University of Colorado Hospital
Anschutz Outpatient Pavilion- 4th floor
1635 N. Ursula St., Suite 4200
P.O. Box 6510, Mail Stop F712
Aurora, Colorado 80045-0510

SPINE CENTER EVALUATION FORM

DEMOGRAPHICS

Age: ____ Height: ______ Weight: ______ Sex: Male/Female Handedness: Right/Left
E-mail address: ____________________________ May we e-mail you? Yes___ No___ Consent obtained? Yes___ No ____

Language Barriers:	Can you understand English? Can you read English?	Y____ N _____ Y____ N _____ 1st language preference_______________
Primary Care Physician ***Referring Physician**:*		*List other treating physicians:* ____ ____

REASON FOR TODAY'S VISIT

What is the reason for your visit today?____
How and when did it start? ____
What specifically do you want to accomplish with today's visit? ____

PAIN HISTORY

Do you have pain that you want to discuss with your doctor? Y N
Site of Pain: ____
When did it start? ____

Describe your pain ____________________
____
____

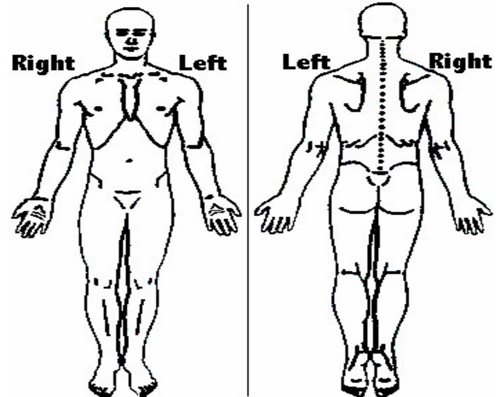
Using one of the pain scales below, please rate how your pain feels today:

0 1 **2** 3 **4** 5 **6** 7 **8** 9 **10**
No Pain **Mild Pain** **Mod Pain** **Severe Pain** **Very Severe** **Worst Possible**

What makes the pain better? Sitting Standing Walking Lying

What makes the pain worse? Sitting Standing Walking Lying

Please draw the location of your pain below



What tests have you had? MRI CTscan X-Ray EMG Other________________

What treatments have you tried? Physical Therapy Acupuncture TENS Unit Surgery Injections Exercise

Chiropractic Massage Counseling Braces Other_____________________

Have any of these treatments helped? (Please list) ____
____

Is this a work related injury? Y N If yes, date of injury__________________
Is this related to a motor vehicle accident Y N If yes, date of accident _________________
Is there litigation pending Y N

MEDICAL HISTORY

HAVE YOU EVER HAD?	Y	N	HAVE YOU EVER HAD?	Y	N
Difficulty swallowing			Rashes or skin problems		
Diabetes, thyroid problems			Difficulty hearing, decreased vision, hoarseness		
Headaches			Dizziness		
Weight loss or gain			Breathing problems		
Chest pain, palpitations			Weakness, numbness or tingling		
Nausea, vomiting, black stools			Depression or sleep problems		
Loss of bowel or bladder control			Musculoskeletal problems		
Urinary, prostate or gynecological problems			Easy bruising or on blood thinners		

PAST MEDICAL HISTORY
(check all that apply)

_____ heart disease
_____ diabetes
_____ lung disease
_____ high blood pressure
_____ kidney problems
_____ cancer
_____ stroke
_____ thyroid problems
____ seizures
____ arthritis
____ depression
____ asthma
____ heartburn
____ ulcers
____ migraines
____ other (please list)
____
____

PAST SURGICAL HISTORY
(include dates)

____
____
____
____
____
____

FAMILY MEDICAL HISTORY

____
____
____
____
____
____

MEDICATIONS

(Include all over the counter and herbal medications)
See attached list
____
____
____
____

ALLERGIES

(list all allergies and reactions)
Contrast or Iodine allergy? Yes No
____
____
____
____

FALL ASSESSMENT

Have you had any falls in the last 6 months? yes no If yes, what was the cause of the fall________________________________
Do you have a fear of falling? yes no
Do you find it difficult to walk yes no Do you use any assistive devices for walking?_____________________________

SOCIAL HISTORY

Occupation: __________ Status: (Circle One) Full-time / Part-time / Restricted-Duty / Off-Duty to Injury / Retired / Not working
Last Date of Employment: _____________
Tobacco use: (Circle One) Current / Never / Quit Packs per Day: ___________ How many years: ______________
Alcohol use: (Circle One) Y N Drinks per week: __________

NUTRITION

Have you ever had? (check all that apply)
____ Inability to eat
____ Are you pregnant or lactating?
____ Unintentional weight loss
____ Unintentional weight gain
____ Swallowing difficulties or chewing problems
____ Special diet requirements for your (circle) kidneys/liver/heart/diabetes
____ Would you like to see a nutritionist
____ Questions about how your diet may impact your current health/medical condition

LEARNING/EDUCATION

Are there any? (check all that apply)
____ Cultural/social/spiritual barriers to learning about your condition
____ Physical barriers to learning about your condition
____ I want to learn more about my medical condition(s)? Y N

How do you learn best? (circle)
Verbal Demonstration Written Visual

Highest grade completed: (circle)
Grade School High School Postgraduate

HAVE YOU BEEN HIT, SLAPPED, KICKED OR IN ANY WAY ABUSED THIS PAST YEAR? Y N
You will be given a brochure if **YES** is checked.

Patient Signature:______________________ Date:_________ Initials of Reviewing Physician: __________