

The Mosenthal Spine Clinic 199 Heater Rd, Lebanon, NH 03766
603.449.0048

Name _____
Date _____ Primary Care Pro-
vider _____ Date of Birth _____
Circle: APD Community Care Center Family Health Cntr Dr. Glazer WRFamily
Practice DHMC Hospital/Internal Med Buck Rd Lyme
Other _____

Present Complaint:

___ TMJ ___ Headache/Migraine ___ Neck Pain/Stiffness ___ Hand Numbness/Tingling
___ Shoulder Pain ___ Carpal Tunnel ___ Mid-Back Pain ___ Low Back Pain ___ Sciatica
___ Disc Condition ___ Stenosis ___ Arthritis ___ Hip Pain ___ Pregnancy Spine Problem

Other _____

Please let us know if your present complaint has, as a component: trauma, fever, night sweats ,urinary or bowel incontinence , unexplained weight loss, a cancer history, long-term steroid use, major motor weakness and numbness, or progressing neurological deficit and/or intense localized pain (unrelenting, unaffected by position, severe nighttime pain and unable to get into a comfortable position).

History of Present Complaint:

When did pain begin? _____ Was it caused by a car accident Y N Work Accident
Y N How did your pain begin?

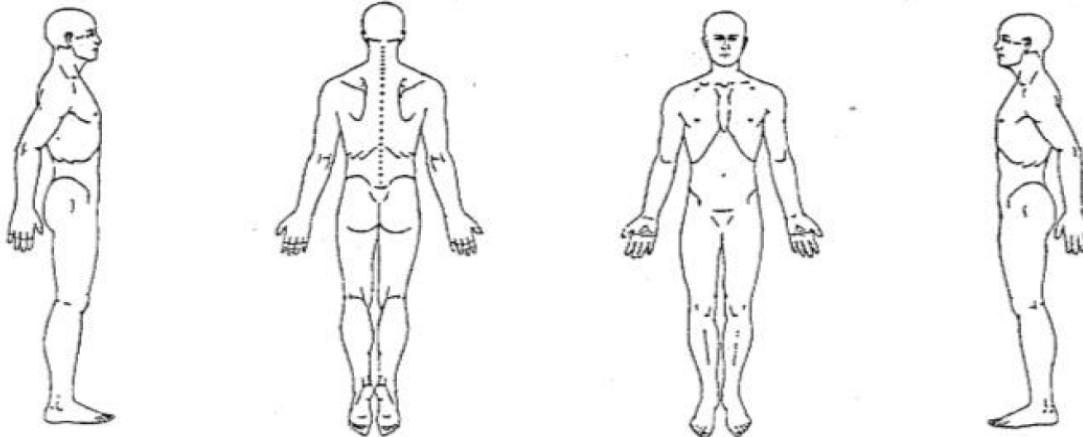
Briefly describe injury de-
tails: _____ What
have you been told is wrong or what do you think is causing your symptom?

_____ Is your pain constant intermittent improving worsening
not changed Have you had a similar problem before? Yes No
Is there anything that decreases your current pain? Y N

_____ Anything that increases your current
pain? Y N _____ **Current treatment**
for this problem? None Physical therapy Chiropractic Acupuncture Massage
 Injections Surgery Other _____ X-Ray MRI CAT Scan
Medications (frequency/dosage) _____

Fill out the pain drawing below using the following symbols: Please place an X where your symptom is and a number between 0 and 10 indicating the severity of your pain where 0 is NO pain and a 10 is

EXTREME pain.



PLEASE CONTINUE ON TO NEXT PAGE , COMPLETE AND SIGN THANK YOU!

Mosenthal Spine Clinic page 2

Medical History: Please place an X in those that apply: Cancer (Active or in Remission) Arthritis Alcoholism Kidney disease Diabetes Seizures Anemia Thyroid Disease Ulcers Pregnant Heart Disease Stroke MS AIDS/HIV Hepatitis Diverticulitis High Blood Pressure Lung Disease Pacemaker Blood Thinners Joint Replacement Depression/Anxiety Birth Control Asthma Scoliosis Sinusitis Fibromyalgia Metal Implant(s) Light Sensitive Medication Recent Steroid Injection

List of all supplements and medications you are currently taking:

Surgeries/Hospitalizations Injuries/Fractures/Dislocations

Year

Year

Drug or Other Allergies No Yes; _____
Living parents? Mother Yes No; Father Yes No Did either have chronic spinal problems? Y N

Current Work Occupation _____ **Employer** _____

Status: % of Day ___ Sitting ___ Standing ___ Walking ___ Driving ___ Lifting

If lifting at work, what is the average weight? ___ lbs. How Often? _____

Lifestyle Habits: Tobacco ___ (# cigs/day) Years smoked ___ Alcohol ___ (#drinks/day)
 Caffeine beverages ___ (#/day) Computer Use ___ minimal ___ moderate ___ lots Laptop Desktop
Do You Wake Up ___ Not Stiff/Sore At All ___ Somewhat Stiff/Sore ___ Quite Stiff/Sore
Do You Usually Sleep ___ On Your Side ___ On Your Back ___ On Your Stomach
When You Sleep Are Your Hands ___ Under Your Pillow Above Your Head or ___ Down By Your Sides
Do You Feel You _____ Have Good Posture Y N Eat Healthy Y N Exercise Regularly Y N
Are Dealing With More Stress Than You Would Like Y N Drink Enough Water Y N Stretch Frequently Y N
Do You Wear Orthotics Y N Do You Wear A Heel Lift Y N Do You Have "Flat" Feet Y N
 Do You Read In Bed Watch TV In Bed

Has your symptom(s) prevented you from doing any activity that you would normally do?
No Yes Describe _____

How Important Do You Think Your Spine Health Is? Not Very 0 1 2 3 4 5 6 7 8 9 10 Very
If You Have Children, Have They Ever Had A Spinal Check-Up By A Chiropractor Y N

Do You Have A Friend/Family Member With Headaches Neck Pain Low Back Pain Arthritis
Sport's Injury Disc Condition Other Problem That We Can Help If yes, please describe _____

Hobbies/Things You Like To Do/What You Are Passionate About:

Are there any other health issues/concerns that you would like us to know about? Please describe:

Signature of Patient or Personal Representative

Date

