PATIENT INFORMATION—ORTHO

Today's Date:_____

PATIENT'S LEGAL NAME_____
LAST FIRST MIDDLE DATE OF BIRTH AGE

_____
PRIMARY CARE/FAMILY PHYSICIAN REFERRING PHYSICIAN

Chief Complaint:
Reason for Today's Visit: Date of Injury:

_____

Factors of complaint
Explain circumstances of injury or onset in detail, state accident occurred, & date:
☐ Work comp injury ☐ Automobile accident ☐ Recent injury ☐ Other injury:_____

_____

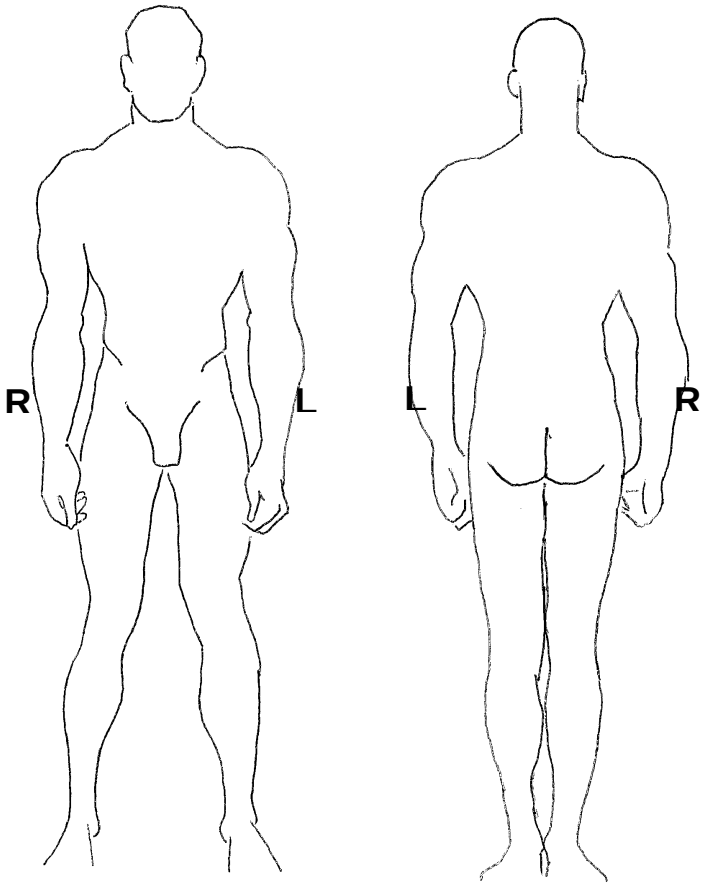
_____

What do you want to happen as a result of this visit?
☐ Discuss surgical options ☐ Discuss non-surgical options ☐ Other:_____

Pain chart
Mark the areas on your body where you find the described sensations using the appropriate symbol from the list below.

Please include all affected areas.

Numbness:	= = = =
Aches:	^ ^ ^ ^
Pins & Needles:	o o o o
Stabbing:	/ / / / /
Burning:	X X X
Cramping:	+ + + +



Prior surgery for this problem: ☐ Yes ☐ No

Time off work due to this problem: ☐ Yes ☐ No
How long? _____

Have you had previous occurrences? ☐ Yes ☐ No

FOR OFFICE USE ONLY

DX: PLAN:	HEIGHT:_____ WEIGHT:_____	B/P:_____ PULSE:_____

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Current pain levels
Please indicate your current pain level by placing an x on the line
"0" = no pain & "10" = worst pain imaginable

Example *0* ____X_____|_____ *10*

How bad is your pain now?

Pain on average *0* _____|_____ *10*
Pain at its worst *0* _____|_____ *10*
Pain at its best *0* _____|_____ *10*

Current pain profile

List anything that increases your pain (ex. temperature changes, activities, positions, etc.):
_____

Family history (Please check all that apply)

- ☐ Scoliosis
- ☐ Spine disease
- ☐ Arthritis
- ☐ Heart disease
- ☐ **No significant family history**
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer_____
- ☐ Bleeding problems
- ☐ Mental illness
- ☐ Alcoholism
- ☐ Kidney disease
- ☐ Other:_____

Tests & treatment (Any previous tests, examinations or treatments for your current condition?) ☐ Yes ☐ No

Medications

Anti-inflammatories	_____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Muscle relaxants	_____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Pain medications	_____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Other(s)	_____	☐ Temporary relief	☐ Lasting relief	☐ No relief

Therapies

Physical therapy	_____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Other(s)	_____	☐ Temporary relief	☐ Lasting relief	☐ No relief

