Kristoffer R. West, M.D.

230 N 1680 E, Suite I-1
St. George, UT 84790
Phone: 435-652-6024
Fax: 435-652-6025
Web: www.sgspine.com
Email: westorthospine@gmail.com

ST GEORGE ORTHOPEDIC SPINE

Patient Name:_____

Age: _____ Date of Birth: _____ Sex: _____ Visit Date: _____

About Your Pain

Briefly describe your current complaints for which you are seeking treatment?

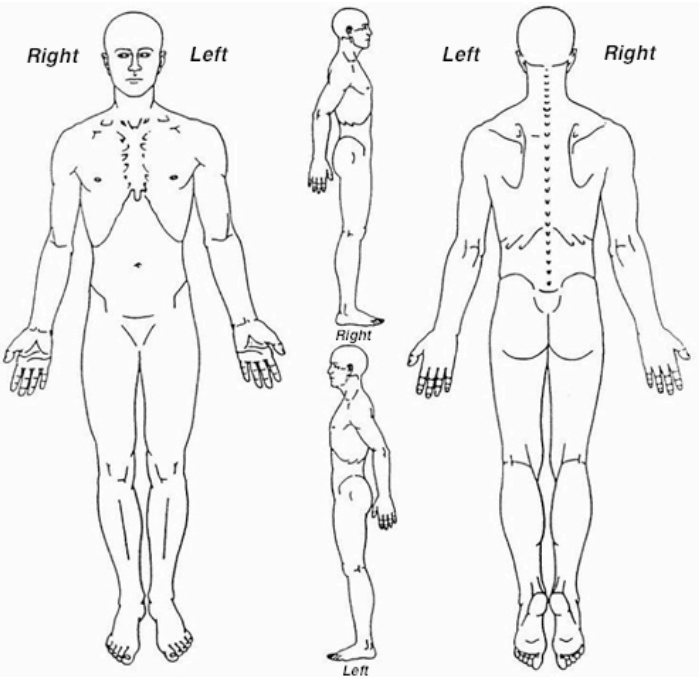
When did the problem start:

❑Weeks:_____ ❑Months:_____ ❑Years:_____

Other:

Where Do You Hurt? Mark all that apply →

❑ Abdomen	❑ Headaches	❑ Mid Back
❑ Buttocks	❑ Hip	❑ Neck
❑ Chest Wall	❑ Knee	❑ Pelvic
❑ Foot	❑ Legs	❑ Shoulder
❑ Hand/Fingers	❑ Low Back	❑ Wrist
❑ I Hurt Everywhere	❑ **OTHER**	



Pain Quality – How would you describe the pain

(Mark as many adjectives as are applicable)

❑ Aching	❑ Numbness	❑ Shooting
❑ Burning	❑ Pins/Needles	❑ Stabbing
❑ Cramping	❑ Pressure	❑ Throbbing
❑ Cutting	❑ Sharp	❑ Weakness
❑ Dull		
❑ Electric Like	❑ **OTHER**	

Timing of Pain – How often do you have your pain (mark one)

❑ Constantly (100% of the time) ❑ Frequently (75% of the time)
❑ Intermittently (50% of the time) ❑ Occasionally (25% of the time)

Rate Your Intensity

Circle the one number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

Since the onset of symptoms, has the problem

❑ Improved ❑ Worsened ❑ Stayed the same

Have you had any new or recurrent problems with:

Control of urination: ❑ YES ❑ NO
Bowel movements: ❑ YES ❑ NO

Have you experienced recent weight loss or fevers? ❑ YES ❑ NO

Functional Limitations – During the past few, indicate to what degree your condition has interfered with your daily activities (work, householdhold chores, yard work, shopping, recreation, driving, sleeping, self care):
❑ Not at all ❑ Minimally ❑ Moderatly ❑ Greatly ❑ Severly

Endurance
How many blocks can you walk before having to stop secondarily to pain? _____ blocks.
How long can you stand before you have to sit down? _____ minutes.

