OIP Orthopedic Institute of Pennsylvania

Dr. Fernandez

New Patient Spine Form

Date of Appointment: _____ SS: _____

Name: _____

Date of Birth: _____ Age: _____

Referring Physician: _____

Current Complaint: _____

_____

Duration of Complaint: _____

Accident: ◯ Yes ◯ No Current Lawsuit: ◯ Yes ◯ No

Spinal Fracture: ◯ Yes ◯ No Accident Type: ◯ MVA ◯ Fall Date: _____

Pain: ◯ Intermittent ◯ Constant

Describe Pain: ◯ Sharp ◯ Burning ◯ Stabbing ◯ Tingling ◯ Achy

◯ Other: _____

Pain Intensity On Scale Of 1(least)-10(most): _____

Is The Pain: ◯ Improving ◯ Getting Worse ◯ Remaining the Same

Do You Have Back Pain: ◯ Yes ◯ No

- If Yes, Does the Pain Radiate to Your Lower Extremities (Buttocks, Legs, Thighs, or Feet): ◯ Yes ◯ No
- Location of Your Worst Pain: ◯ Back ◯ Lower Extremities

Do You Have Neck Pain: ◯ Yes ◯ No

- If Yes, Does the Pain Radiate to Your Lower Upper (Shoulders, Arms, or Hands): ◯ Yes ◯ No
- Location of Your Worst Pain: ◯ Neck ◯ Upper Extremities

Date of Appointment: _____ SS: _____

Name: _____

Pain Worse With: ◯ Standing ◯ Sitting ◯ Lying down ◯ Working ◯ Walking
◯ Sleeping ◯ Stairs ◯ Leaning Forward
◯ Other: _____

Pain Better With: ◯ Standing ◯ Sitting ◯ Lying down ◯ Changing Position
◯ Workin Sleeping ◯ Stairs ◯ Leaning Forward
◯ Other: _____

Associated Symptoms: ◯ Intermittent ◯ Constant ◯ None

- Dexterity Issues: ◯ Yes ◯ No
- Sensory Disturbance: ◯ Yes ◯ No
- Weakness: ◯ Yes ◯ No
- Balance Issues: ◯ Yes ◯ No
- Incontinence: ◯ Bowel ◯ Bladder ◯ None
- History of Cancer: ◯ Yes ◯ No
- Please Explain: _____

Recent Weight Loss: ◯ Yes ◯ No
If Yes, How Many LBS: _____ Height: _____ Weight: _____

- Tobacco Use? ◯ Yes ◯ No - If Yes, Do You - ◯ Smoke ◯ Chew
- Alcohol Use? ◯ Yes ◯ No
- Recreational Drug Use? ◯ Yes ◯ No
- Occupation: _____
- Receiving Disability? ◯ Yes ◯ No

Treatment	Past	Recent	# Of Sessions	Treatment	Past	Recent
Physical Therapy	◯	◯		Bracing/Collar	◯	◯
Chiropractic	◯	◯		Rest	◯	◯
Acupuncture	◯	◯		Narcotic Medications	◯	◯
Injections	◯	◯		NSAID Medications	◯	◯

Past Spinal Surgery: ◯ Yes ◯ No
If Yes, Please List Procedure & Date: _____
_____