ORTHOPAEDIC SPECIALTY GROUP

Pain Intake Form

Height: _____ Weight: _____

Patient: _____ Soc Sec #: _____ Date: _____

Sex: ☐ Male ☐ Female Race: _____ Age: _____ Date of Birth: _____

Home Address: _____ Phone #: _____

Business Address: _____ Phone #: _____

Insurance Co.: _____ Policy #: _____

Workers Comp: ☐ Y ☐ N Auto Accident: ☐ Y ☐ N Other Accident: _____

Referred By: _____ Family Doctor: _____ Chiropractor: _____

Describe your pain problem: _____

When did pain start? _____ Did anything cause the pain? _____

Is the pain getting: ☐ better ☐ worse ☐ staying the same Is the pain: ☐ constant ☐ intermittent

Is the pain worse during any particular time? _____

Quality of pain: ☐ aching ☐ knifelike ☐ burning ☐ throbbing ☐ shooting ☐ cramping ☐ stabbing

Where is pain located and does it travel anywhere? _____

_____

What makes the pain worse? ☐ sitting ☐ standing ☐ walking ☐ driving ☐ most physical activity
☐ coughing, sneezing ☐ bowel movements ☐ cold or damp weather
☐ stress ☐ bending forward ☐ bending backward ☐ sexual activity ☐ working
☐ other _____

What makes the pain better? ☐ sitting ☐ standing ☐ walking ☐ exercise ☐ lying down ☐ rest
☐ relaxing ☐ other ☐ medication (list) _____

Is your pain associated with: ☐ numbness ☐ tingling, pins and needles ☐ weakness ☐ coldness
☐ bowel problems ☐ bladder problems ☐ increased sweating
☐ muscle spasm, tightness ☐ skin discoloration ☐ swelling ☐ warmth
☐ other _____

What treatments have you had for your pain? ☐ physical therapy ☐ medication ☐ exercise ☐ chiropractor ☐ psychotherapy
☐ surgery ☐ nerve blocks ☐ epidurals ☐ cortisone injections
☐ trigger point injections ☐ Botox
☐ other _____

What tests have you had for your pain? ☐ X-rays ☐ MRI ☐ CAT scan ☐ EMG ☐ bone scan ☐ discogram
☐ myelogram ☐ other _____
Findings *(physician will fill in)* _____

If 0 is no pain and 10 is the worst imaginable pain, what is your pain level (0-10):
worst pain: _____ least pain: _____ usual or average pain: _____

If any members of your family have had a pain or medical problem, list relation and type of problem:

_____

Marital status: ☐ married ☐ divorced ☐ single ☐ widowed Ages of children: _____

With whom do you live? _____ Occupation: _____

Are you currently working? ☐ Y ☐ N If no, when did you last work? _____

If yes, are you working: ☐ full time ☐ part time ☐ light duty (*list restrictions)* _____

Are you receiving workers comp.? ☐ Y ☐ N Are you suing because of your pain? ☐ Y ☐ N

Is your sleep: ☐ good ☐ fair ☐ poor Are you depressed? ☐ no ☐ mild ☐ moderate ☐ severe

Do you smoke cigarettes? ☐ N ☐ Y packs/day _____ Do you drink alcohol? ☐ no ☐ occ. ☐ mod.

Any past history of drug or alcohol problems? ☐ N ☐ Y describe: _____

List all past hospitalizations not for surgery: _____

List all surgical operations you have had: _____

ROS: Please check all symptoms you have experienced in the last MONTH. ☐ All ROS is Negative
PMH: Please check any of the conditions below which you have been diagnosed with. ☐ All PMH is Negative

Musculoskeletal		Gastrointestinal		Eyes
ROS	**PMH**	**ROS**	**PMH**	**ROS**
☐ Pain with walking ☐ Limitation of motion ☐ Myalgia/muscle aches	☐ Rheumatoid arthritis	☐ Blood in stool ☐ Nausea/vomiting ☐ Indigestion or heartburn ☐ Stomach pain with NSAIDS	☐ GERD/Reflux Disease ☐ Ulcers	☐ Glasses/contacts ☐ Double vision
Respiratory		**Cardiovascular**		**ENT**
ROS	**PMH**	**ROS**	**PMH**	**ROS**
☐ Persistent cough ☐ Shortness of breath ☐ Wheezing ☐ Recurrent upper respiratory infections	☐ Asthma ☐ COPD ☐ Pneumonia ☐ Sleep Apnea ☐ Use C-PAP	☐ Irregular heart beat ☐ Swelling of feet/ankles/legs ☐ Palpitations ☐ Chest pain or discomfort	☐ Heart Attack/MI ☐ Atrial fibrillation ☐ Hypertension/High Blood Pressure ☐ Pacemaker/Defibrillator	☐ Hearing loss ☐ Hoarseness ☐ Ringing in ears **PMH** ☐ Deafness
Constitutional/General		**Hematology**		**Skin/Int**
ROS	**PMH**	**ROS**	**PMH**	**ROS**
☐ Weight loss ☐ Loss of appetite ☐ Fever/chills	☐ Cancer • Year:_____ • Type:_____	☐ Easy bleeding/bruising ☐ Blood clotting problem ☐ Currently taking blood thinners:_____	☐ Anemia ☐ DVT ☐ Pulmonary Embolism ☐ Ever taken blood thinners: _____	☐ Rash ☐ Lumps
Genitourinary		**Endocrine**		**Immunological**
ROS	**PMH**	**ROS**	**PMH**	**ROS**
☐ Pain with Urination ☐ Blood in Urine ☐ Difficulty urinating	☐ Kidney Disease ☐ Liver Disease	☐ Excessive thirst/fluid intake ☐ Temperature intolerance ☐ Feeling tired (fatigue)	☐ Diabetes (insulin) ☐ Diabetes (non-insulin) ☐ Thyroid Disease	☐ Sinus pressure
Neurological		**Psychological**		
ROS	**PMH**	**ROS**	**PMH**	
☐ Balance problem ☐ Headaches ☐ Numbness or tingling	☐ Migraines ☐ Seizures ☐ Stroke	☐ Nervousness ☐ Memory loss	☐ Anxiety Disorder ☐ Depression ☐ Psychological Disorder	

SURGICAL HISTORY

Prior Non-Orthopaedic Operations: ☐ None _____

Prior Orthopaedic Operations: ☐ None _____

Complications with anesthesia: ☐ No ☐ Yes, reaction: _____

History of malignant hyperthermia? ☐ No ☐ Yes

Past Hospitalizations (not for surgery): ☐ No ☐ Yes: _____

SOCIAL HISTORY

Smoking status: ☐Current ☐Former ☐Never Alcohol Use: ☐Not at all Daily:____ Weekly:____ Monthly:_____

Substance/IV Drug History: ☐None ☐Yes, type:_____

How many people live with you: _____ Marital Status: **M S D W**

Are you currently working: ☐ Yes ☐ No Occupation:_____ Employer:_____

If not, how long have you been off work:_____ ☐Student Sports activity:_____

Have you ever received the pneumococcal vaccine: ☐Yes ☐No

Have you had 2 or more falls or a fall with injury in the past year: ☐Yes ☐No

FAMILY HISTORY

☐ All Negative

Anesthetic Reaction:	☐ Mother	☐ Father	Diabetes:	☐ Mother	☐ Father
Arthritis:	☐ Mother	☐ Father	High Blood Pressure:	☐ Mother	☐ Father

FOR OFFICE USE ONLY

Reviewed by MD _____ Date _____/_____/_____