ATLANTA
SPINE CENTER

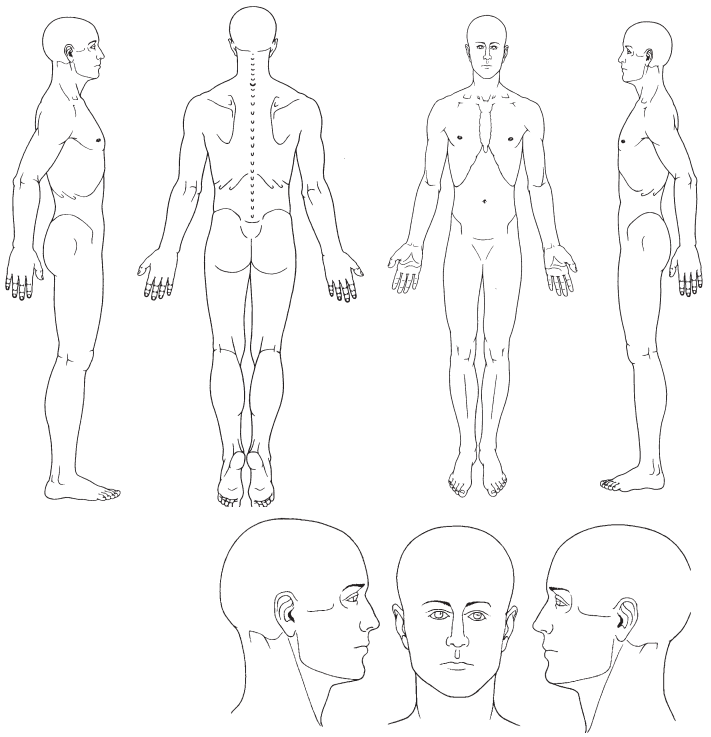
Patient Name

CURRENT COMPLAINTS -

Please list, in detail, all current symptoms / complaints in order of severity

1) _____

Please mark your areas of pain on the figures below



Date when symptom first appeared _____

How often do you experience the symptoms?

◯ Constant 76-100% ◯ Frequent 51-75%

◯ Intermittent 26-50% ◯ Occasional 11-25% ◯ Rare 10%

Describe any recently related accident or fall _____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 ——— 5 ——— 10

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2) _____

Date when symptom first appeared _____

How often do you experience the symptoms?

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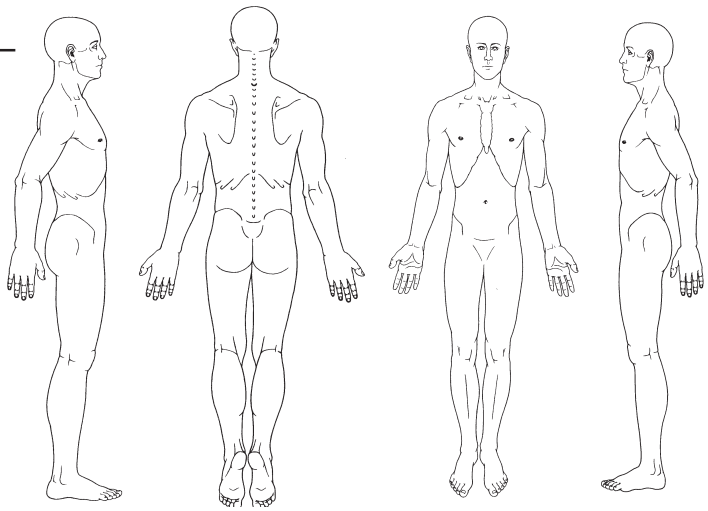

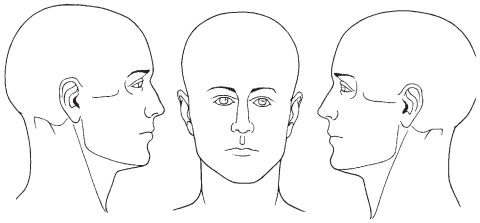

Patient signature

Date

ATLANTA
SPINE CENTER

PAST HEALTH HISTORY

Patient Name _____

Please list all surgeries you have had:

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Please list all previous fractures and dislocations:

What _____ When _____

What _____ When _____

Please list any prior history of current complaints:

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

Please list all prior accidents, associated complaint and treatments:

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

Please list any medications and/or vitamins you take:

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

OCCUPATIONAL INFORMATION

Job Involves:

○ Sitting ○ Standing How long _____ ○ Desk ○ Counter ○ Other _____

○ Lifting How much weight _____ ○ Bending ○ Stooping ○ Twisting ○ Turning

Type of shoes ○ High heels ○ Boots ○ Arch supports Other ○ _____

How long do you speak on the telephone each day _____ ○ Traditional telephone receiver ○ Headset

Physical activity at work ○ Sedentary ○ Light manual labor ○ Manual labor ○ Heavy manual labor

Do any of your work activities aggravate your present main complaints? Please describe _____

X-RAY CONFIRMATION- FEMALES

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____

Signed Date

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____

Patient Signature Date