Relieving and Aggravating Factors – How do the following affect your pain (please mark one for each item)

Condition	Improves	Worsens	No Change
Lying Down			
Standing			
Sitting			
Walking			
Exercise (if applicable)			
Lifting			
Medication			
Relaxation			
Coughing/Sneezing			
Urination / Bowel Movements			

Previous Treatments - Please check all of the treatments you have tried for your pain:

Treatment	Date (approx)	Excellent Relief	Moderate Relief	No Relief
❑ Surgery				
❑ Physical Therapy				
❑ Pain Medications				
❑ Anti-Inflammatory/NSAIDS				
❑ Exercise				
❑ Back Brace				
❑ Chiropractic				
❑ Hospitalization				
❑ Other:				
❑ Steroid/Epidural Injections				
Steroid/Epidural Injections - Doctor:		Levels:		

Allergies ❑ NONE

Medications – please list ALL medications you are currently taking:

Name of Medication	Dosage	Frequency

Medical History:
Have you had any of the following health problems? (Please mark all that apply)

❑ Angina	❑ Cancer	❑ High Blood Pressure	❑ Psychological Problems
❑ Arthritis	❑ Chronic Cough	❑ Kidney Disease	❑ Seizures or Epilepsy
❑ Asthma	❑ Diabetes	❑ Liver Disease	❑ Stroke
❑ Bleeding Problems	❑ Heart Attack	❑ Psychiatric Problems	

Please explain any medical conditions circled above:

Other (please specify):

ALL Surgeries- approximate date and type of operations

Surgery Type	Approximate Date

Previous Diagnostic Studies – please indicate approximate date and result if known:

MRI:	X-Rays:
CT:	EMG:
OTHER:	

Review of Systems Please mark any of the following signs or symptoms that you are currently experiencing:

- ❑ Abdominal Pain
- ❑ Back Pain
- ❑ Blackouts
- ❑ Bleeding Gums
- ❑ Chest Pain
- ❑ Cold Intolerance
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty concentrating
- ❑ Difficulty falling asleep
- ❑ Difficulty remaining asleep
- ❑ Difficulty Swallowing
- ❑ Difficulty Urinating
- ❑ Dizziness
- ❑ Double or Blurred Vision
- ❑ Drowsiness
- ❑ Excessive Fatigue
- ❑ Feeling depressed
- ❑ Fever or Chills
- ❑ Hearing Loss
- ❑ Joint Pain (knee, hip, etc)
- ❑ Loss of Consciousness
- ❑ Loss of interest in hobbies
- ❑ Low Platelet Count
- ❑ Memory Loss
- ❑ Muscle Loss
- ❑ Muscle Pain
- ❑ Muscle Weakness
- ❑ Nausea
- ❑ Night Sweats
- ❑ Palpitations (fast heart)
- ❑ Seizures
- ❑ Sexual Dysfunction
- ❑ Shortness of Breath
- ❑ Tremors
- ❑ Thyroid Problems
- ❑ Trouble Walking
- ❑ Unplanned Weight Loss/Gain
- ❑ Urinary Retention
- ❑ Vomiting
- ❑ NONE OF THE ABOVE

Family History:

Have any blood relatives had any of the following health problems? (Please check all that apply)

Health Problem	Parent	Sibling	Health Problem	Parent	Sibling
Anesthesia Problems			Heart Disease		
Arthritis			High Blood Pressure/Hypertension		
Asthma			High Lipids		
Back Pain			Migraines		
Blood Disease			Psychiatric Problems		
Cancer			Stroke		
Diabetes			Suicide		
Genetic Problems			Thyroid Problems		
Gastrointestinal Disease			OTHER:		
Genitourinary			OTHER:		

Substance Abuse

Do you drink alcohol? ❑ Yes ❑ No If yes how often: _____

Do you have a history illicit drug use? ❑ Yes ❑ No

If yes, which ones? _____

Do you currently smoke cigarettes or use tobacco? ❑ Yes ❑ No

How many years have you or did you smoke? _____ years

How many packs per day do you or did you smoke? _____ packs per day

Have you quit using tobacco, and if so when? _____

Employment

Current Employment Status – please mark all that apply

- ❑ Employed Full Time
- ❑ Employed Part Time
- ❑ Temporarily Disabled
- ❑ Permanently Disabled
- ❑ Unemployed
- ❑ Homemaker
- ❑ Retired
- ❑ Student
- ❑ Unemployed Due to Pain

Family Life

- ❑ Living Alone
- ❑ Living With Friends
- ❑ Living With Children
- ❑ Living With Spouse/Partner
- ❑ Living With Spouse/Partner and Children
- ❑ Other: