

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

Corey J. Wallach, MD
 Medical Director



Referring Physician:

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

Primary Physician:

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

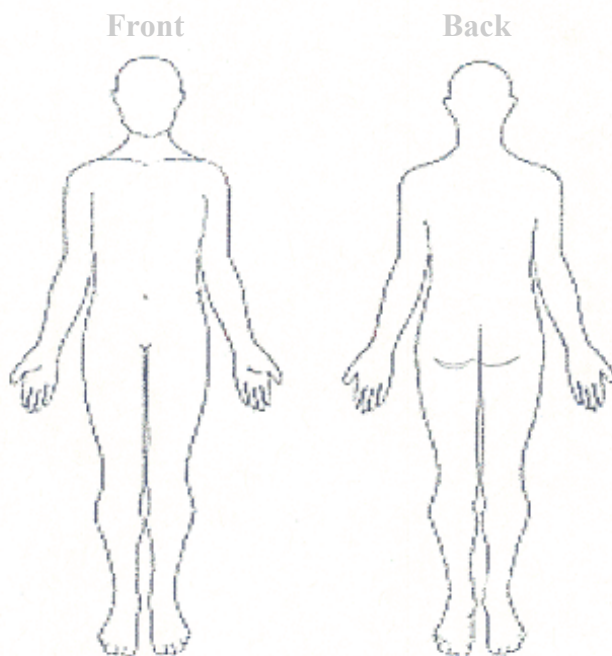
Please check if you **DO NOT** want a consultation letter sent to your physician

Date of Consultation:

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

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

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



<u>Pain</u> -	XXXX
<u>Numbness</u> -	-----
<u>Tingling</u> -	/////

Describe the location of your pain:

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

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

Other? _____

Have they helped?

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

How many? _____

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

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 |