California Spine Group
New Patient Packet

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: _____ Right/Left Handed

Height: _____ Weight: _____

Current Complaints (Reason for visit):

1. 4.
2. 5.
3. 6.

When did you first notice this medical problem? Date: _____

Please describe in detail the specifics of your injury: _____
_____
_____
_____
_____

What were your immediate symptoms? _____

Were you at work when this injury occurred? Yes / No

When did you report your injury? _____ To Whom? _____

Did you finish what you were doing? Yes / No.

When did you first seek treatment? _____ Who referred you? _____

Have you missed any work due to this injury? Yes / No

Dates you have missed work: _____

What specific job duties are you unable to do or have difficulty performing? Why? ____
_____
_____
_____

Please list the doctors and treatment you have received for this injury:

Initial facility or Doctor: _____
Date of first visit: _____ Diagnosis: _____
Medication: _____

Please circle

Physical therapy MRI EMG/NCV Injections CT scan Chiropractic
Other: _____

Next facility or Doctor: _____
Date of first visit: _____ Diagnosis: _____
Medication: _____

Please circle

Physical therapy MRI EMG/NCV Injections CT scan Chiropractic
Other: _____

Next facility or Doctor: _____
Date of first visit: _____ Diagnosis: _____
Medication: _____

Please circle

Physical therapy MRI EMG/NCV Injections CT scan Chiropractic
Other: _____

Next facility or Doctor: _____
Date of first visit: _____ Diagnosis: _____
Medication: _____

Please circle

Physical therapy MRI EMG/NCV Injections CT scan Chiropractic
Other: _____

Next facility or Doctor: _____
Date of first visit: _____ Diagnosis: _____
Medication: _____

Please circle

Physical therapy MRI EMG/NCV Injections CT scan Chiropractic
Other: _____

Next facility or Doctor: _____
Date of first visit: _____ Diagnosis: _____
Medication: _____

Please circle

Physical therapy MRI EMG/NCV Injections CT scan Chiropractic
Other: _____

Next facility or Doctor: _____
Date of first visit: _____ Diagnosis: _____
Medication: _____

Please circle

Physical therapy MRI EMG/NCV Injections CT scan Chiropractic
Other: _____

Have you ever had similar symptoms? Yes / No

Date: _____ Body Part: _____
Nature of Accident: _____
_____

Date: _____ Body Part: _____
Nature of Accident: _____
_____

Employment Information

Employer: _____

Job Title: _____

Hours worked per day prior to injury: _____ Days per week worked: _____

Did you work any overtime prior to the injury? Yes / No. O.T. hours per week: _____

Work Duties: _____
_____
_____
_____
_____

Maximum amount of weight yourself: _____ How many times per day: _____

Current Work Status: _____

Restrictions if any: _____
_____

Please check any activities required in the course of your work:
_____ lift _____ Carry _____Bend _____ Stoop _____Squat _____ Push
_____ Pull _____ Walk _____ Sit _____ Stand _____ Reach overhead
_____ Reach forward _____ Awkward positions

List any machines/tools you use at work:
_____
_____
_____

How long have you been employed with this company? _____

How long have you been in this line of work? _____

Do you have a second job? Yes / No. Please explain: _____
_____
_____
_____

Past Medical History

Have you ever had any other work related injuries? Yes / No

Date of Injury: _____ Body Part: _____
Date of Injury: _____ Body Part: _____
Date of Injury: _____ Body Part: _____
Date of Injury: _____ Body Part: _____

Have you had any NON-WORK related injuries (including motor vehicle accidents)?
Explain: _____
_____
_____
_____

Have you ever been hospitalized? Explain: _____
_____
_____
_____

Have you ever had surgery? Yes / No
Date: _____ Procedure: _____
Date: _____ Procedure: _____
Date: _____ Procedure: _____
Date: _____ Procedure: _____
Date: _____ Procedure: _____

List Current Medications:_____
_____
_____

Allergies to Medications: _____
_____

Please check any of the following conditions in which you currently have:

_____ Diabetes	_____ Thyroid Problem	_____ Rheumatoid Arthritis
_____ Stroke	_____ Cancer	_____ Stomach Ulcers
_____ Liver Disease	_____ Kidney Problems	_____ High Blood Pressure
_____ Heart Attach	_____ Tuberculosis	_____ Other: _____

Social History

Please check one of the following:

_____ Married _____ Single _____ Divorced _____ Separated _____ Widowed

Do you have any children? Yes / No How Many? _____

Where were you born? _____ Date of Birth: _____

Highest education Completed: _____ Did you attend a trade school? Yes / No

If yes, what kind: _____

Hobbies: _____
_____
_____

Recreational Activities: _____
_____
_____

Do you smoke? Yes / No If so how much? _____ per day
Do you drink? Yes / No If so how much? _____ per month

Have you ever done any street drugs? Yes / No. If yes, what kind? _____

Have you ever been in an alcohol or drug rehab facility? Yes / No

Have you ever been in the military? Yes / No If yes, what branch: _____