0   1   2   3   4   5   6   7   8   9   10
- d) If you have headaches how severe is it?  
|-----|  
0   1   2   3   4   5   6   7   8   9   10
- e) If you have right arm pain how severe is it?  
|-----|  
0   1   2   3   4   5   6   7   8   9   10
- f) If you have left arm pain how severe is it?  
|-----|  
0   1   2   3   4   5   6   7   8   9   10
- g) If you have right leg pain how severe is it?  
|-----|  
0   1   2   3   4   5   6   7   8   9   10
- h) If you have left leg pain how severe is it?  
|-----|  
0   1   2   3   4   5   6   7   8   9   10

9) Which of the following increase your pain to the level mentioned in the preceding set of questions?

- Lift objects  Bend forward  Bend backward  Bend to the right
- Bend to the left  Lye on your back  Lye on your stomach
- Lye on right side  Lye on left side  Look up  Look down
- Turn head to the left  Turn head to the right
- Move left ear toward left shoulder  Move right ear toward right shoulder
- In the morning  In the afternoon  In the evening

10) Which of the following decrease your pain level?

- Lift objects  Bend forward  Bend backward  Bend to the right
- Bend to the left  Lye on your back  Lye on your stomach
- Lye on right side  Lye on left side  Look up  Look down
- Turn head to the left  Turn head to the right
- Move left ear toward left shoulder  Move right ear toward right shoulder
- In the morning  In the afternoon  In the evening

11) Select if have any of the associated signs and symptoms?

- weakness  numbness  tingling  urinary incontinence
- bowel incontinence  weight loss  weight gain  trouble sleeping
- increased pain at nighttime  Fever  Chills  Night sweats

12) Please answer the following questions using the following scale:

- 1: unable to tolerate
- 2: several minutes only
- 3: about 10 minutes only
- 4: about 20 minutes only
- 5: about ½ hour only
- 6: about 1 hour
- 7: several hours
- 8: indefinite period

- a. How long can you sit? \_\_\_\_\_
- b. How long can you stand? \_\_\_\_\_
- c. How long can you walk? \_\_\_\_\_
- d. Any history of falls? Y N
- e. History of Physical/Emotional/ or Sexual abuse? Y N
- f. If yes did you seek counseling or any form of treatment? Y N

13) Prior History

- a) Did you do try physical therapy for at least 6 weeks? Y N
- b) Did physical therapy provide you with 80% relief? Y N
- c) Did you try anti-inflammatory medications? Y N
- d) Did you try this type of medication at least 6 weeks? Y N

14) Which physicians have you seen for treatment of your current pain? Please list in chronological order and describe what was done.

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15) **Review of Systems:** Check ones that apply to you

- Constitutional:  Weight loss  Weight gain  Change in appetite  Fever  Chills  Night sweats  
Head and Neck:  Headache  Neck pain  Stiff neck  Limited neck motion  
Eyes:  Change in vision  Vision loss  Glasses  Contacts  
Ears:  Loss of hearing  Ringing in the ears  
Nose:  Change in smell  Snoring  
Mouth and Throat:  Mouth Breathing  Change in taste  Voice change  Difficulty swallow  
Cardiovascular:  Chest pain  Tachycardia  Light headedness  
Respiratory:  Shortness of breath at rest  Cough  TB exposure  
Gastrointestinal:  Abdominal pain  Heart burn  Stomach ulcer  Rectal Bleeding  
Skin:  Lesions  Easy bleeding  Easy bruising  Bowel Incontinence  
Genito-Urinary:  Incontinence  Problems urinating  
Female: Last menstrual period: \_\_\_\_\_ Any chance of pregnancy? Y N  
Musculoskeletal:  Muscle pain  Bone pain  
Neurologic:  Numbness  Weakness  Unsteady walking  
Psychiatric:  Depression  Anxiety  
Endocrine:  Diabetes  Thyroid  Osteoporosis  
Hematologic/Lymphatic:  Slow healing after cuts  Easy bleeding and bruising
- 16) **Past Medical History:** Please list all of your major illnesses or diseases

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17) **Past Surgical History:** Please list all of your surgeries.

