The Anderson Clinic Spine Center
2445 Army Navy Drive, Arlington, VA 22206
2501 Parker's Lane, Suite 200, Alexandria, VA 22306
(703) 769-8424

Corey J. Wallach, MD

Patient Name: _____

Referring Physician:
Name: _____
Specialty: _____
Address: _____
_____

Primary Physician: ☐ *Please check if the same*
Name: _____
Specialty: _____
Address: _____
_____

Date of Consultation: _____

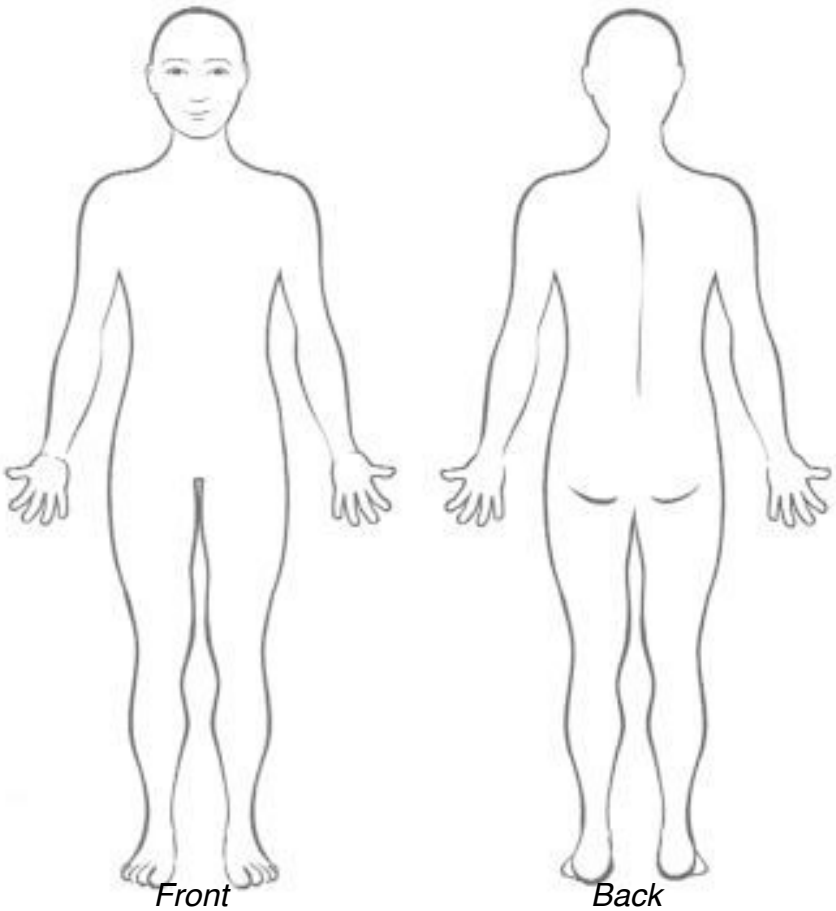
Pharmacy: _____

Chief Complaint: *In your own words, please describe your symptoms and their duration:*

_____
_____
_____
_____
_____

Are your complaints due to an automobile accident or work related injury? ☐ *Yes* ☐ *No*

Please mark the areas that you are experiencing any abnormal sensations, pain, etc.



Pain -	XXXX
Numbness -	- - - - -
Tingling -	/ / / / /

For Staff only: Reviewed by/on

Neck or Back Pain:	**%**
Arm or Leg Pain:	**%**
Total:	**100%**

History of Present Illness -

Location - **Where is your pain/numbness/complaint located?**

☐ Neck ☐ Right Arm ☐ Left Arm ☐ Right Shoulder ☐ Left Shoulder
☐ Back ☐ Right Leg ☐ Left Leg ☐ Right Hip/Buttock ☐ Left Hip/Buttock
☐ Other? _____

Do your complaints affect your quality of life? ☐ Yes ☐ No

Quality - **Is your pain or complaint?**
☐ Dull ☐ Sharp ☐ Throbbing

Severity - **How severe is your pain or complaint?**
☐ Mild ☐ Moderate ☐ Severe

On a scale from 1-10, please identify the pain you typically experience, the pain when it is most severe, and the pain you are experiencing currently -

None - 0 1 2 3 4 5 6 7 8 9 10 - ***Severe***

Typical - ___/10 *Most severe* -____/10 *Current* -____/10

Duration - **How long have your experienced your pain or complaint?**
☐ Years ☐ Months ☐ Weeks ☐ How many? _____

Is your pain or complaint?
☐ Constant ☐ Episodic

Timing - **When do you experience your pain or complaint?**
☐ Morning ☐ Evening ☐ At work
☐ While standing ☐ While walking ☐ While sitting

Do you have limitations in your?
☐ Walking tolerance
☐ Standing Tolerance
☐ Sitting Tolerance

Context - **Is your pain or complaint?** ☐ Improving ☐ Unchanged ☐ Worsening

Associated - factors
Do you experience any of the following symptoms in your arms? ☐ Yes ☐ No
Do you experience any of the following symptoms in your legs? ☐ Yes ☐ No
☐ Weakness ☐ Numbness ☐ Abnormal sensations ☐ Pain ☐ Other: _____

Have you had any loss of control of your bladder? ☐ Yes ☐ No **Of your bowels?** ☐ Yes ☐ No
Have you had recent change in your balance or coordination? ☐ Yes ☐ No

How do your symptoms respond to the following?

