

Patient Information

[Empty text box for patient name]

Patient Name

Date of Birth
Height

[Empty text box for date of birth]

[Empty text box for height]

Weight
Age

Male
 Female

[Empty text box for weight]

[Empty text box for age]

Blood Pressure

[Empty text box for blood pressure]

Right handed
 Left handed

Physician Information

[Empty text boxes for physician name and phone]

Family Doctor Name
Phone

Who directly referred you to Beacon Orthopaedics & Sports Medicine?

Family doctor Attorney Employer Case Manager
Chiropractor Other

REASON FOR OFFICE VISIT

History of Illness

Describe the symptom(s) for which you are here

Pain Numbness and/or tingling Muscular weakness Other

Where is your pain located?

Neck Low-back Mid-back

Other _____

Does your pain radiate or move to other parts of body? Yes No If Yes, which apply?

From neck to left arm From neck to right arm

From low back to left leg From low back to right leg

Other (Describe) **The pain is:** Constant Intermittent Sharp/Stabbing

Dull/Aching **These symptoms have been present for:**

1-7 Days 8-14 Days 14-21 Days 1 Month 2 Months

3 Months 6 Months 9 Months 12 Months Greater than 12 Months

These symptoms started on (give specific date, if known) These symptoms improve when you:

Stand Walk Sit Lie down

Are you able to perform your daily routine with these symptoms? Yes No

If no, since when? _____

The symptoms began:

Spontaneously with no known cause As a result of a motor vehicle accident

As a result of an injury at work As a result of an injury outside of work

If marked, describe briefly the onset and how it occurred:

Since the onset of symptoms, have you experienced any new problems urinating or having

bowel movements? Yes No
If Yes, Please describe

What other physicians have treated you for this problem?
Doctor's Name Type of Doctor Month / Year

Check the following treatment(s) you have had for this illness or injury:

None Hot packs Ultrasound Massage Traction Ice
Electrical Stimulation Exercises Chiropractic Manipulation Steroid spine
injection

Physical Therapy: When (Mo./Year) ___/___

Where _____

How many times have you gone? _____

Medication:

Have you ever taken prescription pain medication? Yes No

Are you using any now? Yes No

Please list medications for this illness or injury:

Prescribing Doctor's Name: Medication Name Pharmacy where filled

Diagnostic Tests

Check any of the following diagnostic tests you have had for this illness or injury.
(Please indicate when and where tests were done)

When (Mo./Year)

Where

Plain spine X -rays

___/___

MRI scan

___/___

CT scan

___/___

EMG

___/___

Bone scan

___/___

Past Medical History

Have you ever had any neck or back operations/surgery? Yes No

If yes, when?

Surgeon's name

Describe area of spine operated: _____

Have you ever had any other operations/surgery?

If

yes,

describe

when

surgery: _____

Have you ever been treated for blood clots or excessive bleeding? Yes

No Have you ever had a blood transfusion? Yes No

Is there any reason you cannot receive blood or blood products? Yes

No

If Yes, Explain: _____

Family History

Has anyone in your family had any of the following conditions? (please explain who and what they had)

Cancer	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
Heart problems	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
Diabetes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
Kidney disease	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
Depression/mental problems	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
Alzheimer's/Memory loss	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
High blood pressure	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
Stroke/brain tumor/aneurysm	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
Lung problems	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
Parkinson's	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
Multiple Sclerosis	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____
Other problems	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	_____

Social History

Indicate your marital status: Single Married Widowed **Do you live alone?** Yes No

If married, does your spouse work? Yes No **Do you have any children?** Yes No

If yes, indicate age(s) and whether they live at home: _____

Do you now use any tobacco products? Yes No

If yes, specify: Cigarettes Snuff Tobacco Cigars Pipe
How much/day? _____
For how many years? _____

Did you use any tobacco products in the past? Yes No

If yes, specify:
 Cigarettes Snuff Tobacco Cigars Pipe
For how long? _____
How much/day? _____
When did you quit? _____

Do you now drink alcohol? Yes No

If yes, specify: Beer Wine Liquor
How many drinks/week? _____
For how many years? _____

Did you drink alcohol in the past? Yes No

If yes, specify: Beer Wine Liquor
For how long? _____
How much/day? _____
When did you quit? _____

Have you ever received treatment for drug and/or alcohol problems? Yes No

If yes, specify when and where _____

Review of Systems

**Do you currently have or have had any of the following problems
(if yes, give date began): Yes No (Mo/Year)**

Fever, chills, or night sweats, weight loss, weight gain

____/____

Headaches

____/____

Vision blurring, loss of vision

____/____

Hearing, balance problems, dizziness

____/____

Problems with the mouth, teeth or gums

____/____

Do you wear dentures?

Difficulty swallowing, persistent sore throat, swollen glands

____/____

Neck pain, stiffness

____/____

Chest pain, palpitations, heart disease

____/____

High blood pressure

____/____

Diabetes

____/____

Hepatitis

____/____

Tuberculosis Active Inactive

____/____

Shortness of breath, chronic cough, asthma

____/____

Nausea, vomiting, diarrhea, bright red blood per rectum, dark tarry
or sticky stools, changes in bowel or bladder habits

____/____

Frequency, urgency, burning with urination, bowel or bladder
incontinence or difficulty starting a urine stream

Impotence

____/____

Other joint pains, loss of motion,
problems with circulation in the arms or legs

____/____

Loss of sensation, power, strength any other numbness, tingling

____/____

Problems with coordination, walking, history of seizures or passing
out

____/____

Female Patients:

Are you pregnant? If yes, when is your due date?

____/____

Have you had your ovaries/uterus surgically removed? If yes, give date

____/____

Work History

Highest grade level achieved in school:

Grade school High school College Post college

Other

Do you work outside the home? Yes No

If yes, are you currently working with these symptoms? Yes No

If no, when did you stop working? _____

Did a physician place you off work? Yes No

Employer _____ Length of

employment _____ Job

Title _____

How long have you done this job? _____

Does your job require you to perform the following activities:

Lift pounds Sit Use a computer

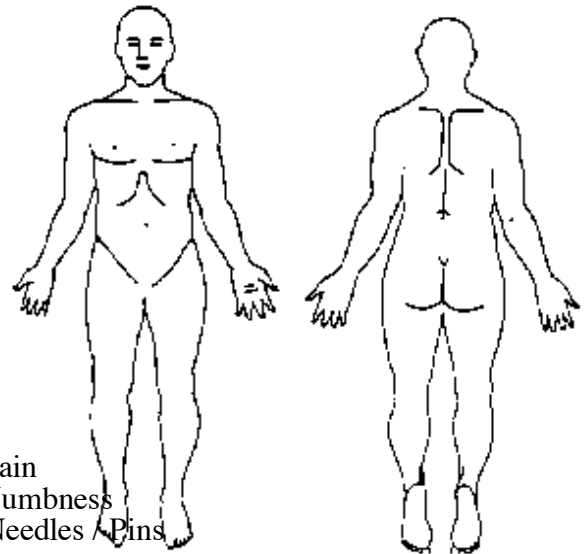
Lift over head Bend Drive a truck or forklift Reach over head

Stand

Please mark location, type and level of pain:

Please score your present pain 0-10,
with 0 = No pain; 10 = worst pain ever

0 1 2 3 4 5 6 7 8 9 10



_____ Date _____

Patient Signature

_____ Date _____

Beacon Orthopaedic Physician's Signature

Beacon Orthopaedics & Sports Medicine