North Jersey Spine Group

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INITIAL PATIENT ASSESSMENT
FOR FIRST VISIT ONLY

1 Patient information

Today's Date ____________________

First Name ____________________ Last Name ____________________

Doctor you are seeing today ____________________

Phone: (A nurse may call to follow up) ____________________ ☐ Day ☐ Evening

Age: ☐ <18 ☐ 18 - 64 ☐ 65+ Sex: ☐ M ☐ F

How did you fist hear of us?

☐ Friend/relative/word-of-mouth ☐ Newspaper/magazine
☐ Internet/web site ☐ Billboard
☐ Yellow pages ☐ Dr. ____________________

2 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?

☐ < 6 weeks ☐ 7 - 12 weeks ☐ > 4 months

Is there 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?

☐ No pills ☐ 1 - 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.

no pain 1 2 3 4 5 6 7 8 9 10 extreme pain

3 Your expectations

What result do you expect from your care?

Relief from pain symptoms	☐ Yes	☐ No	☐ Doesn't apply
Return to your job	☐ Yes	☐ No	☐ Doesn't apply
Return to leisure activities	☐ Yes	☐ No	☐ Doesn't apply
Improved sleep	☐ Yes	☐ No	☐ Doesn't apply

4 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 that 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