Initial Patient Evaluation

Thank you for taking the time to fill out this form. We use this form to help organize information about your problem. Please fill out as completely as possible.

Name: _____

Today's Date: _____ Referred by: _____

Family Doctor: _____ Date of Birth: _____ Age: _____

Would you like us to send a copy of this report to another health care provider? (Please give the address.)

Family Physician: _____

Other Physician: _____

Other Person(s):_____

Present History: Check Correct Item or Fill In Blank(s)

1. Briefly describe the primary reason you are here to see the doctor:

_____

_____

2. When did the present problem start? (month/day/year) _____

3. If your problem is pain related, complete the following questions. (If not, go on to question 7, page 2.) How did the pain start? (Check appropriate box.)

□ Suddenly	□ Fall	□ Injured at work	□ Injured during sports
□ Gradually	□ Bending	□ Injured in auto accident	□ No apparent cause
□ Lifting	□ Pulling	□ Hit from behind	□ Injured at home

□ Other: (Specify) _____

4. What activities make the pain worse?

□ Exercise (during)	□ Standing	□ Bending backwards	□ At night
□ Exercise (after)	□ Walking	□ Coughing	□ By end of the day
□ Sitting	□ Bending forward	□ Sneezing	

□ Other: (Specify) _____

5. What reduces the pain?

□ Lying down	□ Standing	□ Medication	□ Brace/Corset
□ Sitting	□ Walking	□ Injections for Pain	□ Nothing
□ Manipulation	□ Tens Unit	□ Exercise	□ Physical Therapy

□ Other: (Specify) _____

PATIENT NAME: _____DATE OF BIRTH: _____/_____/_____

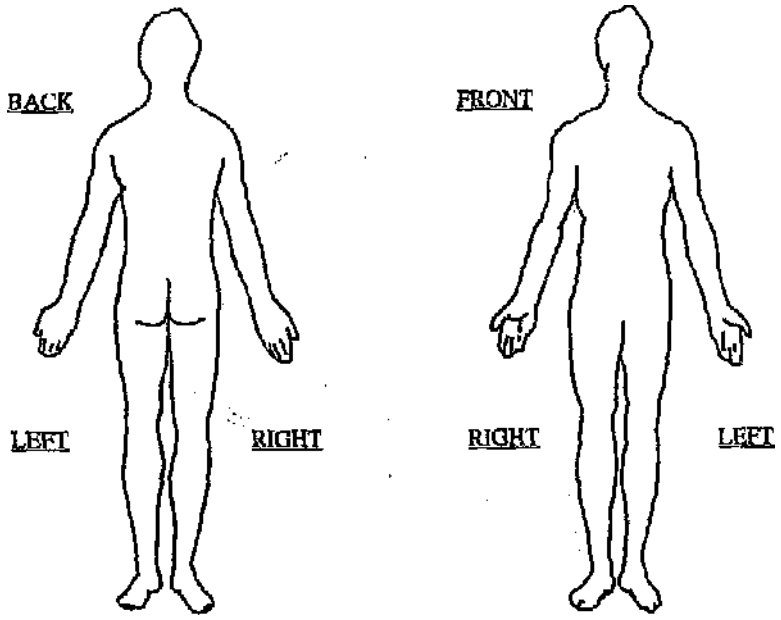
6. My pain is: (Check all that apply)
   - □ Present intermittently (comes and goes)
   - □ Always present but of variable intensity
   - □ Improving

Worsening in that it is:
- □ Present more often
- □ More intense
- □ Changing in character
- □ Changing in location

Where is your pain now?:

Mark the areas on your body where you feel the sensations described above, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw your face.

Aching	Numbness	Tingling	Pins and Needles	Burning	Stabbing
△△△	= = =	000	+++	X X X	/ / /



Pain Rating Scale:

Please make an "X" on the line that corresponds to the area of your body that you feel pain and its severity. Rate how much pain hurts on an average day by placing the "X" along the line from "No Pain" and on the left to "Worse Pain I Can Possibly Imagine" on the right.

