



ST GEORGE ORTHOPEDIC SPINE

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Patient Name: _____

Age: _____ Date of Birth: _____ Sex: _____ Visit Date: _____

Emergency Contact

Name _____ Relation: _____

Do you have an Advanced Care Plan: Yes No
If yes please provide a copy for our records

Surrogate Decision Maker - a person able to make medical decisions on your behalf

Name _____ Relation: _____

OFFICE USE ONLY

BP _____ / _____ Pre 120-139/80-89 High 140/90
 Plan: PCP Cadrio DX Hypertension
 P _____ Temp _____
 HT _____ WT _____
 SMK Never Current Past
 FLU Current Not Current

About Your Pain
 Briefly describe your current complaints for which you are seeking treatment?

Is your pain related to:

Work Comp Auto Accident Other

Date of injury: _____

When did the problem start:

Weeks: _____ Months: _____ Years: _____

Other:

Where do you have pain? Mark all that apply

<input type="checkbox"/> Abdomen	<input type="checkbox"/> Headaches	<input type="checkbox"/> Mid Back
<input type="checkbox"/> Buttocks	<input type="checkbox"/> Hip	<input type="checkbox"/> Neck
<input type="checkbox"/> Chest Wall	<input type="checkbox"/> Knee	<input type="checkbox"/> Pelvic
<input type="checkbox"/> Foot	<input type="checkbox"/> Legs	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Hand/Fingers	<input type="checkbox"/> Low Back	<input type="checkbox"/> Wrist
<input type="checkbox"/> I Hurt Everywhere	<input type="checkbox"/> OTHER	

Pain Quality – How would you describe the pain
 (Mark as many adjectives as are applicable)

<input type="checkbox"/> Aching	<input type="checkbox"/> Numbness	<input type="checkbox"/> Shooting
<input type="checkbox"/> Burning	<input type="checkbox"/> Pins/Needles	<input type="checkbox"/> Stabbing
<input type="checkbox"/> Cramping	<input type="checkbox"/> Pressure	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Cutting	<input type="checkbox"/> Sharp	<input type="checkbox"/> Weakness
<input type="checkbox"/> Dull	<input type="checkbox"/> OTHER	
<input type="checkbox"/> Electric Like		

Timing of Pain – How often do you have your pain (mark one)

Constantly (100% of the time) Frequently (75% of the time)
 Intermittently (50% of the time) Occasionally (25% of the time)

Rate Your Intensity

Circle the one number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

Since the onset of symptoms, has the problem

Improved Worsened Stayed the same

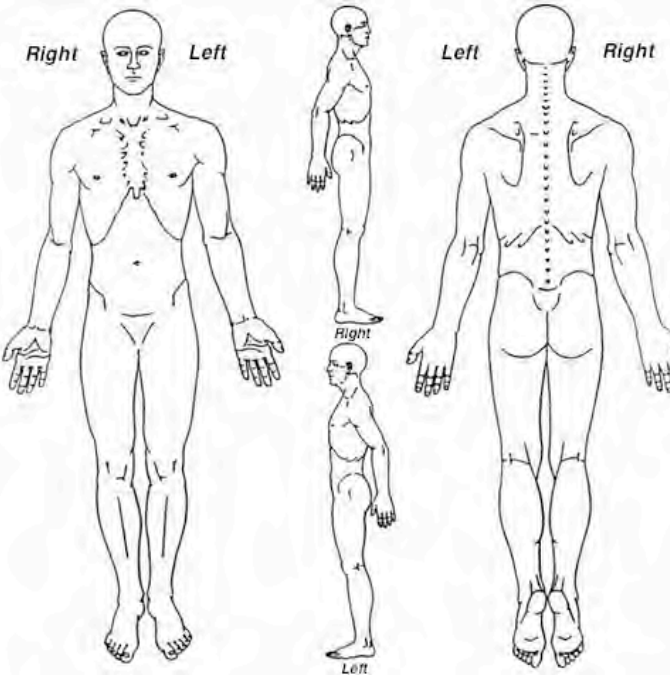
Have you had any new or recurrent problems with:

Control of urination: YES NO Bowel movements: YES NO

Have you experienced recent weight loss or fevers? YES NO

PLEASE MARK WHERE YOU HAVE PAIN
 Mark all that apply

▼ ▼ ▼ ▼ ▼ ▼ ▼ ▼



Functional Limitations – During the past few, indicate to what degree your condition has interfered with your daily activities (work, household chores, yard work, shopping, recreation, driving, sleeping, self care):
 Not at all Minimally Moderately Greatly Severly

Endurance

How many blocks can you walk before having to stop secondarily to pain? _____ blocks.
 How long can you stand before you have to sit down? _____ minutes.