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18) **Past Family History**

a) Does your mother have history of cancer? If yes indicate what type.

b) Is your mother alive or deceased? Please indicate her age. \_\_\_\_\_

c) Does your father have history of cancer? If yes indicate what type.

d) Is your father alive or deceased? Please indicate his age. \_\_\_\_\_

19) **Personal and Social History**

- a) Marital Status:      Single                      Married              Widow              Other  
b) Alcohol use:        None                      Yes      Amount: \_\_\_\_\_  
c) Drug abuse:        None                      Yes      Type: \_\_\_\_\_  
d) Smoking:            None                      Yes      Amount: \_\_\_\_\_

- 20) **Allergies:** 1. Medications: \_\_\_\_\_  
2. Shrimp:    Y    N  
3. Shellfish: Y    N  
4. Iodine:    Y    N

21) **Current Medications and dosages**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

22) **Pharmacy Name and Number:** \_\_\_\_\_

23) **Work History**

a) **Which statements describe your current employment situation? (Circle all that apply)**

- 1      Currently working
- 2      On paid leave
- 3      On unpaid leave
- 4      Unemployed
- 5      Homemaker
- 6      Student
- 7      Retired
- 8      Disabled and/or retired because of my back pain
- 9      Disabled due to health problem not related to my back
- 10     Other, please specify: \_\_\_\_\_

b) How many jobs have you had the last 3 years?

c) Are you self-employed? YES NO

d) **If not working now, how long has it been since you stopped?**

- 1      Less than one week ago
- 2      One week to less than three months ago
- 3      Three months to less than six months ago
- 4      Six months to less than twelve months ago
- 5      One to two years ago
- 6      More than two years ago
- 7      Currently working
- 8      Never employed

e) If you are not working who put you off work? \_\_\_\_\_

- f) Provide the date you last went to work? \_\_\_\_\_
- g) What are your current work restrictions?

e) What is your Primary occupation? If you are not working now, what WAS your primary occupation? (Please be as specific as possible)

Occupation: \_\_\_\_\_

f) Is your current job the same one you had when your current pain symptoms started?

- 1 Yes, exact same job
- 2 Yes, but job was modified or hours reduced because of my back
- 3 No, I have changed jobs because of my back symptoms
- 4 No, I have changed jobs but for reasons unrelated to my back
- 5 Not working now

g) How long have you worked at your current job?

- 1 Less than six months
- 2 Six to twelve months
- 3 More than twelve months
- 4 Not working now

h) Please answer each of the following questions about your current job (or the one you plan to go back to if on leave). Circle one answer on each line.

	Less than 1 hour	1 to 2 hour	3 to 4 hours	5 to 6 Hours	7 to 8 hours	Greater than 8 hours
How much sitting does your work involve?	1	2	3	4	5	6
How much standing or walking does your work involve?	1	2	3	4	5	6
How often do you lift 25 pounds on the job?	1	2	3	4	5	6
How often do you lift 50 pounds on the job?	1	2	3	4	5	6

Please answer each of the following questions about your current job (or one you plan to go back to if on leave).

	Extremely	Very Much	Quite a bit	Somewhat	A little	Not at all
Is your current work physical demanding?	1	2	3	4	5	6
Is your work stressful to you?	1	2	3	4	5	6
How much do you like your job?	1	2	3	4	5	6
How much do you like your co-workers?	1	2	3	4	5	6
How much do you like your supervisor?	1	2	3	4	5	6

i. Other than your salary, what other source of income does your household receive?  
 (Circle all that apply)

- 1 Another person's salary
- 2 State support
- 3 Social Security
- 4 Disability
- 5 Other (investments, retirement plan, etc.)
- 6 No other source of income

j. Are you experiencing financial difficulties because of your pain condition?

- 1 None at all
- 2 Only a little
- 3 Some
- 4 A lot

Are you on or planning to apply for any of the following programs?	Already on it	Applied for it	Planning to apply for it
Social Security	1	2	3
Disability	1	2	3
Workers Compensation	1	2	3
Other	1	2	3

NONE OF THE ABOVE APPLIES

24. Do you think the fault for your current back condition is: (Circle all that apply)

- 1. Yours?
- 2. Your employers?
- 3. A co-workers's?
- 4. Another person's?
- 5. Nobody's?

25. Have you hired a lawyer because of your back condition?

- 1. No, I have not hired a lawyer
- 2. Yes, I have and the case is in litigation
- 3. Yes, I have and the case has been settled

26. What is the name of your lawyer and phone number? \_\_\_\_\_

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THANKYOU FOR YOUR ANSWERING THESE QUESTIONS!