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Mount Sinai Spine Center
Leni & Peter W May
Department of Orthopedic Surgery
5 E 98th St, 4th Floor
New York, NY 10029

**Name**:_____**DOB**:_____
First Last MI

**Primary Care Physician**:_____**Address/Phone**:_____

**Who Referred You?**:_____**Address/Phone**:_____

**Would you like us to contact your Primary or Referring Physician about today's visit? [ ]YES [ ]NO**

**Age**:_____ **Are you [ ] Right or [ ] Left Handed?**

**Gender Assigned at Birth: Male or Female Preferred Pronoun: _____ Gender Identity: _____**

**What is the main problem for which you are seeking treatment?**

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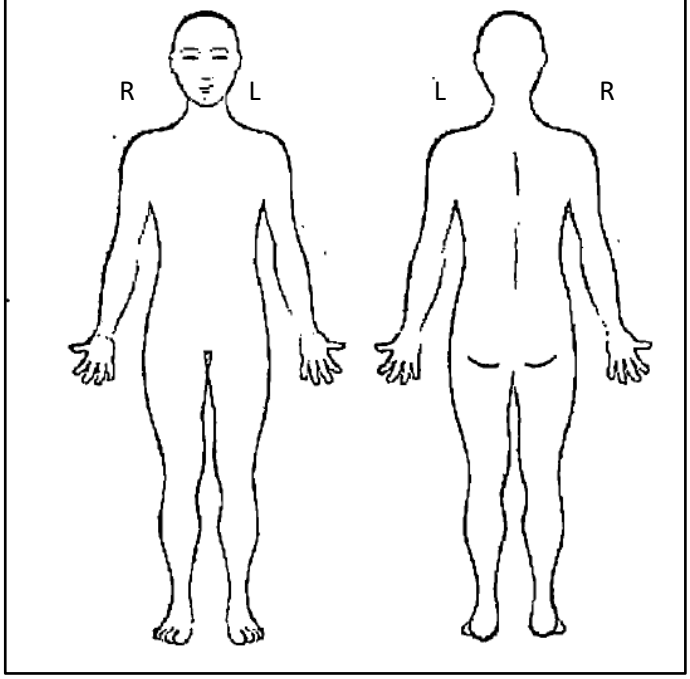
**When did your symptoms begin?**_____

**Did anything bring on your symptoms?**_____

**Please mark the locations of your pain on the diagram**:




**Which of the following best describes your pain ratio?**
[ ] 100% Back/Neck pain
[ ] 75% Back/Neck and 25% Leg/Arm
[ ] 50% Back/Neck and 50% Leg/Arm
[ ] 25% Back/Neck and 75% Leg/Arm
[ ] 100% Leg/Arm pain

**How would you describe the pain? (eg: sharp, burning, electric, cramp, etc)**

**What is the average level of pain over the last month? (0-10)**

**What is your current pain level? (0-10)**

Do you feel you have developed any **weakness or loss of strength in arms or legs**? If so where?

Do you feel you have developed any **numbness/tingling**? If so where?

**What activities or positions make the pain better or worse?**

| | Better | Worse | | Better | Worse |
|---|---|---|---|---|---|
| **Standing** | | | **Bending** | | |
| **Sitting** | | | **Lifting** | | |
| **Walking** | | | **Coughing** | | |
| **Stairs** | | | **General Activity** | | |
| **Lying Down** | | | **Bowel Movement** | | |

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**What have you done to treat this so far?**

**[ ] Physical Therapy (for how long):**
**[ ] Epidurals/Injections (dates; did it help?)**
**[ ] Massage**
**[ ] Heat or Ice:**
**[ ]Chiropractor:**
**[ ]Acupuncture:**
**[ ]Stretching/Yoga:**
**[ ] Other (Please elaborate):**

**[ ] Pain Medications (please list all):**

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Please list any **MEDICAL CONDITIONS** you have (example: high blood pressure, diabetes, heart attack, stents, etc.)

Please list any **SURGERIES** you have had (Spine and any others). Include dates if possible.

Please list any **MEDICATIONS** you take, either daily or as needed. Include doses if known.

Please list any **ALLERGIES** you have. Include reaction if known.

Is there a **history of low back pain or spine problems** in your family?

**SOCIAL/WORK HISTORY**

**Occupation:** _____

**Are you currently?**

**___Working Full time** **___ Working Part time**
**___Unemployed** **___ Retired**
**___Disabled, Temporarily** **___ Disabled, Permanently**
**___ Other _____**

**If you are currently NOT working:**
**How long have you been off work due to your pain?_____**

Do you currently or have you ever **smoked or used tobacco products** (Please include for how many years and how many packs per day)?

Do you consume **alcoholic beverages** (Please include quantity and frequency)?

**Is there anything else you would like to mention before you see Dr. Bronson?**

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**[Please leave this area below blank]**