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Date: _____

Name:_____
Last First M.I.

DOB: _____ **Age:** _____

Please complete this form. Your careful answers will help us to understand your presenting problem and design the best treatment program for you.

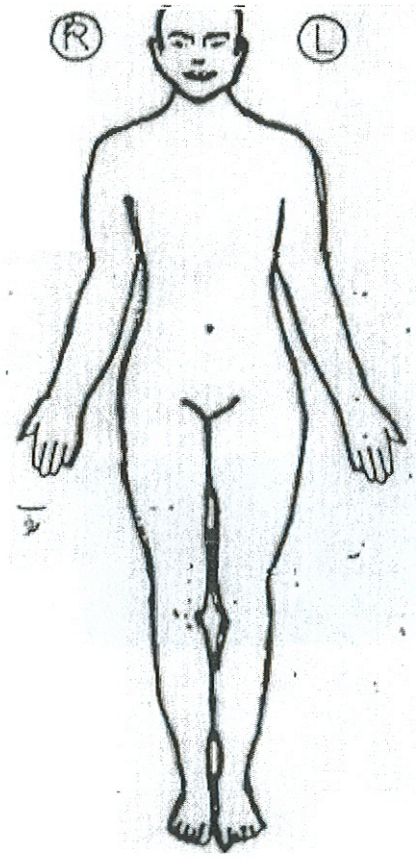
Chief Complaint/Main Problem: _____

When did your current problem start? _____/_____/_____ (month/day/year)

Have you ever had similar problems before? ☐yes ☐no If yes, please explain: _____

USING SYMBOLS BELOW, MARK DRAWING ACCORDING TO YOUR PAIN. INCLUDE ALL AFFECTED AREAS (Please draw in your face):

ache/sore: **>>>**	dull: **DDD**	sharp: **sss**	throbbing: **TTT**	numb: **nnn**
cramping: **ccc**	pressure: **ppp**	tingling: **xxx**	pins/needles: **ooo**	stabbing: **/ / /**
	burning: **BBB**	shooting**: +++**		



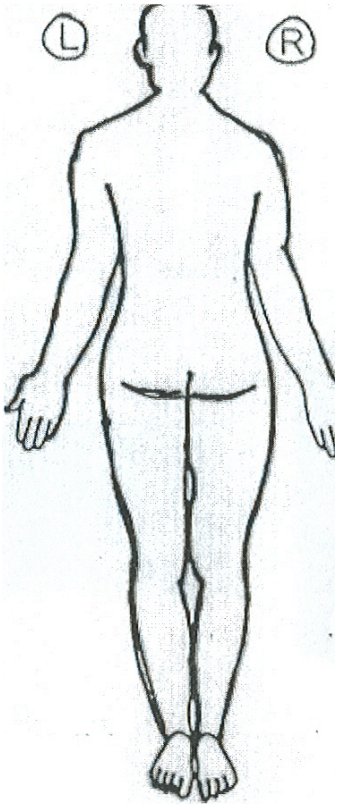
Neck Pain: Circle Severity Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

☐ Neck pain worse than shoulder/arm pain
☐ Neck pain same as shoulder/arm pain
☐ Neck pain less than shoulder/arm pain

Upper Back: Circle Severity Pain Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

Low Back Pain: Circle Severity Pain Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

☐ Back pain worse than hip/leg pain
☐ Back pain same as hip/leg pain
☐ Back pain less than hip/leg pain



FRONT **BACK**

Height: _____

Weight: _____

CHECK/CIRCLE/HIGHLIGHT **ANY** THAT APPLY

ARE YOU GETTING:
☐ Better
☐ Worse
☐ Unchanged

ARE YOU USUALLY IN:
☐ Mild discomfort
☐ Moderate discomfort
☐ Severe discomfort

PAIN IS WORSE IN THE:
☐ Morning (6am – Noon)
☐ Afternoon (1 – 8)
☐ Night (8 pm – 6am)

DOES PAIN COME ON:
☐ Suddenly
☐ Gradually

PAIN IS:
☐ Constant
☐ Good & bad days

Are you working? ☐yes ☐no If not, when did you stop? _____
Is this problem the result of an on-the-job injury? ☐yes ☐no
Do you have an attorney helping you? ☐yes ☐no

