PLEASE ANSWER ALL QUESTIONS THANK YOU
MAIN LINE SPINE RECHECK FORM

Patient Name:_____ **Date:**_____

1. Today's visit is being billed to (please circle one): Private Insurance/Medicare Workman's Comp. Auto Insurance

2. Today's visit is for (please circle one): Follow up Review imaging studies EMG study Myobloc/Botox

3. Do you have (please circle all that apply): Neck pain Arm pain Low back pain Leg pain Other:_____

4. **Is your pain:** Right-sided Left-sided Both

5. Since your last visit are you: Better Worse Same

6. By what percentage have you improved or worsened: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

7. Describe your pain (please circle all that apply):

aching burning cramping dull fiery hot numbing pinching pressure-like pulsing sharp shock-like

shooting spasms squeezing stabbing stinging tenderness tingling

8. Is the pain (please circle one only): continuous intermittent

9. Is the pain worse (please circle one only): in the morning at night no difference

10. Pain scale of 1 to 10 is graded as (PLEASE CIRCLE) SINCE THE LAST TIME YOU WERE HERE

On average: (least) 1 2 3 4 5 6 7 8 9 10 (severe)

At its worst: (least) 1 2 3 4 5 6 7 8 9 10 (severe)

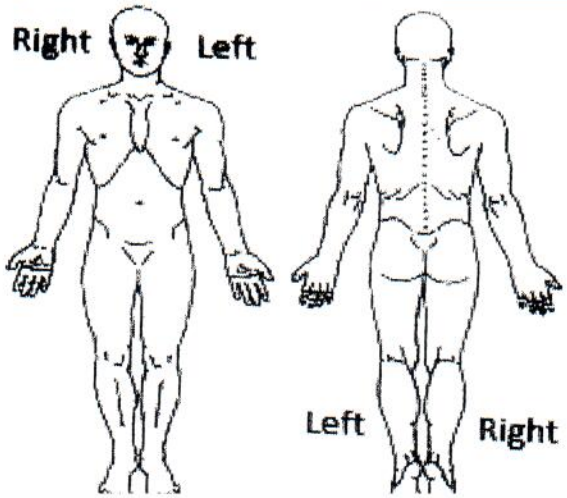
11. Pain scale of 1 to 10 is graded as (please circle) in the past week

best describes your pain on average in the past week: 1 2 3 4 5 6 7 8 9 10
best describes your pain that has interfered with your enjoyment of life: 1 2 3 4 5 6 7 8 9 10
best describes your pain that has interfered with your general activities: 1 2 3 4 5 6 7 8 9 10

12. Please note any changes since your last visit: Cardiac Care_____ **Mental Status:**_____

New onset weakness_____ **Medication changes (please circle) Discontinued /New**_____

13. Use the diagram to indicate where your pain is:



(Over)

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14. How long can you do the following without pain (PLEASE USE MINUTES):

Sit: _____ **Stand:** _____ **Walk:** _____

15.SINCE YOUR LAST VISIT HAVE YOU HAD ANY NEW IMAGING STUDIES NOT REVIEWED BY YOUR DOCTOR?:

MRI X-ray CT Scan Bone Scan Nerve conduction/electrodiagnostic studies None

IF YES, PLEASE LIST BODY PART: _____

16. What treatments have you received since your last visit (please circle all that apply):

no specific treatment physical therapy home exercise program massage therapy chiropractor epidural steroid injections

facet injections SI joint injections trigger point injections knee injections EMG study radiofrequency ablation

acupuncture myobloc/botox spinal cord stimulator medications PRP tenotomy kyphoplasty venous ablation

17. If you have received physical therapy, please list name of facility and dates you attended:
Facility Name:_____ **From:**_____ **To:**_____

18. Are you currently (please circle all that apply):

working full-time part-time not working retired sedentary level modified duty no restrictions

19. What is your occupation: _____**Date last worked:**_____

20. Are you on disability: Yes No **Date disability began:**_____

21. Date of Injury (WC/MVA ONLY):_____

22. Are you a smoker: Yes or No **Do you want to quit?** Yes No / **Do you consume alcohol:** Yes No

23. Any NEW allergies to medications, seafood, shellfish, or xray/iv dye: Yes no

(If yes please include reaction):_____

24. Review of systems: Do you have any of the following (circle all that apply):

painful joints swollen joints headaches weight gain weight loss congestion rash blurred vision

dizziness shortness of breath chest pains constipation bowel incontinence urinary incontinence

gait abnormalities seizures anxiety depressed mood

25 What is your approximate: Height: _____ **Weight:** _____

26. For Medicare Patients Only - When did you last see your Primary Care Provider (PCP)? Appx. Date _____
Medicare is requesting that Medicare patients visit their PCP at least once a year.

PLEASE RETURN THIS FORM TO THE FRONT DESK WHEN COMPLETED THANK YOU.