Shoreline Orthopaedics

Spine/Physiatry Initial Eval

Patient Name_____ **DOB**_____ **Date**_____

To help us meet your healthcare needs, please complete this form in its entirety. This is a confidential record of your medical history and will not be shared without your authorization.

Reason for Today's Visit:

Date of onset or injury ___/___/_____ **What side is affected?** ☐ **Left** ☐ **Right** ☐ **Both** ☐ **N/A**

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

_____

_____

Present History

How did the pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ Other (specify below)
- ☐ Fall
- ☐ Bending
- ☐ Pulling
- ☐ Injured at Work
- ☐ Injured in auto accident
- ☐ Hit from behind
- ☐ Injured during sports
- ☐ No apparent cause
- ☐ Injured at home

If other, please specify:_____

What activities make the pain worse?

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Bending forward
- ☐ Bending Backward
- ☐ Coughing
- ☐ Sneezing
- ☐ At night
- ☐ By the end of the day
- ☐ Other (Specify below)

If other, please specify:_____

What reduces the pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Manipulation
- ☐ Exercise-Physical Therapy
- ☐ Medication
- ☐ Injections for pain
- ☐ TENS Unit
- ☐ Brace/Corset
- ☐ Nothing
- ☐ Other (Specify below)

If other, please specify: _____

Do you have any emotional reactions to your current problem? ☐ Yes ☐ No

If yes, what are the emotional reactions you have related to your current problem?

- ☐ I feel nothing matters
- ☐ I feel frustrated
- ☐ I feel angry
- ☐ I feel like taking my own life (suicidal)
- ☐ I feel sad (depressed)
- ☐ Nothing can help me

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Pain

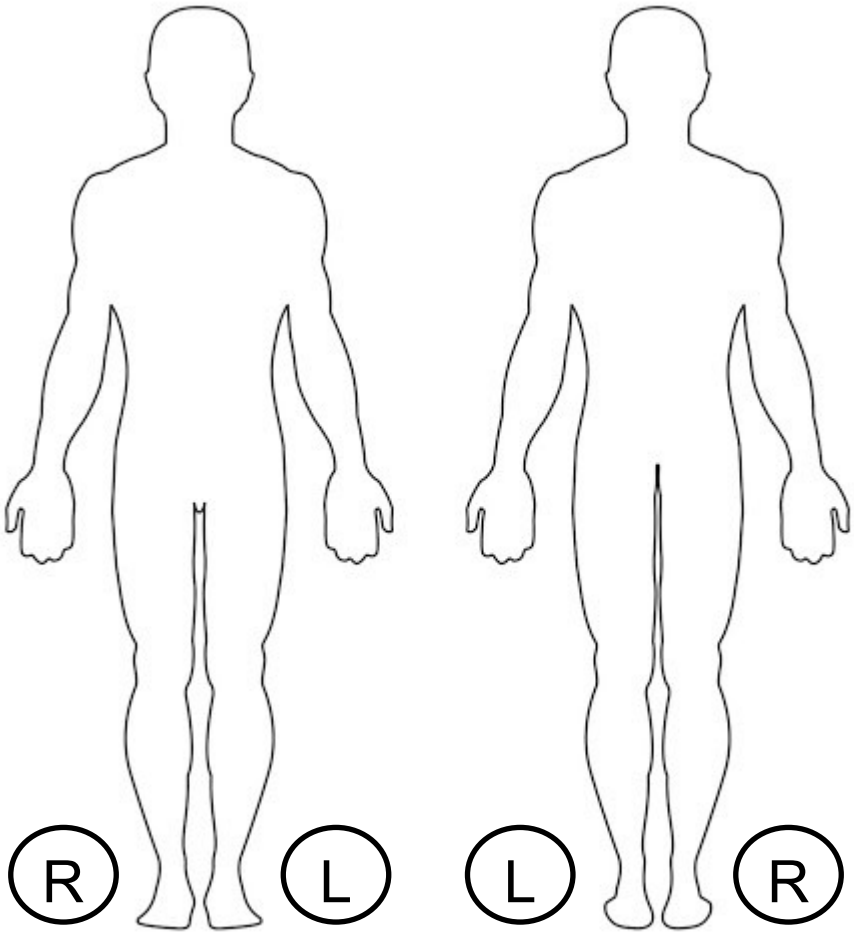
My pain is:

- ☐ Present intermittently
- ☐ Worse-preset more often
- ☐ Present but varies in intensity
- ☐ Worse-more intense
- ☐ Improving
- ☐ Worse– changing in character
- ☐ Worse– changing in location

Please mark the severity of pain that corresponds to the area of your body. Rate how much pain hurts on an average day.

	None 0	1	2	3	4	5	6	7	8	9	10 Worst
Back Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Leg Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arm Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Mark the areas on your body where your feel the sensations described above, using the appropriate symbol. Mark the areas to which your pain spreads.