Is this problem the result of a motor vehicle accident (MVA)? ☐yes ☐no If yes, please check, circle or highlight one of the following:

MVA/Driver (E812.0) **MVA/Passenger** (E812.1)
Motorcyclist (E810.2) **Motorcycle/Passenger** (E810.3)
MVA vs. Bike (E813.6) **MVA vs. Pedestrian** (E814.7) **Pedestrian Hit By Car** (E812.7)

Is this problem the result of a fall? ☐yes ☐no If yes, please check, circle or highlight one of the following:

At Home (E888.8) **Stairs** (E880.9) **Chair** (E884.2) **Commode** (E884.6)
Sidewalk/Curb (E880.1) **Tree** (E884.9) **Ladder** (E881.0) **Scaffolding** (E881.1)
Snow Skis (E885.3) **Snowboard** (E885.4) **Inline Skate** (E885.1) **Skateboard** (E885.2)
Water Skis (E835.4)

Which <u>INCREASES</u> your pain/discomfort? Please check, circle or highlight.

Standing Sitting Sitting in a soft chair Sitting in a straight chair Rising from sitting
Climbing stairs Walking Pain stops me from walking distances After walking, bending forward relieves pain
Bending forward Bending forward to brush teeth Back gets stuck when I bend forward Forward
bending causes giveway sensation in back My back feels like giving way when I bend forward Bending backward
Lying on back Lying on stomach Lying on side with knees bent Rolling over in bed
Pain wakens me from sleep at night Pain keeps me from sleeping at night Riding in a car
Turning head while driving Looking up Overhead reaching
Working on computer Making the bed Unable to do housework Putting on socks (hose)
Coughing/Sneezing Urination Bowel movement Hurts when I'm tense I have shoulder tip tenderness
Heat Cold

Which <u>DECREASES</u> your pain/discomfort? Please check, circle or highlight.

Standing Sitting Walking Bending forward Bending backward
Lying on back Lying on stomach Lying on side Getting out of bed Rising from sitting
Coughing/Sneezing Urination Bowel movement Driving
Heat Cold

What is the approximate amount of time you can perform the following activities?

Sit _____ minutes Stand _____ minutes Walk _____ minutes

For your current problem, have you had (Please List Dates is Available):

X-rays MRI CT scan Myelogram EMG Bone Scan Discogram

Please check, circle or highlight all of the treatments you have tried for your pain and then check the appropriate column:

	Treatment	Date (approx)	No Relief	Moderate Relief	Excellent Relief
☐	Physical/Occupational Therapy		☐	☐	☐
☐	Heat/Ice		☐	☐	☐
☐	Traction		☐	☐	☐
☐	Injections (epidural, facet, etc.)		☐	☐	☐
☐	TENS – Electrical Stimulator		☐	☐	☐
☐	Ultrasound		☐	☐	☐
☐	Brace or collar		☐	☐	☐
☐	Massage		☐	☐	☐
☐	Psychotherapy - Biofeedback		☐	☐	☐
☐	Chiropractic		☐	☐	☐
☐	Dorsal Column Stimulator		☐	☐	☐
☐	Morphine Pump		☐	☐	☐
☐	Other _____		☐	☐	☐

PAST MEDICAL HISTORY: Check, circle or highlight any illnesses you currently have, or have had in the past.

Lung Cancer (V10.00) **Breast Cancer** (V10.3) **Pancreas Cancer** (V10.88) **Prostate Cancer** (V10.46)

Colon Cancer (V10.5) **Ovarian Cancer** (V10.45) **Cervical/uterine Cancer** (V10.41)

Skin/melanoma (V10.82) **Multiple myeloma** (203.0) **Other Cancer _____**

Adverse drug reaction (995.2) **Anemia** (285.9) **Bleeding disorder** (286) **Blood clots** (V12.51)

Transfusions **Sickle Cell** **Elevated lipids** (272.4) **High cholesterol** (272.0)

