

The Anderson Orthopaedic Clinic Spine Center
 2445 Army Navy Drive
 Arlington, VA 22206
 (703) 892-6500

Corey J. Wallach, MD



Patient Name: _____

Referring Physician:

Name: _____
 Specialty: _____
 Address: _____
 Phone: _____

Primary Physician: *Please check if the same*

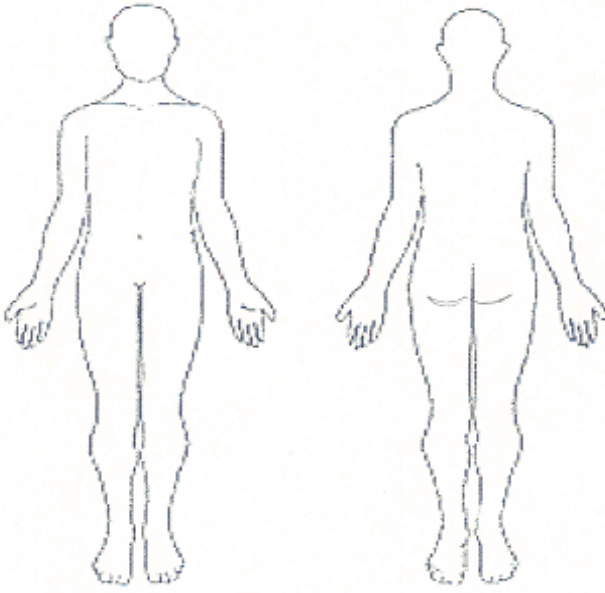
Name: _____
 Specialty: _____
 Address: _____
 Phone: _____

Please check if you **DO NOT** want a consultation letter sent to your physician

Date of Consultation: _____

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

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

	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;"><u>Pain</u> -</td> <td style="text-align: right; padding: 2px;">XXXX</td> </tr> <tr> <td style="padding: 2px;"><u>Numbness</u> -</td> <td style="text-align: right; padding: 2px;">-----</td> </tr> <tr> <td style="padding: 2px;"><u>Tingling</u> -</td> <td style="text-align: right; padding: 2px;">/////</td> </tr> </table>	<u>Pain</u> -	XXXX	<u>Numbness</u> -	-----	<u>Tingling</u> -	/////
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	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Neck or Back Pain:</td> <td style="text-align: right; padding: 2px;">%</td> </tr> <tr> <td style="padding: 2px;">Arm or Leg Pain:</td> <td style="text-align: right; padding: 2px;">%</td> </tr> <tr> <td style="padding: 2px;">Total:</td> <td style="text-align: right; padding: 2px;">100 %</td> </tr> </table>	Neck or Back Pain:	%	Arm or Leg Pain:	%	Total:	100 %
Neck or Back Pain:	%						
Arm or Leg Pain:	%						
Total:	100 %						

Patient Name: _____

On the following scale, please indicate the pain you typically experience, the pain at its most severe, and the pain you are experiencing today-

[no pain] 0 1 2 3 4 5 6 7 8 9 10 [worst pain]

Symptoms:

How long have you experienced these symptoms? _____

When are your symptoms worse? Standing Sitting Lying down No difference

What position, movements, or activities makes your symptoms worse? _____

What activities do your symptoms prevent you from doing? _____

What improves your symptoms? _____

How far can you walk before your symptoms become so severe that you stop? _____

Are your symptoms completely relieved by sitting? Yes No Partially relieved? Yes No

Any recent change in sexual function? Yes No

Any weakness in arms or legs? Yes No

Any decreased or abnormal sensation in arms or legs? Yes No

Any radiating pain in arms or legs? Yes No

Any recent change in bowel or bladder function? Yes No

Any recent change in balance or coordination? Yes No

What treatments have you had so far? None

Type of Treatment

Anti-inflammatory medications

Narcotic medications

Physical Therapy

Chiropractor

Epidural Steroid Injection *How many?* _____

Other? _____

Have they helped?

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

What studies/imaging have you had so far?

Type of study

What dates were these obtained?

X-rays _____

CT scan _____

MRI _____

EMG/NCS _____

Have you seen a spine surgeon before? Yes No

Who? _____

Was surgery recommended? Yes No

Patient Name: _____

Past Medical History

- Diabetes Mellitus
- Hypertension
- Cardiac Disease
- Pulmonary Disease
- Rheumatoid Arthritis
- Osteoporosis
- Other Conditions _____

Past Surgical History

- Prior spine surgery 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
- Neck/Back Conditions If so, what type? _____
- Other: _____

Social History

Occupation _____ Dominant Hand: Right Left
Residence _____ Single Married Divorced
Tobacco use: Yes No How long? _____
Alcohol use: Yes No How frequently? _____

Review of Systems [Please check all that apply]

- | | | | | |
|--|--|---|---|---|
| Constitutional:
<input type="checkbox"/> Fevers
<input type="checkbox"/> Chills
<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Weight Loss/Gain | Eyes & ENT:
<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Double Vision
<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Hoarseness | Cardiovascular:
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Leg Swelling
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Cough
<input type="checkbox"/> Wheezing | Gastrointestinal:
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Abdominal Pain | Genitourinary:
<input type="checkbox"/> Difficulty Urinating
<input type="checkbox"/> Frequent Urinating
<input type="checkbox"/> Other? _____ |
| Psychiatric:
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Mood swings
<input type="checkbox"/> Suicidal Thoughts | Neurological:
<input type="checkbox"/> Difficulty Walking
<input type="checkbox"/> Tingling
<input type="checkbox"/> Incoordination
<input type="checkbox"/> Seizures | Hematological:
<input type="checkbox"/> Easy bleeding
<input type="checkbox"/> Fatigue | Integument:
<input type="checkbox"/> Skin Lesions
<input type="checkbox"/> Rash
<input type="checkbox"/> Other? _____ | Musculoskeletal:
<input type="checkbox"/> Diffuse Joint Pain
<input type="checkbox"/> Focal Joint Pain
<input type="checkbox"/> Muscular Swelling
<input type="checkbox"/> Muscle Pain |