	No pain										Worst Pain I Can Imagine
Back Pain	0	1	2	3	.4	5	6	7	8	9	10
Leg Pain	0	1	2	3	4	5	6	7	8	9	10
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Arm Pain	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

PATIENT NAME: _____DATE OF BIRTH: _____/_____/_____

7. What emotional reactions have you had to your current problem? (Check all that apply.)

☐ I have none ☐ I feel like taking my life (suicidal)

☐ I feel nothing matters ☐ I feel blue and no good (depressed)

☐ I feel frustrated/angry ☐ Nothing can help me

I have a history of Psychiatric problems

8. Do you have loss of bowel or bladder control? ☐ Yes ☐ No

9. My weight is : ☐ increasing ☐ decreasing ☐ steady

10. Are there any problems with weak muscles, numbness or pins and needle feeling?

☐ none ☐ generally weak ☐ weak in arms ☐ weak in legs ☐ numbness ☐ pins/needles

11. I have no difficulty with sleep OR I have difficulty with sleep:

☐ Unable to fall asleep ☐ maintaining sleep ☐ waking frequently because of pain

12. Functional activities: I can comfortably

Stand for _____ minutes sit for_____ minutes walk for _____ minutes

I can do the following:

Housework	☐ all	☐ some	☐ none
Leisure activities	☐ all	☐ some	☐ none
Work	☐ all	☐ some	☐ none

13. Have you had any trouble with this problem before ☐ yes ☐ no

When was your FIRST time? _____

14. Have you seen any others doctors for YOUR CURRENT problem? ☐ Yes ☐ No

15. Which of the following treatments have you had for this problem?

Treatment	**Date**	**Doctor's Name**	**Other Information**
Physical Therapy			What was done? Number of Sessions?
Exercise			Are you doing a home exercise program now?
Brace			What type of brace?
TENS Unit			Using now?
Epidural Steroid Injection (cortisone shot in back)	1st 2nd 3rd		Helpful? How Long? Helpful? How Long? Helpful? How Long?
Chiropractic Manipulation			Helpful? How Long?

PATIENT NAME: _____DATE OF BIRTH: _____/_____/_____

16. Test I have had for this problem:

	Date	Where	Result if known
X-rays			
Myelogram			
CT Scan			
Bone Scan			
Magnet Resonance Imagining (MRI)			
EMG			
Discogram			

17. Surgery/Surgeries I have had for this problem:

Date	Surgeon	Helpful (Yes/No)	What was done?

18. Are you currently employed? ☐ Yes ☐ No

Present Employer _____

How long have you worked there? _____

Present Job/Occupation _____

My job duties consist of: _____

My Present job involves : Hours sitting _____ Hours standing _____ Lifting _____ pounds

19. If unemployed or not currently working:

Retired? ☐ Yes ☐ No

On Medical Leave? ☐ Yes ☐ No Since:_____

Laid Off? ☐ Yes ☐ No Since:_____

On Total Disability? ☐ Yes ☐ No Since:_____

Social Security Disability? ☐ Yes ☐ No Since:_____

20. I last worked on: _____

My employer would allow me to return to work with restrictions: ☐ Yes ☐ No

PATIENT NAME: _____DATE OF BIRTH: _____/_____/_____

Past Medical History:

HEALTH HISTORY: (please indicate with a check mark if you have been diagnosed or treated for any of the following)

☐ AIDS	☐ bronchitis	☐ goiter	☐ pacemaker/defibrillator
☐ Acid reflux	☐ cancer	☐ gout	☐ osteoporosis
☐ Alcoholism	☐ chemical dependency	☐ heart attack/heart disease	☐ pneumonia
☐ Anemia	☐ CHF	☐ high blood pressure	☐ seizure disorder
☐ Arthritis	☐ COPD	☐ high cholesterol/lipids	☐ sleep apnea
☐ Asthma	☐ diabetes	☐ kidney disease	☐ stroke
☐ Atrial fibrillation	☐ emphysema	☐ liver disease	☐ thyroid
☐ Bleeding disorder	☐ glaucoma	☐ migraines	☐ ulcers
☐ Blood thinning medications			

INJECTIONS:

Have you been diagnosed with MRSA (Staph)? ☐ Yes ☐ No Were you treated for MRSA? ☐ Yes ☐ No

Have you ever been diagnosed with VRE? ☐ Yes ☐ No Were you treated for VRE? ☐ Yes ☐ No

(Vancomycin Resistant Enterococcus)

SURGERIES: (please list ALL surgeries that you have had)

_____

_____

_____

Have you had breast implant surgery? ☐ Yes ☐ No

(This information is necessary for surgeries that may require you to lie on your stomach)

Have you had any problems related to surgery or anesthesia either before, during or after surgery? ☐ Yes ☐ No

Can you describe the problems you had? _____

_____

Would you accept blood products or blood transfusions if necessary? ☐ Yes ☐ No

CARDIAC PROCEDURES: (please indicate any cardiac procedures or tests and where and when they were done.)