Hypertension (401.9) **Heart attack** (410.90) **Arrhythmia** **Other heart disease**

Afibrillation (427.31) **CHF** (428.02) **CHF on anticoagulants** (V58.61) **Stroke** (431)

Seizures (780.39) **Asthma** (493.9) **Emphysema** (492.8) **TB**

Depression (311) **Stress** (308.0) **Insomnia** (780.51) **Sleep apnea**

Drug/Alcohol Dependency **HIV** (042) **GERD/Reflux** (530.81) **Gastric ulcer** (V12.71)

Irritable bowel (564.1) **Bowel dysfunction** (564.89) **Nausea/vomiting** (787.02) **Obesity** (278.00)

Low thyroid (244.9) **Elevated thyroid** (242.8) **Elevated liver tests** (790.4) **Hepatitis** (573.3)

Bell's palsy **Headache** (784.0) **Glaucoma** **Psoriasis** (696.1)

Shingles (053.9) **Osteoarthritis** (715.9) **Osteoporosis** (733.00) **Osteopor. FX** (733.13)

Rheumatoid arthritis (714.0) **Drop foot** (736.79) **Kyphotic deform.** (737.41) **Lupus** (710.0)

Scoliosis **Sjogren's syndrome** **Tailbone Pain** (724.79) **Ankylosing spondylitis** (720.0)

Carpal tunnel **Gout** (274.0) **Hip, bursitis** (726.5) **Abnormal gait** (781.2)

Renal failure (586) **Dialysis** (V45.1) **UTI** (599.0) **Urinary incontinence** (788.30)

Abnormal urination (788.69) **Insulin dependent diabetes** (250.1) **Non-insulin dependent diabetes** (250.0)

Diabetic neuropathy (250.60) **Diabetes for how long?_____**

Other _____

_____

None of the above:_____

Past Injuries:_____

PAST SURGICAL HISTORY: Check, circle or highlight all that you have had.

Tonsils/Adenoids **Appendectomy** **Gallbladder** **Hysterectomy**

Vasectomy **Hernia** **Prostate** **Bladder Suspension**

Heart Surgery **Pacemaker** (V45.01) **D-fib** (V45.02) **Coronary Bypass #_____**

Cataracts **Prostate** **Biopsies of _____**

Cancer _____ **Due to motor vehicle accidents**

Back Surgery: **Discectomy/Laminectomy/Fusion** **#_____** **Date of last _____/_____/_____**

Neck Surgery: **Discectomy/Laminectomy/Fusion** **#_____** **Date of last _____/_____/_____**

Fracture Repair **Joint Replacement:** **Hip (L) (R)** (V43.64) **Knee (L) (R)** (V43.65)

Transplant: **Heart** (V42.1) **Heart valve** (V42.2) **Kidney** (V42.0) **Liver** (V42.7) **Lung** (V42.6)

Other _____

MEDICATIONS: Circle any medications you are currently taking.

Antibiotics or Sulfa drugs Anticoagulants (blood thinners) High Blood Pressure Cortisone (steroids)

Tranquilizers Aspirin Insulin, Tolbutamide (Orinase) or Similar drug Digitalis or drugs for heart trouble

Nitroglycerin Hydrocodone/Norco Vicodin/Lortab Soma

Flexeril Robaxin Tylenol Antidepressants Other:

_____

ALLERGIES: Circle any allergies that you have.

No known drug allergies Anti-Inflammatories Local Anesthetics Anesthetic (V14.4)

Penicillin (V14.0) Other antibiotic(V14.1) Aspirin (V14.6) Codeine (V14.5)

Morphine (V14.5) Hydrocodone (V14.5) Sulfa drugs Asthma or Hayfever

Barbiturates, Sedatives or Sleeping Pills Iodine – shellfish Demerol "Mycins" Ceclor

Robaxin Bextra Vioxx Celebrex

Other _____

Food Allergies/Intolerance:_____

CHILDHOOD ILLNESSES: Circle all that apply

Rheumatic fever Measles Mumps Chicken Pox

Scheurmann's Disease Juvenile Rheumatoid Arthritis Growing Pains

Osgood-Schlatter's Disease Spondylolisthesis

Other:_____

DIET: Regular Other:_____

SOCIAL HISTORY:

Marital Status: Single Married Widowed Divorced

Do you smoke cigarettes? Yes No Former smoker Packs/Day _____ # of Years _____

Do you dip/chew tobacco? Yes No

Do you drink alcohol? Yes No Drinks/Week _____

Occupation _____ Highest Education Level _____

Is your job ☐ sedentary ☐ light ☐ medium ☐ heavy?

