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 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 numbing pinching pressure-like

sharp shock-like shooting spasms stabbing tingling

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

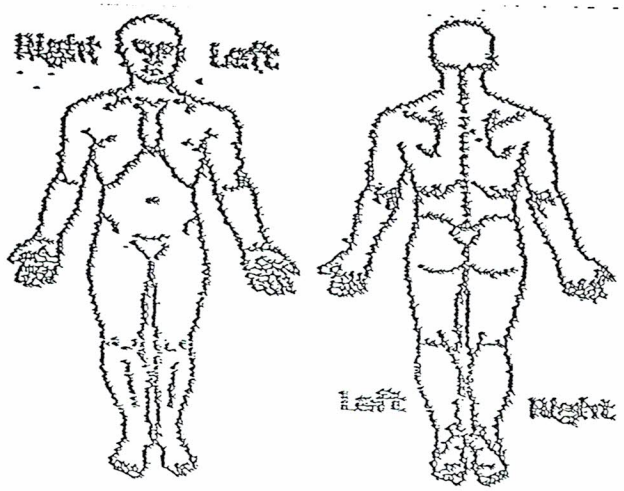
Does your pain interfere with you quality of life and activities of daily living: YES OR NO

11. Please note any changes SINCE your last visit:

None:_____**Cardiac Event**_____ **Stroke Event:**_____ **New onset weakness**_____

Medication changes (PLEASE LIST AND CIRCLE) Discontinued:_____ **OR New**_____

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



(OVER)

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

14. 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: _____

15. 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

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

17. Are you currently working (please circle all that apply): full-time part-time not working retired sedentary level modified duty . **What is your occupation:_____ Date last worked:_____**

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

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

20. Any NEW allergies to medications, seafood, shellfish, or xray/iv dye: Yes No / If yes please list reaction:_____

21. 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

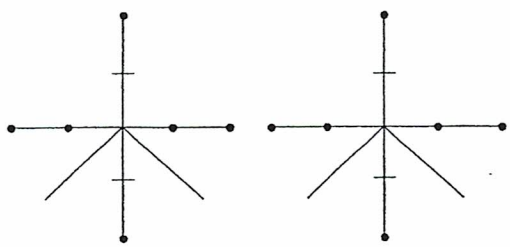
22. What is your approximate: Height: _____ Weight: _____

23. 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 L1 2 3 4 5 S1
FACETS R C1 2 3 4 5 6 7 T1 2 3 4 L1 2 3 4 5 S1
L C1 2 3 4 5 6 7 T1 2 3 4 L1 2 3 4 5 S1
R L TRAP RHOMBOID INTERSCAPULAR
R L SI GLUT

SENSORY_____ MOTOR_____ DTR_____