Dr. Brandon A. Ortega

PATIENT INFORMATION

Date: _____
Last Name: _____ First Name: _____ MI ____
Date of Birth (M/D/Y): _____ Age: _____
Gender: ☐ Male ☐ Female ☐ Other

REASON FOR VISIT

Do you have any neck pain? ☐ Yes ☐ No
(If yes, describe) _____

Do you have any mid back pain? ☐ Yes ☐ No
(If yes, describe) _____

Do you have any low back pain? ☐ Yes ☐ No
(If yes, describe) _____

Any pain/numbness/tingling radiating to arms/hands? ☐ Yes ☐ No
(If yes, right/left/both) _____

Any pain/numbness/tingling radiating to legs/feet? ☐ Yes ☐ No
(If yes, right/left/bilateral) _____

Any weakness in the arms/hands? ☐ Yes ☐ No
(If yes, right/left/bilateral) _____

Any weakness in the legs/feet? ☐ Yes ☐ No
(If yes, right/left/bilateral) _____

Date of injury/date of onset? _____

Are symptoms getting better/worse/same? _____

What makes pain better? (laying/sitting/standing/walking) _____

What makes pain worse? (laying/sitting/standing/walking) _____

Difficulty with fine motor tasks? (buttons/keys/typing/writing) ☐ Yes ☐ No
(If yes, describe) _____

Difficulty with balance/coordination? ☐ Yes ☐ No
(If yes, describe) _____

Difficulty controlling bowel/bladder function? ☐ Yes ☐ No
(If yes, describe) _____

PREVIOUS TREATMENT

Have you seen a spine surgeon in the past? ☐ Yes ☐ No
(If yes, describe) _____

Have you had any X-Ray/MRI/CT/EMG/NCV? ☐ Yes ☐ No
(If yes, describe) _____

Have you had any previous treatments? ☐ Yes ☐ No
(If yes, describe) _____

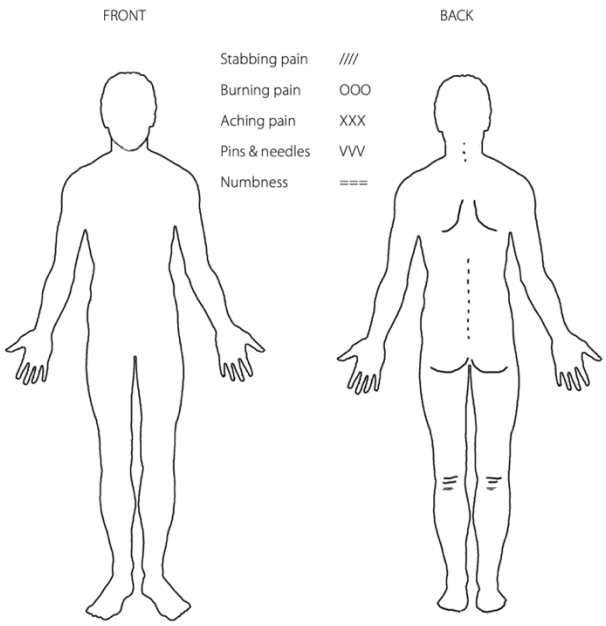
Do you take any pain medication? ☐ Yes ☐ No
(If yes, describe) _____

Have you done any physical therapy/chiropractor? ☐ Yes ☐ No
(If yes, describe) _____

Have you had any injections? (epidural/transforaminal/facet) ☐ Yes ☐ No
(If yes, describe) _____

Have you had any spine surgery? (type/date/surgeon) ☐ Yes ☐ No
(If yes, describe) _____

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



Circle your pain level on a scale of 1 to 10, with 10 being unbearable pain.

1 2 3 4 5 6 7 8 9 10
no pain extreme pain

MEDICAL HISTORY

Do you have any medical problems? ☐ Yes ☐ No
(If yes, describe) _____

Do you have diabetes? ☐ Yes ☐ No
(If yes, what is your HgbA1C) _____

Do you have osteopenia/osteoporosis? ☐ Yes ☐ No
(If yes, when was your last DEXA/Bone Scan) _____

ALLERGIES

Do you have any allergies? ☐ Yes ☐ No
(If yes, describe) _____

Do you have any adverse reaction to anesthesia? ☐ Yes ☐ No
(If yes, describe) _____

FAMILY HISTORY

Do you have any family history of scoliosis/osteoporosis? ☐ Yes ☐ No
(If yes, describe) _____

SOCIAL HISTORY

Occupation: _____

Does your condition affect your ability to work? ☐ Yes ☐ No
(If yes, describe) _____

Do you smoke? (cigarette/marijuana/vape/e-cigarette) ☐ Yes ☐ No
(If yes, how packs per day?) _____

Do you consume alcohol? ☐ Yes ☐ No
(If yes, how many days per week?) _____

Do you exercise regularly? ☐ Yes ☐ No
(If yes, how many days per week?) _____