Are you ☐ right ☐ left handed?

FAMILY HISTORY: (Circle all that apply)

Mother Alive Father Alive Adopted Brothers & Sisters Alive

Grandparents Alive Relatives with Orthopedic Problems

TB Diabetes Mellitus Heart Problems Cerebral Vascular Accident

Arthritis Cancer Hypertension

Other: _____

ORTHOPEDIC FAMILIAL RELATIONSHIPS: (Circle all that apply)

Skeletal Dysplasia Achondroplasia Morquio Pseudoachondroplasia

Diastrophic dwarfism Spondyloepiphyseal dysphasia congenital

CONNECTIVE TISSUE DISEASE: (Circle all that apply)

Marfan's Ehlers-Danlos Osteogenesis imperfecta Homocystinuria

CHROMOSOMAL: (Circle all that apply)

Down's syndrome Turner's Syndrome Noonan's Syndrome

NEUROMUSCULAR: (Circle all that apply)

Duchenne's muscular dystrophy Charcot-Marie Tooth Arthrogryposis multiplex

MISCELLANEOUS PROBLEMS WITH ORTHOPEDIC SIGNIFICANCE: (Circle all that apply)

Sickle cell disease Thrombocytopenia Hemi-hypertrophy

Pseudocholinesterase deficiency Malignant hyperthermia

BONE MINERAL: (Circle all that apply)

Rickets Osteoporosis Paget's

ARTHRITIS: (Circle all that apply)

Rheumatoid arthritis Gout Ankylosing spondylitis Chondrocalcinosis Bone Cancer

NEUROLOGIC PROBLEMS: (Circle all that apply)

Multiple sclerosis Alzheimer's Disease Bipolar syndrome

Are there any peculiar diseases in your family that you would like to mention: _____

RECREATIONAL ACTIVITIES/EXERCISE/STAYING PHYSICALLY FIT:

Running Walking Cycling Golf Yoga Treadmill Elliptical Machine

Weightlifting Aerobics class Other_____

REVIEW OF SYSTEMS: Circle all symptoms that apply to you from each of the 14 categories.

1. Constitutional	Night Sweats Fever/Chills Weight loss/gain _____lbs. in last yr	None
2. Eyes	Visual Changes Glasses/Contacts	None
3. Ears, Nose, Throat	Hearing Problem Sore Throat Cold Sinus Allergies	None
4. Cardiovascular	Chest Pain Palpitations Leg Swelling Calf Cramps with Walking	None
5. Respiratory	Short of Breath Wheezing Frequent Cough Coughing up Blood	None
6. Gastrointestinal	Ulcer Bowel/Bladder Control Problem Diarrhea Vomiting	None
7. Genitourinary	Incontinence Burning While Urinating Blood in Urine Kidney Stones	None
8. Sexual Function	Impotence Painful Intercourse Not Sexually Active	None
9. Musculoskeletal	Backache Joint Stiffness Joint Swelling Joint Pain	None
10. Integumentary	Rash Hair Problem Nail Problem	None
11. Neurological	Headaches Fainting Memory Loss Tingling/Numbness	None
12. Psychiatric	Depression Nervousness Personality Change Previous Psych Care	None
13. Endocrine	Excessive Urination Excessive Thirst Intolerance to Heat/Cold	None
14. Hematologic/Lymphatic	Abnormal Bleeding Anemia	None
15. Allergic/Immunologic	Immunization Problems Allergy Shots	None

Primary Care / Attorney Contact Info

Name:

Address:

Email:

Fax:

Please do NOT write below this space

Physician has reviewed the form and acknowledges the findings:

_____

Kern Singh, MD (Signature)