PLEASE ANSWER ALL QUESTIONS THANK YOU

MAIN LINE SPINE RECHECK FORM

PATIENT NAME:_____ D.O.B.:_____DATE:_____

1. Today's visit is being billed to (PLEASE CIRCLE ONE): Private/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 ONE): Neck pain Arm pain Lower back pain Leg pain Other: _____

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

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 numbing pinching pressure-like sharp shock-like

Shooting spasms stabbing tingling

8. Is the pain (PLEASE CIRCLE ONE): Continuous or intermittent

9. Is the pain worse (PLEASE CIRCLE ONE): 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 worse: (least) 1 2 3 4 5 6 7 8 9 10 (SEVERE)

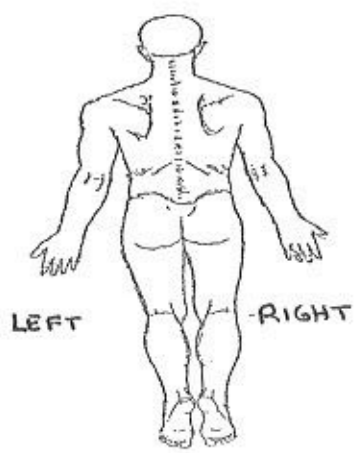
11. Does your pain interfere with your quality of life and activities of daily living: YES OR NO

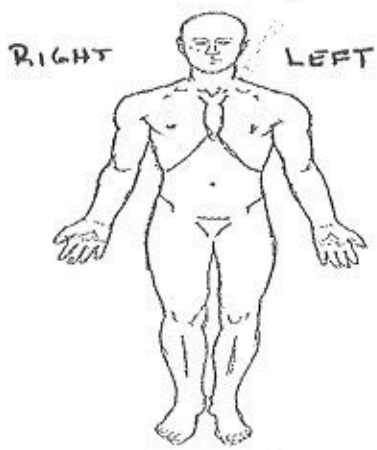
12. Please note any changes SINCE YOUR LAST VISIT: Cardiac Event:_____ Stroke Event: _____
New onset weakness: _____ None:_____ Medication changes: Discontinue:_____New:_____

13. *WITH IN THE LAST 3 TO 6 MONTHS HAVE YOU HAD ANY HOSPITALIZATION OR TREATMENTS FOR CARDIAC PROBLEMS:
YES OR NO ****IF YES, PLEASE DESCRIBE THE HOSPITALIZATION:_____

_____

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



15. How long can you do the following without pain (PLEASE USE MINUTES): Sit:_____ Stand:_____ Walks:_____

16. 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:_____

17. What treatments have you received since your last visit (PLEASE CIRCLE ALL THAT APPLY):

No specific treatment home exercise program massage therapy chiropractor epidural injections Facet injections

SI Joint injection Trigger point injection Knee injections EMG study Radiofrequency ablation Acupuncture

Myobloc/botox Spinal cord stimulator Medications PRP tenotomy Kyphoplasty Venous ablation

Physical therapy name:_____ Date:_____

18. Are you currently working Full-time Part-time Not working Retired Sedentary level Modified

What is your occupation: _____Date last worked:_____

19. Are you on disability: YES OR NO Date disability began: _____

20. Are you a smoker: YES OR NO Do you want to quit? YES OR NO / Do you consume alcohol: YES OR NO

21. Any NEW allergies to medications, seafood, shellfish or Xray/IV dye: YES OR NO / IF YES PLEASE LIST REACTION _____

22. Review of systems: Do you have any of the following (CIRCLE ALL THAT APPL

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 abnormality Seizures

anxiety depressed mood

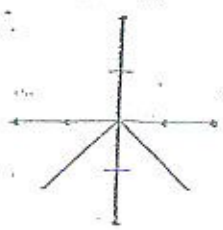
23. What is your approximate: Height:_____ Weight:_____

24. 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.

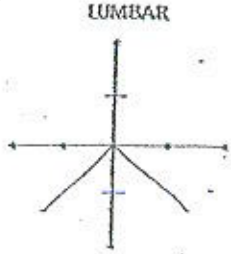
OFFICIAL USE ONLY:

PHYSICAL EXAM

CERVICAL



LUMBAR



NEURO NL ABNL

SHOULDER ABD FLEX IR ER

R: FULL LIMITED ____ ____ ____ ____

L: FULL LIMITED ____ ____ ____ ____

TENDER + – R L ANT SUB POST

RESISTIVE MAN + – R L SUP INF SUB DEL

SLR R____ B L

L____ B L

KNEE TO CHEST R + – L + – B + –

PRESS UP + – B L

INTERSPACE C1 2 3 4 5 6 7 T1 2 3 4 U 1 2 3 4 5 S1

FACETS R C1 2 3 4 5 6 7 T1 2 3 4 U 1 2 3 4 5 S1

L C1 2 3 4 5 6 7 T1 2 3 4 U 1 2 3 4 5 S1

R L TRAP RHOMBOID INTERSCAPULAR

R L SI GLUT

2/23/2022 revised

SENSORY_____ MOTOR_____ DTR_____