Heart bypass surgery _____

Stents places in coronary arteries _____

Heart catheterizations _____

Stress tests _____

Pacemaker or defibrillator devices _____

ALLERGIES: (please indicate any allergies, the name of the substance and the type of reaction you experienced.

☐ Medications	☐ Iodine
☐ Foods	☐ Soaps
☐ Tapes/Adhesives	☐ Latex
☐ NO KNOWN ALLERGIES	☐ Environmental or Pets

PATIENT NAME: _____DATE OF BIRTH: _____/_____/_____

TOBACCO USE:

☐Never ☐Quit ☐Yes ☐Cigarettes ☐Chew

How many years have you used tobacco and how much per day? For _____ years _____ packs/cans per day

ALCOHOL USE:

☐No ☐Yes How many drinks per week? ☐1-6? ☐6-12? ☐12 or more per week?

History or alcohol or drug abuse/addiction ☐Yes ☐No

EXERCISE/PHYSICAL ACTIVITY: _____

FAMILY HISTORY : (Please indicate with a check mark any diseases that run in your family)

☐Diabetes ☐Rheumatoid Arthritis ☐Bleeding Disorders ☐Heart Disease

☐Osteoporosis ☐Osteoarthritis ☐Blood clots ☐High Blood Pressure

☐Alcohol or drug abuse

Problems with anesthesia _____

MEDICATIONS: (Please list all prescriptions and over the counter medications/supplements) ☐None

_____

_____

_____

_____

_____

Dominant Hand: Right Left

Height: _____

Weight: _____

ORA staff to fill out the following:

P_____ R _____ Temp

PATIENT NAME: _____DATE OF BIRTH: _____/_____/_____

Constitutional	Skin	Eyes	Ears/Nose/Throat	Neuro
Fever ☐	Rashes ☐	Double Vision ☐	Deafness ☐	Stroke ☐
Chills ☐	Lesions ☐	Blurry Vision ☐	Sinusitis ☐	Seizures ☐
Sweats ☐	Scars ☐	Glasses/Contacts ☐	Hoarseness ☐	Headaches ☐
Fatigue ☐	No Complaints ☐	No Complaints ☐	Vertigo/dizziness ☐	Dizziness ☐
Weight Loss ☐				Numbness ☐
No Complaints ☐				Visual Changes ☐
				No Complaints ☐

Cardiovascular		Respiratory	Hematologic	Mental Health
Chest Pain ☐	Short of Breath ☐	Shortness of Breath ☐	Anemia ☐	Depression ☐
Palpitations ☐	when lying flat	Cough ☐	Bruise Easily ☐	Anxiety ☐
Swelling in Hands, ☐	Short of Breath ☐	Coughing Blood ☐	Bleeding ☐	Hallucinations ☐
Feet, and Ankles	with daily activity	Asthma/wheeze ☐	Blood Clots ☐	Sleep Problems ☐
Varicose veins ☐	No Complaints ☐	No Complaints ☐	No Complaints ☐	Mood Swings ☐
No Complaints ☐				

Stomach/GI	Reproductive	Urology	Musculoskeletal	Endocrine
Heartburn ☐	Sexual Dysfunction ☐	Pain/burning with ☐	Fractures ☐	Excessive thirst ☐
Trouble swallowing ☐	Erectile Dysfunction ☐	urination	Sprains ☐	Frequent Urination ☐
Nausea ☐	No Complaints ☐	Incontinence ☐	Swelling ☐	Heat Intolerance ☐
Vomiting ☐		Hesitancy ☐	Arthritis ☐	Cold Intolerance ☐
Abdominal Pain ☐		Blood in urine ☐	Stiffness ☐	Increased Appetite ☐
Diarrhea ☐		No Complaints ☐	No Complaints ☐	Decreased Energy ☐
Constipation ☐				Hair/growth Changes ☐
Blood in Stool ☐				No Complaints ☐
No Complaints ☐				

I have reviewed and fully understand these 6 pages to the best of my ability. I understand this information will become part of my permanent medical record at ORA Orthopedics.

Patient Signature: _____ Date: _____

MD Signature: _____ Date: _____

Form-#354