THE SPINE CENTER
AT ROUND ROCK ORTHOPAEDICS & REHAB

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Specializing in Disorders of the Spine
Fellowship Trained Spine Surgeon

NEW PATIENT INFORMATION FORM

Patient Name: _____

Date: _____ **DOB**: _____

How were you referred to The Spine Center at RROR? ☐ Physician ☐ Patient / Friend ☐ Reputation ☐ Insurance ☐ Advertisement ☐ Other: _____

Referring Physician or Referral Source:_____

Primary Care Physician: _____

Pain Management Physician:_____

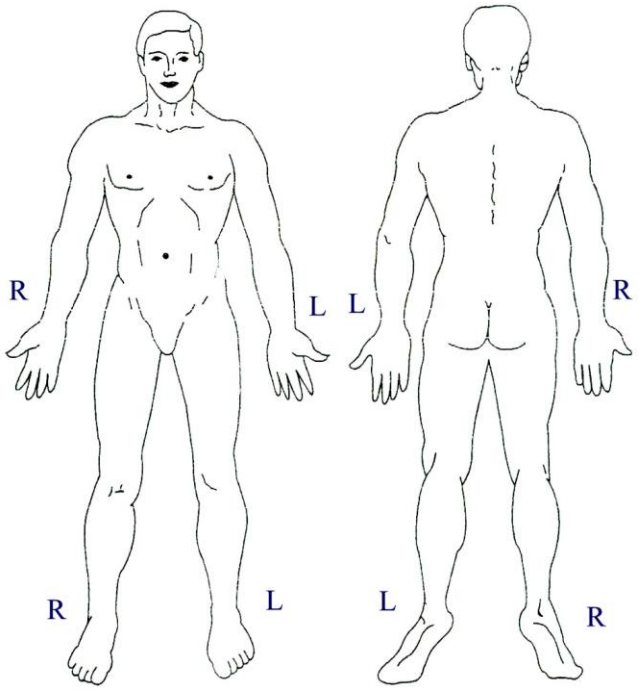
List other physicians with whom you have consulted in the past year for this problem.

_____

ORTHOPAEDIC PAIN CHART

Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas

Numbness =	= = = = = = = = =
Pins & Needles =	0 0 0 0 0 0 0 0 0
Aching = Burning	* * * * * * * * *
Stabbing =	/ / / / / / / / /



Please indicate your pain level by placing a line below with "0" = no pain and "10" = worst pain imaginable

Example: Pain
0 10

Pain at its Worst
0 10

Pain at its Best
(Lying Down, Resting)
0 10

Pain on Average
0 10

1. How long have you had this problem? _____ Since ____ / ____ / _____

2. Briefly, please describe how this problem started & your pain/problem now:

_____

_____

_____

3. Have you had any past episodes of similar pain or injury? □ No □ Yes - (Please Describe):

_____

_____

4. Have you had spine surgery in the past? □ No □ Yes

What type of operation? □ Neck □ Back □ Discectomy □ Laminectomy □ Fusion

□ Other:_____ What spinal level?_____

When was your most recent spine operation? _____

What was the name of your surgeon? _____

Did you improve from your spine operation? □ No □ Yes

5. Have you had any of the following treatments? Please describe.

Medications:_____

Physical Therapy, Chiropractor, Acupuncture, Massage: _____

Spinal Injections:_____ _____

6. Please indicate whether you have had any of the following studies.

	Yes	When/Where		Yes	When/Where
X-Ray	□	_____	CT Scan	□	_____
MRI	□	_____	Myelogram	□	_____
EMG	□	_____	Discogram	□	_____
Bone Scan	□	_____	Bone Density	□	_____