Orthopedics New England

Dedication. Compassion. Experience.

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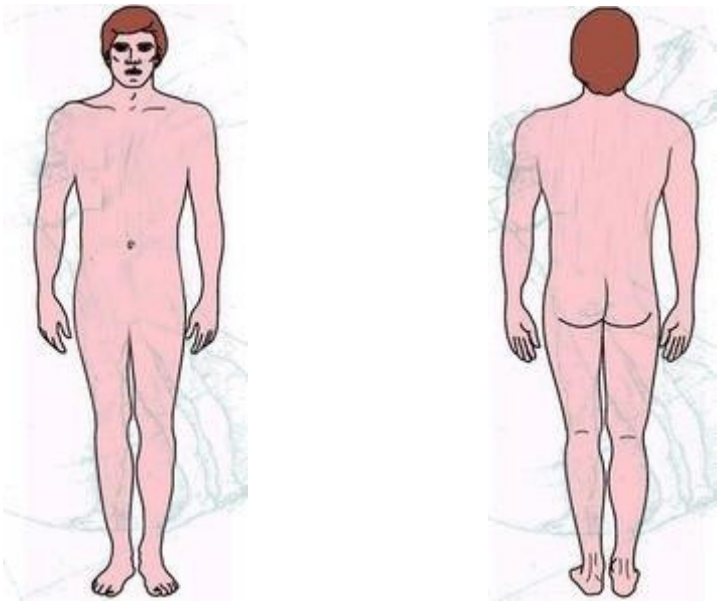
Karl Haywood, PA-C
Ryan C. Gulla, PA-C
Brian Sheehy, PA-C
Matthew Richardson, PA-C
Hannah Moomey, PA-C
Brianna Leung, PA-C

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_____