



**Mohawk Valley  
Orthopaedics, PC  
Spine Center  
New Patient Form**

Today's Date \_\_\_\_\_

Birth Date \_\_\_\_\_

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

7. Did your pain start because of an accident?

- Yes  
 No

8. Changing degree of pain (please select one):

- My pain is getting rapidly better  
 My pain changes, but overall is getting better  
 My pain seems to be getting better, but improvement is slow  
 My pain is neither getting better nor worse  
 My pain is getting rapidly better  
 My pain is rapidly worsening

9. Are you involved in physical activities?

- Never, my disability prevents it  
 Never  
 An average of once per week  
 An average of 2-3 times per week  
 An average of 4 or more times per week

10. If you are involved in physical activities, please list the activities in which you participate:

11. How does each of the following affect your symptoms?

- |                  |                                 |                                |                                    |
|------------------|---------------------------------|--------------------------------|------------------------------------|
| Sitting          | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Change |
| Standing         | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Change |
| Walking          | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Change |
| Bed Rest         | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Change |
| Bending Forward  | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Change |
| Bending Backward | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Change |

12. How much relief did you receive from each of the following parts of your overall treatment (on a scale from 0% to 100%, with 0% being no relief and 100% being complete relief)? (Mark only one answer in each row. "N/A" if it does not apply.)

	0%-30%	31%-60%	61%-100%	N/A
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bracing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injections/Blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Modalities (heat, ultrasound, massage, electrical stimulation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biofeedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed Rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Indicate what medications you take for your back, and how frequently. (Mark one choice in each group.)

	Never	Once or Less per Week	More Than Once per Week	Daily
Over the counter (e.g., Tylenol, aspirin, Excedrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-steroidal anti-inflammatories (e.g. ibuprofen, anaprox, Motrin, Feldene, Vioxx, Celebrex, Naprosyn, Arthrotec, Cataflam, Mobic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle relaxers (e.g., Flexeril, Robaxin, Soma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotics (e.g., Vicodin, Lortab, MS Contin, Percodan, Percocet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-depressants (e.g., Elavil, Paxil, Prozac, Wellbutrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuroleptics (agents to calm nerves e.g., Neurontin, Klonopin, Tegretol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Have you had spine surgery (neck or back) before?

- No  
 Yes

If yes, please indicate the approximate date

Month Year

If yes, what type of surgery and on what levels?

\_\_\_\_\_

15. Have you ever had, or been told you had, any of the following medical conditions: (Mark all that apply.)

- Anemia or other blood disease  
 Chronic anti-inflammatory medication use  
 Depression/anxiety/memory loss/confusion  
 Heart disease  
 History of cancer  
 Leg pain  
 Long term steroid use  
 Lupus/rheumatoid arthritis/ankylosing spondylitis  
 Osteoarthritis/degenerative arthritis  
 Recent unexplained weight loss/gain  
 Back pain  
 Circulatory disorder  
 Diabetes  
 High blood pressure  
 Kidney disease  
 Leg pain when walking  
 Lung disease/asthma  
 Nervous system disorder  
 Osteoporosis  
 Stroke

**Mohawk Valley  
Orthopaedics, PC  
Spine Center  
New Patient Form**

Today's Date \_\_\_\_\_

Birth Date \_\_\_\_\_

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

16. Please list ANY prior surgeries or hospitalizations, and the approximate date of each:

17. Please list ANY allergies you have:

18. If you take pain medication, does it upset your stomach?

- Yes  
 No  
 I don't take pain medication

19. If you take anti-inflammatories, do they upset your stomach?

- Yes  
 No  
 I don't take anti-inflammatories

20. Does pain affect your ability to work?

- Yes  
 No

21. What is your current work status?

- Working (including homemaker and self-employed)  
 On PAID leave due to current back/neck condition  
 On UNPAID leave due to current back/neck condition  
 Unemployed or student  
 Retired NOT due to back/neck problem  
 Retired due to back/neck problem

22. What does your current occupation involve (including any work/housework you do at home)?

- Heavy physical labor  
 Moderate physical labor  
 Minimal physical labor  
 No physical labor (desk job)  
 Not working now

23. What is your normal occupation (including homemaker)?

24. Are you receiving Workers' Compensation for your neck/back problems?  
 Yes  No

25. If disabled, retired, or on Workers' Compensation for your back condition, how long has it been since you last worked?

- Less than 6 months  Between 1 and 2 years  
 Between 6 months to 1 year  More than 2 years

26. Are you currently, or were you in the past, involved in a lawsuit because of neck/back problems?

- Yes  No

27. Do you currently smoke or use tobacco products?

- Yes  Quit tobacco use within the last 3 months  
 No  Using nicotine patches or other nicotine products

28. How often do you drink alcoholic beverages?

- Never  Occasionally  
 Selcom  Frequently

26. Do you currently have any of these symptoms? (Check all that apply.)

Constitutional Symptoms

- Fever  
 Night sweats  
 Generalized weakness or fatigue  
 Weight gain  
 Weight loss

Cardiovascular

- Shortness of breath  
 Chest pain  
 Irregular heartbeat  
 Palpitations

Respiratory

- Coughing up blood  
 Chronic cough  
 Wheezing

Gastrointestinal

- Blood in stool  
 Black or discolored stool  
 Abdominal pain  
 Difficulty swallowing  
 Nausea or vomiting  
 Diarrhea  
 Constipation  
 Abdominal distention  
 Abdominal mass or lumps

Genito-Urinary

- Burning with urination  
 Dark or discolored urine  
 Difficulty starting/ending urine stream  
 Poor bladder control  
 Loss of genital sensation  
 Any sexual dysfunction

Skin/Breast

- Dry skin  
 Body rash/hives  
 Nipple discharge  
 Breast lump  
 Problems with wound bleeding  
 Change in a mole  
 Dimpling of skin  
 Change in color/temperature of skin

Hematologic/Lymphatic

- Easily bruise/bleed  
 Nose bleeds

Musculoskeletal

- Masses/lumps  
 Swelling  
 Inability to feel hot/cold  
 Poor coordination  
 Loss of control of arms or legs  
 Loss of muscle mass  
 Abnormal arm/leg sensations  
 Neck pain  
 Back pain  
 Numbness  
 Tingling  
 Back pain

Neurologic

- Poor vision  
 Blurry vision  
 Double vision  
 Loss of hearing  
 Ringing in ears  
 Numbness in face  
 Loss of sense of smell  
 Loss of sense of taste  
 Droopy face/eye  
 Hoarseness  
 Difficulty speaking  
 Difficulty swallowing  
 Slurred speech  
 Headache  
 Dizziness  
 Seizures  
 Unsteady gait

Endocrine

- Poor appetite  
 Cold intolerance  
 Excessive thirst  
 Loss of body hair

Psychosocial

- Depression  
 Hallucinations  
 Anxiety  
 Mood swings