Injections

(i.e. steroid injections, trigger-point injections)

Date_____	Injection type_____	☐ Temporary relief	☐ Lasting relief	☐ No relief
Date_____	Injection type_____	☐ Temporary relief	☐ Lasting relief	☐ No relief

Are you under a doctor's care for any other medical condition? ☐ Yes ☐ No
If yes, please explain _____

Imaging history

Please indicate whether you have had any of the following studies and write when & where the most recent was

☐ Yes ☐ No	Regular x-ray	When_____	Where_____
☐ Yes ☐ No	CT scan	When_____	Where_____
☐ Yes ☐ No	EMG	When_____	Where_____
☐ Yes ☐ No	Bone scan	When_____	Where_____
☐ Yes ☐ No	Myelogram	When_____	Where_____
☐ Yes ☐ No	MRI	When_____	Where_____

Medical history (Please check all current & past medical conditions)

- ☐ Alzheimer's
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart failure
- ☐ Abnormal heart rhythm
- ☐ Lung disease (COPD)
- ☐ Cancer_____
- ☐ Asthma/bronchitis
- ☐ Emphysema
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Thyroid disease
- ☐ Stomach ulcers
- ☐ Irritable bowel
- ☐ CVA/Stroke
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Bleeding disorders
- ☐ Blood clots/DVT
- ☐ Diabetes
- ☐ Anxiety
- ☐ Depression
- ☐ Schizophrenia
- ☐ Alcoholism
- ☐ Seen a psychiatrist
- ☐ AIDS/HIV
- ☐ Sleep apnea (use CPAP? Y or N)

Surgical history

Please list all surgeries you have had:

Type of surgery_____	Date(s)_____
Type of surgery_____	Date(s)_____
Type of surgery_____	Date(s)_____
Type of surgery_____	Date(s)_____
Type of surgery_____	Date(s)_____
Type of surgery_____	Date(s)_____
Type of surgery_____	Date(s)_____

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Current medications (may attach a list) Medication Name	Dose	# per day (SIG)

Allergies (may attach a list) ☐ **No known medical allergies** Substance	Reaction

Review of systems (Please check all that apply) ☐ **No significant history**

General
- ☐ Unexplained weight loss
- ☐ Appetite change
- ☐ Fevers or chills
- ☐ Night sweats
- ☐ Marked fatigue
- ☐ Difficulty sleeping

Lung
- ☐ Morning cough
- ☐ Shortness of breath
- ☐ Productive cough or sputum

Psychiatric
- ☐ Depression
- ☐ Nervous exhaustion
- ☐ Anxiety
- ☐ Paranoia
- ☐ Obsessive/compulsive behavior
- ☐ History of sexual abuse
- ☐ History of physical abuse

Cardiovascular
- ☐ Heart or chest pain
- ☐ Abnormal heartbeat
- ☐ Poor heart function

Neurological
- ☐ Seizures
- ☐ Blackouts/fainting
- ☐ Tremor
- ☐ Headaches/migraines
- ☐ Chronic pain syndrome
- ☐ Fibromyalgia
- ☐ Chronic fatigue syndrome
- ☐ Reflex sympathetic dystrophy
- ☐ Loss of balance
- ☐ Increased clumsiness
- ☐ Difficulty buttoning shirt
- ☐ Dropping things

Skin
- ☐ Easy bruising
- ☐ Swollen ankles

Digestive
- ☐ Nausea or vomiting
- ☐ Stomach pain or ulcers
- ☐ Heartburn/acid stomach
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Uncontrolled loss of stool
- ☐ Blood in stool

Genitourinary
- ☐ Burning on urination
- ☐ Difficulty starting urination
- ☐ Incontinence
- ☐ Pelvic pain
- ☐ Urinate at night more than once
- ☐ Unable to completely empty bladder

Musculoskeletal
- ☐ Joint pain/swelling
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle aches

Social history

☐ Married ☐ Divorced ☐ Significant other ☐ Single ☐ Widow/Widower

Number of children _____

Highest educational level attained ☐ Grade school ☐ High school ☐ College ☐ Post graduate

Do you drink? ☐ Yes ☐ No
Frequency ☐ Heavy ☐ Moderate ☐ Occasionally ☐ Never
Do you smoke? ☐ Yes ☐ No *I quit* (when?_____) *Frequency*_____
Type ☐ Cigarettes ☐ Chew ☐ Cigar ☐ Pipe
Do you exercise? ☐ Yes ☐ No *Frequency*_____

Employment : ☐ Full time ☐ Part time ☐ Student ☐ Disabled ☐ Retired ☐ Unemployed

Occupation:_____ Describe duties:_____

How much weight do you lift?_____pounds