Standing	☐ Relieves	☐ Worsens	☐ Unchanged
Walking	☐ Relieves	☐ Worsens	☐ Unchanged
Sitting	☐ Relieves	☐ Worsens	☐ Unchanged
Lying down	☐ Relieves	☐ Worsens	☐ Unchanged
Exercise	☐ Relieves	☐ Worsens	☐ Unchanged

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What treatments have you had thus far and what relief have they provided?

Anti-inflammatories	☐ Excellent	☐ Moderate	☐ None	☐ *Have not tried*
Muscle Relaxants	☐ Excellent	☐ Moderate	☐ None	☐ *Have not tried*
Narcotics	☐ Excellent	☐ Moderate	☐ None	☐ *Have not tried*
Epidural Injections*	☐ Excellent	☐ Moderate	☐ None	☐ *Have not tried*
Physical Therapy	☐ Excellent	☐ Moderate	☐ None	☐ *Have not tried*
Chiropractor	☐ Excellent	☐ Moderate	☐ None	☐ *Have not tried*

* If you had a recent epidural, how much relief did you receive? _____%

Have you had any recent: ☐ X-rays ☐ CT-scans ☐ MRI ☐ EMG/NCS

Work Status: ☐ Employed ☐ Retired ☐ Not working ☐ Disability ☐ Other?

Are your complaints related to an automobile accident or work related injury? ☐ Yes ☐ No

Have you seen a spine surgeon before? ☐ Yes ☐ No Who? _____
Did they recommend surgery? ☐ Yes ☐ No

Past Medical History:

☐ Diabetes Mellitus ☐ Hypertension ☐ Cardiac Disease ☐ Pulmonary Disease
☐ Rheumatoid Arthritis ☐ Osteoporosis ☐ Other conditions?
Please list any other medical conditions you have? _____

Past Surgical History:

☐ Prior Spine Surgery ☐ Cervical ☐ Lumbar Procedure and date: _____
☐ Other surgeries? _____

Medications: [Please attach list if necessary]

Name	*Dose*	*Name*	*Dose*

Allergies: _____ ☐ No Known Drug Allergies

Family History:

☐ Diabetes Mellitus ☐ Cardiac Disease ☐ Cancer ☐ Other: _____
☐ Spine conditions? If so, what type? _____

Social History:

Occupation: _____ Dominant hand: ☐ Right ☐ Left
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Tobacco use? ☐ *Yes* ☐ *No* *How long?* _____
Alcohol use? ☐ *Yes* ☐ *No* *How frequently?* _____

Review of Systems: Please mark whether or not you have had any of the following symptoms recently:

Systemic		**HEENT**		**Pulmonary**	
Weight Change	☐Y ☐N	Headache	☐Y ☐N	Shortness of breath	☐Y ☐N
Chills	☐Y ☐N	Eyesight issues	☐Y ☐N	Cough	☐Y ☐N
Fever	☐Y ☐N	Nosebleeds	☐Y ☐N	Wheezing	☐Y ☐N
Night sweats	☐Y ☐N	Swallowing pain	☐Y ☐N		
Fatigue	☐Y ☐N				
Cardiovascular		**Gastrointestinal**		**Genitourinary**	
Chest pain	☐Y ☐N	Abdomen pain	☐Y ☐N	Frequent Urination	☐Y ☐N
Palpations	☐Y ☐N	Heartburn	☐Y ☐N	Difficulty Urinating	☐Y ☐N
Leg swelling	☐Y ☐N	Nausea	☐Y ☐N	Incontinence	☐Y ☐N
Musculoskeletal		**Skin**		**Endocrine**	
Joint pain	☐Y ☐N	Rash	☐Y ☐N	Increased sweating	☐Y ☐N
Muscle pain	☐Y ☐N	Lesions	☐Y ☐N	Increased thirst	☐Y ☐N
Neurological		**Psychiatric**		**Hematologic/Allergic**	
Trouble walking	☐Y ☐N	Depression	☐Y ☐N	Easy Bleeding	☐Y ☐N
Incoordination	☐Y ☐N	Anxiety	☐Y ☐N	Allergic response	☐Y ☐N
Seizures	☐Y ☐N	Mood swings	☐Y ☐N	Abnormal swelling	☐Y ☐N
		Suicidal thought	☐Y ☐N		

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