INTERVENTIONAL SPINE & SPORTS MEDICINE P.C.

MIDDLEBURY EDGE
1579 STRAITS TPK, LOWER LEVER
MIDDLEBURY, CT 06762

POND PLACE
166 WATERBURY ROAD, SUITE 204
PROSPECT, CT 06712

Patient Name: ______________________________ Date: __________

Age:________ D.O.B:____________ Date of Appointment: __________

☐ Right Handed ☐ Left Handed

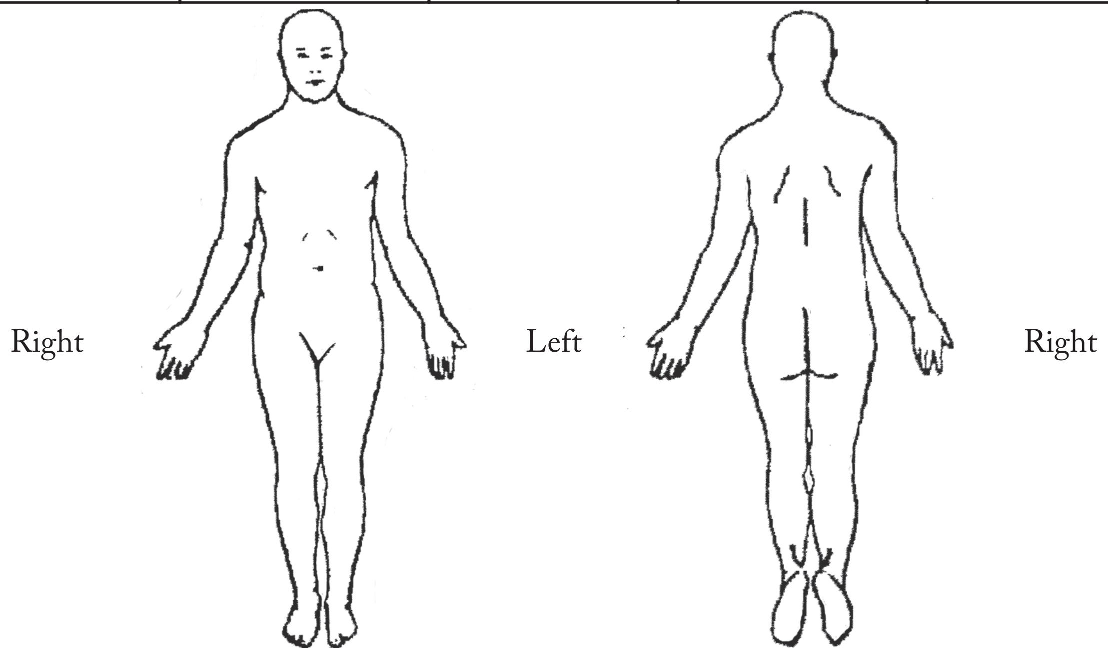
Height _______ Weight_______ Pulse_______ Respiration_______

PAIN DRAWING

Instructions:

Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc. Please indicate which sensations you feel by referring to the key below.

//// Stabbing	XXXX Burning	0000 Pins & Needles	===== Numbness	++++ Aching



Pain Level: 0 1 2 3 4 5 6 7 8 9 10
(Circle your current pain level)

0	**No Pain**
1	**Mild Pain; you are aware of it, but it doesn't bother you**
2	**Moderate pain that you can tolerate without medication**
3	**Moderate pain that requires medication to tolerate**
4-5	**More severe pain; you being to feel antisocial**
6	**Severe pain**
7-9	**Intensely severe pain**
10	**Most severe pain; it may make you contemplate suicide**

1. List all physicians, physical therapists and chiropractors you have consulted for your present conditions.

____

____

2. Have you had any of the following studies? (Please Check)
   - ☐ Regular X-Rays
   - ☐ CT Scan (Short Tube)
   - ☐ MRI (Long Tube)
   - ☐ EMG (Nerve/Muscle Test)
   - ☐ Myelogram
   - ☐ Discogram
   - ☐ Bone Scan
   - ☐ Other ______________

3. Date of injury or symptom onset: _____/_____/_____

4. Is this a:
   - ☐ Work related injury
   - ☐ Injury related to a motor vehicle accident
   - ☐ Sports related injury
   - ☐ Unrelated to any particular incident
   - ☐ Other ______________

