Orthopedics
New England
Dedication. Compassion. Experience.

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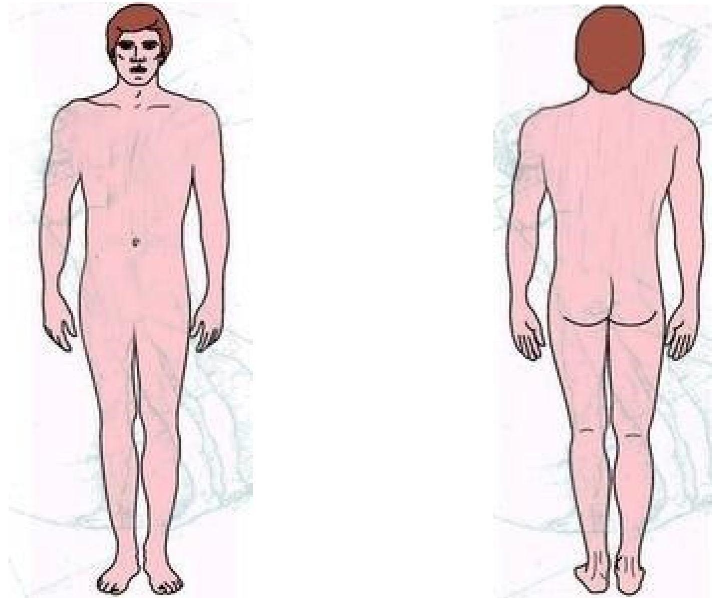
Karl Haywood, PA-C
Sarah C. Jacoby, PA-C
Ryan C. Gulla, PA-C
Brian Sheehy, PA-C
Matthew Richardson, PA-C

Patient Intake Questionnaire Name: ___________________________ DOB ___/___/___ Date___/___/____
Patient Address: ____ Home Ph: ________________Cell: ___________
PHARMACY NAME AND ADDRESS: ____
Primary Care Physician: _____________________________________ Email address: _______________________

Using the symbols below, mark the area on your body where you feel the described sensations.

>>>>> Numbness   **XXX** Burning   ^^^^^ Other Pain
000000 Pins and Needles   **!!!!!!!!!** Stabbing   ●●● Aching

Right   **Left**   **Left**   **Right**



Please place a hash-mark (□) along the line at the point that corresponds to your average BACK/NECK pain over the last few days.

No Pain 0____1____2____3____4____5____6____7____8____9____10 Worst Pain Possible

Please place a hash-mark (□) along the line at the point that corresponds to your average LEG/ARM pain over the last few days.

No Pain 0____1____2____3____4____5____6____7____8____9____10 Worst Pain Possible

Are you experiencing:

Numbness Yes / No ____
Weakness Yes / No ____
Do your legs tire/hurt if you walk too far? Yes / No ____
If YES, how far can you walk? ___less than 1 block ___ 1-3 blocks ___ more than 3 blocks
When did your symptoms begin? _____/_____/_____
Have you had similar attacks in the past? ____
What was the cause of your pain? ____

How does each of the following affect your pain? (check your answer)

Sitting	__ Better	__Worse	__ No change	__ Don't know
Standing	__ Better	__Worse	__ No change	__ Don't know
Walking	__ Better	__Worse	__ No change	__ Don't know
Lying Down	__ Better	__Worse	__ No change	__ Don't know
Rising from chair	__ Better	__Worse	__ No change	__ Don't know
Physical activity	__ Better	__Worse	__ No change	__ Don't know
Heat Cold	__ Better	__Worse	__ No change	__ Don't know
Massage	__ Better	__Worse	__ No change	__ Don't know

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Patient Intake Questionnaire 2 of 3

Name____ DOB: ____/____/____ Date____/____/____

IF YOU HAVE HAD ANY DIAGNOSTING TESTING DONE PLEASE BRING IMAGES AND REPORTS :

	DATE	LOCATION
Bone Scan	____/____/____	
CT Scan	____/____/____	
Myelogram	____/____/____	
EMG	____/____/____	
X-Rays	____/____/____	
Blood Work	____/____/____	
Discogram	____/____/____	
MRI	____/____/____	

What kind of treatment have you received in this current episode of pain?

Physical Therapy Yes____ No____ DATES: FROM: __________ TO: __________
Chiropractor Yes____ No____ DATES: FROM: __________ TO: __________
Bed Rest Yes____ No____ Medication Yes____ No____ Brace Yes____ No____
Facet Injections Yes____ No____ Epidural Injections Yes____ No____ Acupuncture Yes____ No____
Other Injections Yes____ No____ Other: ____________________
Spine Surgery Yes____ No____ Type: ____________________

If yes, (When/Where/by Whom) ____

What medications (ALL) are you currently taking (dose) including pain medication/anti-inflammatory etc.?

Medication Allergies/Reactions ____

Have you had any previous complications with anesthetics? No______ Yes ______
Have you had problems with addiction to prescription or non-prescription medications? No ______ Yes ______

Past **MEDICAL/SURGICAL** history (please include When/Where/by Whom):

Family Medical History: ____

Do you exercise regularly? Yes______ No______
What activities do you do?

Strengthening:__________ Bike:__________ Running:________

Stretching:__________ Walking:__________ Other:__________

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Patient Intake Questionnaire 3 of 3

Name____ DOB: ____/____/____ Date___/___/___

Check all symptoms/conditions that you have:

__Heart trouble
__Chest pain
__Heart skipping
__Palpitations
__High blood pressure
__Stroke
__Bleeding disorder
__Easy bruising
__Fainting
__Lightheaded
__Incontinence
__Urinary frequency
__Blood in urine
__Menstrual changes
__Jaundice
__Renal disorder
__Vaginal bleeding
__Vision changes
__Eye pain/redness
__Headaches
__Hearing loss
__Nose bleeds

__Abdominal Pain
__Reflux
__Heartburn
__Gerd
__Diarrhea
__Loss of appetite
__Constipation
__Change in bowl habits
__Significant weight change
__Unexplained weight loss
__Pain in joints
__Decreased range of motion
__Swollen ankles
__Leg cramps
__Numbness
__Muscle weakness/paralysis
__Tremor dizziness
__Fever/Chills
__Excessive sweating
__Persistent infections
__Rash/bumps

__Shortness of breathe
__Cough
__Wheezing
__Bloody sputum
__Throat disorder
__Thyroid trouble
__Swollen glands
__Trouble swallowing
__Mouth sores
__Sore throat
__Anxiety/disorders
__Depression
__Nervousness
__Insomnia
__Night sweats
__Fatigue

__Oral lesions
__Skin lesions
__Skin sores
__ Diabetes

What is your height: ________ **Weight:** ______

Relationship Status: Married Single Divorced Widowed Children, if so how many? ________

Smoking Status:
___ never smoker
___ current every day smoker
___ current some day smoker
___ former smoker
___ smoker current status unknown
___ unknown, if ever smoked

Years smoked ____
Packs per day: <=0.5
1.0
1.5
2.0
>2.0

Do you Drink Alcohol? Yes ______ **No** _______ **# of Drink(s) per week?** __________
What is your current occupation/work status? ____
Are you involved in a personal injury lawsuit because of your pain? Yes_____ No____
If so: Are you currently working? Yes______ No______ How long have you been out of work: _______________
Is this a work related injury? Yes /No **EMPLOYER:** ____________________________ **PHONE:** _____________
If so: Are you currently working ? Yes ______ NO ______ How long have you been out of work: ______________
Are you receiving Workers Compensation Benefits? Yes______ No______