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## Patient History Form – Back & Spine

Name \_\_\_\_\_ Date \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_

1. When (roughly what date) did your present pain start? \_\_\_\_\_

2. How did it start? (Check appropriate response)

Lifting     Twisting     Fall     Bending     Pulling  
 Hit in the back     Auto Accident     No accident

3. Your pain is worse in your (check appropriate response)

Back     Neck     Head     Arm(s)     Back and hip(s)  
 Down the leg(s)     All of these     None of these

4. How long have you been unable to work or do normal housework? \_\_\_\_\_

5. How long have you had any problem with your back, neck, legs or arms? (circle appropriate parts)

6. Your pain is (check appropriate response)

Better	Worse	No Different	
_____	_____	_____	When coughing or sneezing
_____	_____	_____	Sitting in a straight chair
_____	_____	_____	Sitting in a soft easy chair
_____	_____	_____	Bending forward to brush your teeth
_____	_____	_____	When you wake up in the morning
_____	_____	_____	In the middle of the night
_____	_____	_____	Midday
_____	_____	_____	Lying flat on your back
_____	_____	_____	Lying flat on your stomach
_____	_____	_____	Lying on your side with your knees bent

7. Do you have to rest during the because of your pain?

(check appropriate response)

No     A little     Half the day     More than half the day

8. Have you ever been in a hospital for back, leg, neck or arm pain?

Number of times \_\_\_\_\_ Give dates \_\_\_\_\_

9. What doctor (or doctors) took care of you previously? \_\_\_\_\_  
\_\_\_\_\_
10. What was your diagnosis? \_\_\_\_\_  
\_\_\_\_\_
11. Have you ever had a myelogram (x-ray of the spine with dye injection)?  
Number of times \_\_\_\_\_ Give dates \_\_\_\_\_
12. Have you ever had an electromyogram (EMG)? Number of times \_\_\_\_\_
13. Have you ever had neck or back surgery? Number of times \_\_\_\_\_  
Give types and dates \_\_\_\_\_  
\_\_\_\_\_
14. Do you exercise on a regular basis? Yes \_\_\_\_\_ No \_\_\_\_\_
15. What other medical problems do you have? (check appropriate response)  
\_\_\_\_\_Diabetes \_\_\_\_\_Arthritis \_\_\_\_\_Gout \_\_\_\_\_Cancer \_\_\_\_\_Heart Problems  
\_\_\_\_\_Stomach problems, ulcer, etc. \_\_\_\_\_Epilepsy (seizures) \_\_\_\_\_Other  
\_\_\_\_\_
16. Do you have an attorney helping you? Yes \_\_\_\_\_ No \_\_\_\_\_
17. Do you want a report sent to your attorney? Yes \_\_\_\_\_ No \_\_\_\_\_
18. Do other members of your family have significant back or neck trouble?  
Who (relationship)? \_\_\_\_\_
19. What treatments have made your pain better? \_\_\_\_\_  
\_\_\_\_\_
20. What treatment have made your pain worse? \_\_\_\_\_  
\_\_\_\_\_
21. What is the most aggravating thing about your pain? \_\_\_\_\_  
\_\_\_\_\_
22. What brought you to this office? \_\_\_\_\_  
\_\_\_\_\_
23. Please add any other information you would like to include, or additions to your answers to previous questions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_