5. Briefly describe how the injury or symptoms occurred:

____

____

____

6. If you suffered any other injuries at the time you injured your neck, back or joints, please describe:

____

7. If you have suffered neck, back or joint problems <u>prior</u> to this episode, please describe:

____

8. What is your occupation? ____

9. Are you currently working? ☐ Yes ☐ No

10. Date last worked: _____/_____/_____

____

11. What is the longest amount of time you missed from work with your worst episode? ________________________

12. How much time have you missed from work in the past 12 months? ____

13. If you are not working now, do you ever see yourself: (Check one or more)
    - ☐ Returning to the same job
    - ☐ Modifying your work
    - ☐ Changing jobs - different employer
    - ☐ Retraining or returning to school
    - ☐ Applying for early retirement or long term disability benefits

14. Is there an upcoming workman's compensation hearing? ☐ Yes ☐ No Upcoming litigation? ☐ Yes ☐ No

15. Recently are your symptoms: ☐ Worse ☐ Better ☐ Same

16. Have you experienced numbness or tingling in your limbs? ☐ Yes ☐ No

17. Check which of the following activities change the nature of your pain, if applicable:

	Aggravates Pain	Relieves Pain
Sitting	☐	☐
Standing	☐	☐
Walking	☐	☐
Rising from sitting	☐	☐
Bending forward	☐	☐
Bending backward	☐	☐
Lying on your back	☐	☐
Lying on your stomach	☐	☐
Driving	☐	☐
Coughing/Sneezing	☐	☐
Other ______________	☐	☐

18. (For Women) Is there a relationship between your menstrual cycle and your symptoms? ☐ Yes ☐ No

19. Which medications are you currently using for your pain?

____

20. Are you taking medications for other medical conditions? Please list:

____

____

21. Are you allergic to any medications or x-ray dye? ☐ Yes ☐ No (If yes, please list)

____

____

22. Have you had recent treatment with a ☐ Physical Therapist (PT) ☐ Chiropractor (DC) ☐ Osteopath (DO)

23. Have you had any injections for your pain? ☐ Yes ☐ No ________________________

24. Have you had spine surgery in the past? ☐ Yes ☐ No (If no, go to question #29)

____

25. Did you improve after your most recent surgery? ☐ Yes ☐ No

26. What symptoms improved? ________________________________

27. How long did your improvement last after your last surgery? ________________________

28. What was your work status after the last surgery?

☐ Work related injury
☐ Injury related to a motor vehicle accident
☐ Sports related injury
☐ Unrelated to any particular incident

29. List all previous surgeries (Non-Spinal)

_______________________________________ Date ______________

_______________________________________ Date ______________

_______________________________________ Date ______________

30. Please check any of the following problems that you have had.

- ☐ Diabetes
- ☐ Asthma
- ☐ Bronchitis/Emphysema
- ☐ Heart Disease or Heart Attack
- ☐ Rheumatic Disease
- ☐ High Blood Pressure
- ☐ Stomach Ulcers
- ☐ Cancer
- ☐ Seizure Disorder
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Thyroid Disease
- ☐ Kidney Stones/Infections
- ☐ High Cholesterol
- ☐ Prostatic Problems
- ☐ Dizziness
- ☐ Loss of Consciousness
- ☐ Change in Ability to Pass Urine
- ☐ Difficulty in Bowel Movements
- ☐ Nausea/Indigestion
- ☐ Unexplained Weight Loss
- ☐ Night Sweats
- ☐ Swelling of Toe or Finger Joints
- ☐ Headaches
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Feeling Tired in the Morning
- ☐ Fever/Chills
- ☐ Coordination Difficulty
- ☐ Muscle Spasticity
- ☐ Change in Vision
- ☐ Chest Pain
- ☐ Skin Rashes/Scars
- ☐ Night Cramps
- ☐ Bleeding Disorder/Bruising Easily
- ☐ Shortness of Breath
- ☐ Numbness
- ☐ Palpitations
- ☐ Tremor
- ☐ Joint Tenderness/Stiffness
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ G.E.R.D. (Acid Reflux)
- ☐ Anemia

31. Please list any other medical problems not listed above:

____

32. Do you have a family history of

☐ Cancer ☐ Back Problems

☐ Arthritis ☐ Other ______________________

33. Do you smoke cigarettes? ☐ Yes ☐ No ______ packs per day x ______years ☐ Former smoker

34. Do you drink alcoholic beverages? ☐ Yes ☐ No How much per week? ______________

35. Do you drink caffienated beverages? ☐ Yes ☐ No How many cups week? ______________

36. What activities have you been unable to do since your symptoms began that you need or want to get back to?

____

____

37. Are you currently ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

38. How many children do you have?____________ Age of oldest - youngest? ____________

39. Do you care for anyone with a disability in your home? ☐ Yes ☐ No ____________

40. Do you enjoy your work? ☐ Yes ☐ No

41. Do you like your coworkers? ☐ Yes ☐ No

42. If you need to consider job retaining, what is your educational level?

☐ Grade School ☐ High School

☐ College ☐ 2 Year ☐ 4 Year ☐ Post College