GEORGIA COMPREHENSIVE SPINE

Your care is very important to us. For us to manage your care, please answer all questions on this form.

Patient information Today's Date (M/D/Y) First name Last name □ Evening Phone number (A nurse may call to follow up) Doctor you see today Your age: □ <18 □ 18-64 How did you first hear of us? ☐ Friend/relative/word-of-mouth ☐ 65+ Newspaper/magazine ☐ Internet/web site Sex: ☐ Male ☐ Health insurance directory ☐ Female ☐ Yellow Pages/phone book Do you smoke? ☐ Yes Your symptoms Which of the following do you have? (Check all that apply) ☐ Back pain ☐ Neck pain ☐ Tingling in arm or leg ☐ Weakness in arm or leg How long have you suffered from these symptoms? $\square \le 6$ weeks \square 7 to 12 weeks $\square > 3$ months Do you have pain radiating PAST your knee or elbow? ☐ Yes ☐ No Does your leg or arm ever go numb? ☐ Yes ☐ No Have you had back or neck surgery before? ☐ Yes ☐ No Does your back or neck pain wake you up at night? ☐ Yes ☐ No How many pills do you take each day for pain relief? \square No pills ☐ 1 to 4 pills ☐ 5 or more pills daily Circle your pain level on a scale of 1 to 10, with 1 being no pain at all, and 10 being extreme pain. 10 9 no pain extreme pain

INITIAL PATIENT ASSESSMENT

FOR FIRST VISIT ONLY

How do symptoms affect your life?			
Which of the following describes you currently? Working Not working because of back or neck problem Not working because of another health problem Homemaker, retired or unemployed			
Did your back or neck injury happen at work? ☐ Yes ☐ No			
If you are not working, how long have you been off work because of your back or neck problem? ☐ Less than 1 month ☐ Longer than 1 month			
Describe the activities involved in your job that you have now, or hope to return to: (Check all that apply) Heavy/frequent lifting Prolonged sitting or driving Pushing/pulling Prolonged standing			
The following are activities you might do in a typical day. Does your back or neck pain limit you in these activities? If so, how much?			
	Yes, limited a lot	Yes, limited a little	Not limited at all
Strenuous activities like running, lifting heavy objects	□ 1	□2	□3
Moderate activities like housework, pushing a vacuum, playing golf	□ 1	□ 2	□ 3
Lifting or carrying groceries	□ 1	□2	□3
Climbing several flights of stairs	□ 1	□2	□3
Walking for 30 minutes	□ 1	□2	□3
Sitting for 30 minutes	□ 1	□2	□3
Standing for 30 minutes	□ 1	□2	□3
Getting dressed, bathing	□ 1	□2	□3
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We may have a nurse call you to follow up on your symptoms and			

We may have a nurse call you to follow up on your symptoms and check to see how you are doing 3 months from now. Is it okay for us to call you at the number you provided above? $\ \square$ Yes $\ \square$ No