Shoreline Orthopaedics

Spine/ Physiatry Initial Eval

First name_____Last Name_____DOB _____

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

If other, please specify _____

What activities make the pain worse?

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

If other, please specify _____

What reduces the pain? (check all that apply)

☐ Lying down	☐ Walking	☐ Medication	☐ Brace/ Corset
☐ Sitting	☐ Manipulation	☐ Injections for pain	☐ Nothing
☐ Standing	☐ Exercise- Physical therapy	☐ TENS unit	☐ 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 angry	☐ I feel sad (depressed)
☐ I feel frustrated	☐ I feel like taking my own life (suicidal)	☐ Nothing can help me

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Pain

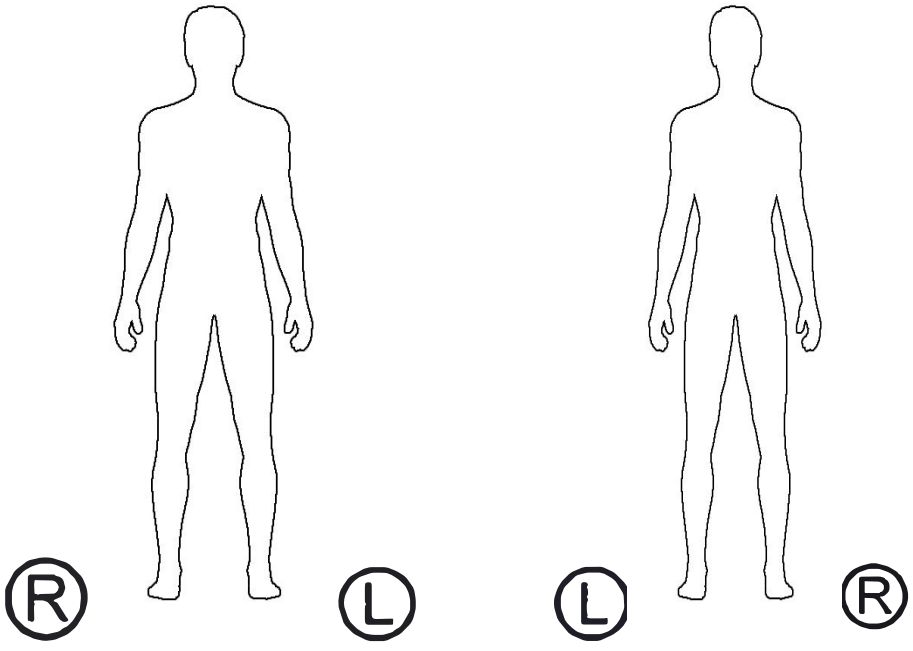
My pain is

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

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

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

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



FRONT BACK

✔ Stabbing
● Tingling
Numbness
✚ Pins and needles
■ Aching
✕ Burning

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

My weight is ❍ Increasing ❍ Decreasing ❍ Steady

Are 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

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

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

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

Daily Activities

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
❍ Severly 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

Past Treatments for this Problem

Have you had any trouble with this problem before ❍ Yes ❍ No If yes, when was the first time it happened ___/___/___

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 ❍ TENS Unit ❍ Chiropractic Manipulation
❍ Home exercies program ❍ Epidural Steroid Injection ❍ N/A- no prior treatment
❍ Brace

If you answered yes to any of the past treatments listed above, please provide additional details below. If you haven't had any prior treatment for this problem please continue to the next section.

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

If 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 a TENS unit? ❍ Yes ❍ NO
Epidural Steroid injeciton	/ /	Was it helpful and how long did it last? _____
Epidural Steroid injeciton # 2	/ /	Was it helpful and how long did it last? _____
Epidural Steroid injeciton # 3	/ /	Was it helpful and how long did it last? _____
Chiropractic Manipulation	/ /	Was it helpul and for how long? _____

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

Past Treatments 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	_____

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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 your stomach) ❍ Yes ❍ No ❍ N/A

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

Employment Status

Are you currently employed? ❍ Yes ❍ No Present Employer_____

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

My presents 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 many pounds do you lift for your job? ❍ < 15 lbs ❍15-25 lbs ❍ 25-40 lb ❍40-60 lb ❍ >60 lbs

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?	/ /

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

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

This form was completed by ❍ Patient ❍ Parent ❍ Guardian ❍ POA ❍ Family member ❍ Other

Agreement

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

X _____ Date _____