- ✓ Stabbing
- ● Tingling/Numbness
- + Pins and Needles
- ■ Aching
- ✕ Burning

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Do you have loss of bowel and bladder control? ☐ Yes ☐ No

My weight is: ☐ Increasing ☐ Decreasing ☐ Steady

Area there any problems with weak muscles? ☐ None ☐ Weak in arms ☐ Weak in legs ☐ Generally Weak

Sleep Pattern: ☐ No difficulty with sleep ☐ Unable to fall asleep ☐ Can't maintain sleep ☐ Wake frequently due to pain

Functional Activities

	1 min	5 min	10 min	15 min	20 min	30 min	45 min	1 hour	2+ hours
I can comfortably sit for	☐	☐	☐	☐	☐	☐	☐	☐	☐
I can comfortably stand for	☐	☐	☐	☐	☐	☐	☐	☐	☐
I can comfortably walk for	☐	☐	☐	☐	☐	☐	☐	☐	☐

Daily Activites

I can do ____ of my housework ☐ All ☐ Some ☐ None
I can do ____ of my leisure activities ☐ All ☐ Some ☐ None
I can do ____ of my work ☐ All ☐ Some ☐ None

My sex life is

☐ Normal with no pain
☐ Normal with some pain
☐ Nearly normal, but painful
☐ Severely restricted by pain
☐ Nearly absent because of pain
☐ Absent, pain prevents any sex

Do you have any difficulty with sexual function? ☐ Yes ☐ No ☐ N/A

Have you had any trouble with this problem before? ☐ Yes ☐ No If yes, when was the first time? ___/___/____

Past Treatment for this Problem

Have you seen any other doctors for your current problem? ☐ Yes ☐ No
If yes, list their name and date seen: _____

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

☐ Physical Therapy
☐ Home exercise program
☐ Brace
☐ TENS Unit
☐ Epidural Steroid Injection
☐ Chiropractic Manipulation
☐ N/A– no prior treatment

If you answered yes to any of the past treatments listed above , please provide additional details on the next page. If you have had any prior treatment for this problem please continue to the next section.

Past Treatment for this Problem

Physical Therapy ____/____/_____ Where? _____ # of Sessions _____

If you did physical therapy, what was done and was it helpful? _____

_____

Exercise ____/____/____ Are you currently doing home exercises? ☐ Yes ☐ No

Brace ____/____/____ If yes, what type of brace? _____

TENS Unit ____/____/____ Are you currently using TENS Unit? ☐ Yes ☐ No

Epidural Steroid Injection ____/____/____ Was it helpful and how long did it last? _____

Epidural Steroid Injection #2 ____/____/____ Was it helpful and how long did it last?_____

Epidural Steroid Injection #3 ____/____/____ Was it helpful and how long did it last? _____

Chiropractic Manipulation ____/____/____ Was it helpful and for how long? _____

If yes to any injections or chiropractic manipulation, provide the doctor's name:

_____

Past Testing for this Problem

What tests have you had done for your problem?

☐ X-ray ☐ Myelogram ☐ CT ☐ Bone Scan ☐ MRI ☐ EMG ☐ Discogram ☐ N/A

If you have had any of the tests listed above, please provide additional details if you know them.

X-ray ____/____/____ Where? _____ Results: _____

Myelogram ____/____/____ Where? _____ Results: _____

CT ____/____/____ Where? _____ Results: _____

Bone Scan ____/____/____ Where? _____ Results: _____

MRI ____/____/____ Where? _____ Results: _____

EMG ____/____/____ Where? _____ Results: _____

Discogram ____/____/____Where? _____ Results: _____

Surgery

Have you had surgery for this problem? ☐ Yes ☐ No

If yes, please list surgeon, if it was helpful, and what was done. _____

_____

Have you had breast implants? (necessary for surgeries that require you to lie on you stomach) ☐ Yes ☐ No

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

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Employment Status

Are you currently employed? ☐ Yes ☐ No **Present Employer: _____**

What is your occupation? _____ How long have you worked there? _____

My present job consists of: ☐ Ladders ☐ Lifting ☐ Sitting ☐ Standing ☐ Stairs ☐ Walking

Other Job Duties: _____

Per work day, how many hours do you sit? ☐ <1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ >8

Per work day, how many hours do you stand? ☐ <1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ >8

How man pounds do you lift for your job? ☐ <15lbs ☐ 15-25lbs ☐ 25-40 lbs ☐ 40-60lbs ☐ >60lbs

Would your employer allow you to return to work with restrictions? ☐ Yes ☐ No

If unemployed or currently not working, please provide a date for at least one of the following:

Retired on ____/____/____ **Total Disability** ____/____/____

Medical leave began ____/____/____ **Social Security Disability** ____/____/____

Laid Off ____/____/____ **When did you last work?** ____/____/____

Social History

What sports, exercise activity, or hobbies do you participate in? _____

_____

Do you live alone or as the only adult in the house? ☐ Yes ☐ No

Form Completion

This form was completed by: ☐ Patient ☐ Parent ☐ Guardian ☐ POA ☐ Family Member ☐ Other

I have reviewed and fully completed these forms to the best of my ability. I understand this information will become part of my permanent record at Shoreline Orthopaedics.

X_____Date: _____/_____/_____