AXIS
NEUROSURGERY AND SPINE

Print Name: _____ Date: _____

Please answer the following questions as clearly as possible.

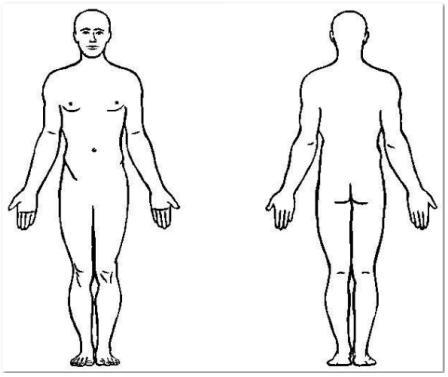
1) Where are your symptoms?

___Neck	___Right Arm/Hand	___Left Arm/Hand
___Right Shoulder	___Left Shoulder	___Head/Face
___Low Back	___Right Leg/Foot	___Left Leg/Foot
___Mid Back	___Buttock	___Right Hip/Groin
___Left Hip/Groin		

2) Dominant hand: Right_____ Left_____

3) Please mark on the drawing to indicate the location and type of pain you may be experiencing:

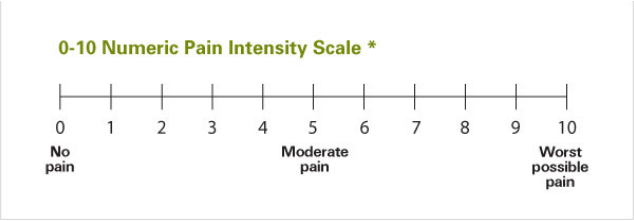
Pins/Needles 000000
Aching >>>>>>>>>>>>
Stabbing ////////////////////
Burning xxxxxxxxxxxx
Numbness ==========
Tingling ++++++++++



4) When did your symptoms start?_____

5) How were you injured? __N/A __Automobile Accident __Fall __Injured at work
__Other:_____

6) How bad is your pain?



7) What relieves your pain ? _____

8) What makes your pain worse? _____

9) Do you have any of the following?

___Clumsy Hands ___Unsteady Walking ___Bowel or Bladder problems ___Headache
___Visual Changes ___Sexual Dysfunction ___Weakness ___Electric Shocks

10) What treatments have you had?

___Massage Therapy ___Pain Management ___Chiropractic ___Physical Therapy
___Trigger Point Injections ___Epidural Steroid Injections ___Facet Blocks
___Acupuncture ___None ___Other:_____

11) What medications do you take for pain? _____

_____

12) Have you had any previous neck or back injuries? __No __Yes, describe_____

_____

13) Have you missed work because of this condition? __Yes __No How long?_____.

14) Are you currently working? ___Yes ___No
If no, when was your last day? _____

15) **PAST MEDICAL HISTORY**: (check all that apply) _____None

__Anemia __Bleeding disorder __Blood clots __Asthma __COPD/Emphysema

__Cancer/Type?_____ __Diabetes __Depression

__HIV __High Cholesterol __High Blood Pressure __Heart Attack

__Stroke __Lupus __Fibromyalgia __Urinary Tract Infections

__Pneumonia __GERD/Ulcers __Seizure __Rheumatic Fever

__MRSA __Hypothyroidism __Hyperthyroidism __Atrial Fibrillation

__Prior Surgical Wound Infections __Headaches/Migraines __Coronary Artery Disease

__Rheumatoid Arthritis __Crohn's Disease __Inflammatory Bowel

__Irritable Bowel Syndrome ___Hepatitis __Anxiety

__Osteopenia/Osteoporosis ___Sleep Apnea

16) **PAST SURGICAL HISTORY**: (please include year and surgeon) ___None

_____

_____

17) **ALLERGIES**: __None

Food Allergies __Yes __No If yes, please list: _____

Latex Allergies __Yes __No

Drug Allergies __Yes __No If yes, please list: _____

18) CURRENT MEDICATIONS: __None

_____

_____

19) FAMILY MEDICAL HISTORY: __None

__Diabetes __High Blood Pressure __Aneurysm __Stroke __Heart Attack

__Cancer: (type?)_____
__Other: _____

20) SOCIAL HISTORY:

Marital Status: __Single __Married __Divorced __Widowed

Occupation: _____

Job Duties:_____.

Alcohol Use: __Never __Socially __Daily

Nicotine Use: __Never __Quit _____Packs per day # Yrs:_____

Recreational Drug Use: ____No ____Yes

21) REVIEW OF SYSTEMS: (circle all that apply)

Constitutional:	None	Night Sweats Weight Loss Loss of Energy Fevers/chills
Eyes:	None	Blurred Vision Double Vision
Ears/Nose/Throat:	None	Ringing Ears Hearing Loss Hoarseness Difficulty Swallowing
Heart:	None	Chest Pain Racing Heart
Lungs:	None	Shortness of Breath Cough Wheeze
Stomach:	None	Abdominal Pain Nausea Vomiting Constipation Diarrhea
Psychiatric:	None	Anxiety Depression Panic Attacks Sleep Disturbances
Urinary:	None	Frequent Urination Incontinence Burning with Urination
Blood/Lymph:	None	Easy Bruising

SIGNATURE: _____ DATE: _____