Relieving and Aggravating Factors – How do the following affect your pain (please mark one for each item)

Condition	Improves	Worsens	No Change
Coughing/Sneezing			
Exercise (if applicable)			
Lifting			
Lying Down			
Medication			
Relaxation			
Sitting			
Standing			
Urination / Bowel Movements			
Walking			

Previous Treatments - Please check all of the treatments you have tried for your pain:

Treatment	Date (approx)	Excellent Relief	Moderate Relief	No Relief
<input type="checkbox"/> Anti-Inflammatory/NSAIDS				
<input type="checkbox"/> Back Brace				
<input type="checkbox"/> Chiropractic				
<input type="checkbox"/> Exercise				
<input type="checkbox"/> Hospitalization				
<input type="checkbox"/> Pain Medications				
<input type="checkbox"/> Physical Therapy				
<input type="checkbox"/> Steroid/Epidural Injections				
Steroid/Epidural Injections - Doctor:		Spinal Levels\Location(s):		
<input type="checkbox"/> Other:				

REQUIRED List Allergies NONE

Medications – please list ALL medications you are currently taking:

Name of Medication	Dosage	Frequency

Medical History:

Have you had any of the following health problems? (Please mark all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures or Epilepsy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Psychiatric Problems | |

Please explain any medical conditions circled above:

Other (please specify):

Surgery Type	Approximate Date

Previous Diagnostic Studies – please indicate approximate date and result if known:

MRI: _____ X-Rays: _____

CT: _____ EMG: _____

OTHER: _____

Review of Systems Please mark any of the following signs or symptoms that you are currently experiencing:

- | | | |
|--|--|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Double or Blurred Vision | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Drowsiness | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Palpitations (fast heart) |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Feeling depressed | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fever or Chills | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Joint Pain (knee, hip, etc) | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Loss of interest in hobbies | <input type="checkbox"/> Trouble Walking |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Low Platelet Count | <input type="checkbox"/> Unplanned Weight Loss/Gain |
| <input type="checkbox"/> Difficulty remaining asleep | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Urinary Retention |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Muscle Loss | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Muscle Pain | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> NONE OF THE ABOVE |

Family History:

Have any blood relatives had any of the following health problems? (Please check all that apply)

Health Problem	Parent	Sibling	Health Problem	Parent	Sibling
Anesthesia Problems			Heart Disease		
Arthritis			High Blood Pressure/Hypertension		
Asthma			High Lipids		
Back Pain			Migraines		
Blood Disease			Psychiatric Problems		
Cancer			Stroke		
Diabetes			Suicide		
Genetic Problems			Thyroid Problems		
Gastrointestinal Disease			OTHER:		
Genitourinary			OTHER:		

Substance Abuse

Do you drink alcohol? Yes No If yes how often: _____

Do you have a history illicit drug use? Yes No

If yes, which ones? _____

Do you currently smoke cigarettes or use tobacco? Yes No

How many years have you or did you smoke? _____ years

How many packs per day do you or did you smoke? _____ packs per day

Have you quit using tobacco, and if so when? _____

Employment

Current Employment Status – please mark all that apply

<input type="checkbox"/> Employed Full Time	<input type="checkbox"/> Employed Part Time	<input type="checkbox"/> Temporarily Disabled
<input type="checkbox"/> Permanently Disabled	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Homemaker
<input type="checkbox"/> Retired	<input type="checkbox"/> Student	<input type="checkbox"/> Unemployed Due to Pain

Family Life

<input type="checkbox"/> Living Alone	<input type="checkbox"/> Living With Friends	<input type="checkbox"/> Living With Children
<input type="checkbox"/> Living With Spouse/Partner	<input type="checkbox"/> Living With Spouse/Partner and Children	<input type="checkbox"/> Other: