alabama orthopaedic surgeons

Name_____ **Date of Birth**_____

Age_____ **Sex:** **Male** **Female** **Height**_____ **Weight**_____

Occupation_____

Employer_____ **# Years employed with this employer**_____

Marital Status (circle one): **Single** **Married** **Divorced** **Separated** **Widowed**

Spouse's Name_____ **# of Children**_____

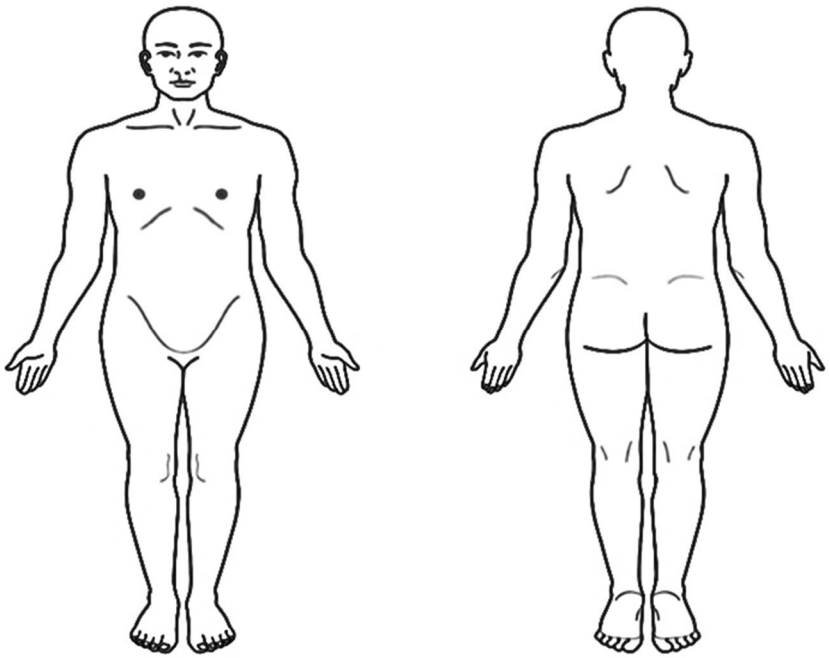
Tobacco use: **Y** **N** **What Type**_____ **# of Years**_____

Alcohol use: **Y** **N** **# Drinks per Day**_____ **# of Years**_____

Using the symbols listed below; mark the areas on your body where you feel the described sensations
Include all affected areas

ACHING Δ Δ Δ **NUMBNESS = = =** **PINS/NEEDLES O O O** **BURNING X X X** **STABBING / / /** **OTHER ●●●**

FRONT **BACK**



RIGHT **LEFT** **LEFT** **RIGHT**

Have you seen Dr. Hodges before? Yes No
Did you injure yourself at work? Yes No **Date of Injury**_____
If yes, what date did you last work? _____ **Full Duty**_____ **Light Duty**_____
Are you currently working now? Yes No **Full Duty**_____ **Light Duty**_____
Have you had any previous neck or back problems prior to this injury? Yes No
When did your pain begin? _____
How did you get injured? _____
What makes your symptoms worse? _____
What makes your symptoms better? _____
Does coughing or sneezing make your symptoms worse? Yes No
Have you had any change in bowel or bladder habits? Yes No
Have you had any sexual dysfunction due to your symptoms? Yes No

Please circle the appropriate answer:
Which is worse: Neck pain or back pain?
Which is worse: Back pain or leg pain?
Which is worse: Leg pain or arm pain?
Which is worse: Neck pain or arm pain?
Which is worse: Left arm or right arm?
Which is worse: Left leg or right leg?

Do you have leg weakness? Yes No **If yes, which leg?** Right Left
Do you have leg numbness? Yes No **If yes, which leg?** Right Left
Do you have arm weakness? Yes No **If yes, which arm?** Right Left
Do you have arm numbness? Yes No **If yes, which arm?** Right Left

Have you had an epidural block or steroid injection? Yes No **Date**_____
If yes, which Doctor performed the block/injection? _____
How long did you get relief from the block/injection? _____
Have you ever seen a Chiropractor? Yes No
Have you ever seen a Psychiatrist? Yes No
Have you had any Physical Therapy for this problem? Yes No
Are you in a medication/pain management clinic with another Physician? Yes No
If yes, which Physician? _____

Have you had any previous neck or back surgery? Yes No
Date and Surgeon's name_____
Please list any other major surgeries_____
Please list any major complications after any surgery performed in the past: (i.e. Infections, Blood Clots, Lung Disorders, Nerve Damage, Bleeding Disorders, Anesthesia Complications, Sexual Dysfunction)
_____
_____

Patient Signature: _____ **Date**_____