Carolina SPINE & NEUROSURGERY Center

Date ____________________

Account # ____________________

Provider # ____________________

PATIENT INFORMATION (DR. GOOCH #48 / 448)

(circle one)

PATIENT NAME: ______________________________

Family Doctor: ____________________ **Family Doctor Phone:** ____________________

Referring Physician ____________________ **DOB** __________ **Sex** M F *(circle one)* **Age:** ______

What body part is involved? Please mark below:

Neck ☐ and radiates to ☐ R arm ☐ L arm ☐ neither	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Hand ☐ R ☐ L	Pelvis ☐ R ☐ L	Knee ☐ R ☐ L	Foot ☐ R ☐ L
Back ☐ and radiates to ☐ R leg ☐ L leg ☐ neither	Arm ☐ R ☐ L	Wrist ☐ R ☐ L	Finger ☐ R ☐ L	Hip ☐ R ☐ L	Ankle ☐ R ☐ L	Toe ☐ R ☐ L

How were you hurt?
- ☐ Bending
- ☐ Falling
- ☐ Lifting
- ☐ Twisting
- ☐ Gradual onset
- ☐ Other

Where were you hurt?
- ☐ No injury
- ☐ Auto accident
- ☐ Sports
- ☐ Work
- ☐ Do not recall
- ☐ Other__________

Do you have any Attorney?
☐ Yes ☐ No

Who? __________

How long have you been hurt?
Days __________
Weeks __________
Months __________
Years __________

On a scale of 0-10 (10 being the worst), how severe is your pain?
0 1 2 3 4 5 6 7 8 9 10

What is the **quality** of your pain?
- ☐ No pain
- ☐ Aching
- ☐ Burning
- ☐ Throbbing
- ☐ Sharp
- ☐ Other __________
- ☐ Constant
- ☐ Comes and goes
- ☐ Stabbing
- ☐ Stinging
- ☐ Dull

Do you have any of the following?
- ☐ None
- ☐ Bruise
- ☐ Swelling
- ☐ Weakness in arm/dropping objects
- ☐ Weakness in leg
- ☐ Loss of control of bowel or bladder
- ☐ Loss of balance or falls
- ☐ Other __________
- ☐ Numbness
- ☐ Tingling

What makes your symptoms **worse**?
- ☐ Standing
- ☐ Walking
- ☐ Lifting
- ☐ Stairs
- ☐ Exercise/activity
- ☐ Kneeling
- ☐ Coughing
- ☐ Sneezing
- ☐ Twisting
- ☐ Lying in bed/sleeping
- ☐ Bending Forward
- ☐ Bending Backward
- ☐ Squatting
- ☐ Sitting
- ☐ Driving/riding in car
- ☐ Other __________

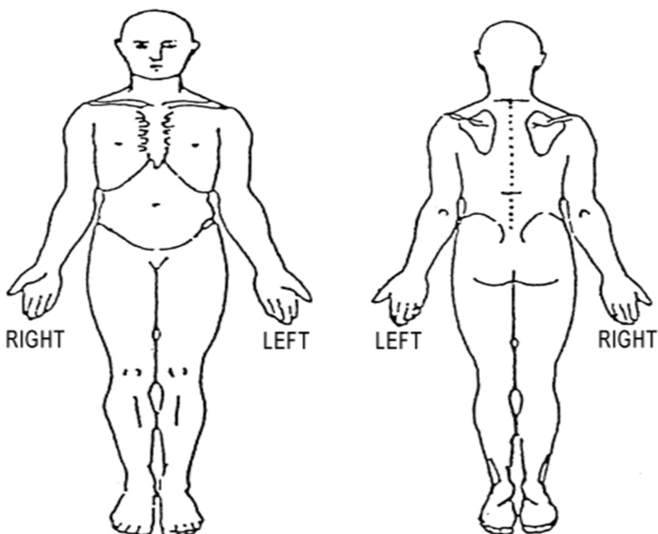
What makes your symptoms **better**?
- ☐ Resting
- ☐ Sitting
- ☐ Heat
- ☐ Ice
- ☐ Other __________
- ☐ Lying in bed/sleeping
- ☐ Exercise
- ☐ Elevation
- ☐ Medication

What tests/scans have you had for your problem?
- ☐ X-rays
- ☐ MRI
- ☐ CAT scan
- ☐ Bone Scan
- ☐ Nerve Test (EMG/NCV)

Have you received any of these treatments?
- ☐ Steroid injections
- ☐ Brace/cast
- ☐ Physical/home therapy
- ☐ Cane/crutch
- ☐ Nerve root block
- ☐ Anti-inflammatory
- ☐ Seen another Physician for this problem?
- ☐ None
- ☐ Chiropractor
- ☐ Pain Medication
- ☐ Epidural
- ☐ Surgery __________

Who? __________

Please mark where your pain exists on the bodies.



XXX - PAIN
OOO - PINS, NEEDLES, NUMBNESS