



**Stony Brook
Orthopaedic Associates**

Dr. Daren McCalla

Spine and Scoliosis Center

TODAY'S DATE: _____

PATIENT NAME: _____ DOB _____ GENDER _____

EMAIL ADDRESS: _____

PRIMARY LANGUAGE: ENGLISH _____ SPANISH _____ OTHER _____

CAN YOU READ ENGLISH? YES _____ NO _____ DO YOU UNDERSTAND ENGLISH? YES _____ NO _____

DID YOU SUFFER AN INJURY? YES _____ NO _____ DATE ___/___/___ IS IT WORK RELATED? YES _____ NO _____

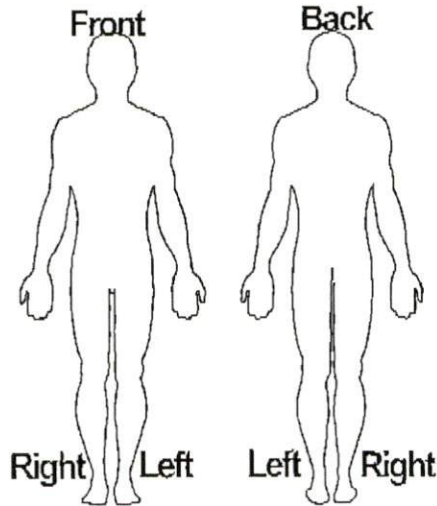
DESCRIBE: _____

DO YOU HAVE PAIN? YES _____ NO _____ IF YES, PLEASE DESCRIBE: _____

WHERE IS YOUR PAIN NOW?

PLEASE USE THE APPROPRIATE SYMBOLS TO DESCRIBE YOUR SYMPTOMS AND MARK THE LOCATION AS ACCURATELY AS POSSIBLE ON THE BODY DRAWING:

ACHING	^ ^ ^ ^ ^
STABBING	/ / / / /
TINGLING	- - - - -
BURNING	X X X X X
NUMBNESS	0 0 0 0 0



PLEASE RATE PAIN ACCORDING TO THE SCALE BELOW

0	1	2	3	4	5	6	7	8	9	10
NO PAIN		MILD		DISCOMFORT		DISTRESSING		HORRIBLE		EXCRUCIATING

WHEN DID THE PAIN BEGIN? _____

HOW DID THE PAIN START? _____

WHERE IS THE PAIN LOCATED? NECK _____ BACK _____ ARM _____ LEG _____

DESCRIBE: _____

IS YOUR PAIN IMPROVING _____ WORSENING _____ STAYING THE SAME OVER TIME _____

WHAT AGGRAVATES YOUR PAIN? _____

WHAT HELPS YOUR PAIN? _____

DO YOU EXPERIENCE WEAKNESS IN THE EXTREMITIES? YES NO

IF YES, PLEASE DESCRIBE: _____

DO YOU HAVE BOWEL/BLADDER INCONTINENCE? YES NO

IF YES, PLEASE DESCRIBE: _____

DO YOU NEED: CANE WALKER WHEELCHAIR TO AMBULATE?

DO YOU SMOKE? YES NO CIGARETTES CIGARS PIPE OTHER

DO YOU DRINK? YES NO IF YES, HOW OFTEN _____ HOW MANY _____

HAVE YOU HAD TREATMENT FOR YOUR CONDITION? YES NO

NONE PHYSICAL THERAPY CHIROPRACTOR EPIDURAL STEROID ACCUPUNCTURE

TRIGGERPOINT INJECTIONS PAIN MANAGEMENT SURGERY OTHER

PLEASE DETAIL ANY SIGNIFICANT PAST MEDICAL HISTORY: _____

PLEASE DETAIL ANY PAST SURGICAL HISTORY: _____

PLEASE LIST ANY ALLERGIES: _____

DO YOU HAVE A METAL ALLERGY? YES NO

PLEASE LIST ALL CURRENT MEDICATIONS: (CONTINUE ON BACK OF THIS PAPER IF YOU NEED MORE ROOM)

DRUG

DOSE

FREQUENCY

DO YOU HAVE ANY SIGNIFICANT FAMILY MEDICAL HISTORY? _____

WHAT IS YOUR OCCUPATION? _____

TYPE OF WORK: HEAVY LABOR LIGHT LABOR SEDENTARY

ARE YOU CURRENTLY EMPLOYED: YES NO

STATUS: FULL TIME PART TIME DECREASED CAPACITY DISABLED RETIRED

REVIEW OF SYSTEMS

PLEASE CHECK ALL THAT APPLY

<input type="checkbox"/> ULCER	<input type="checkbox"/> FRACTURES NECK/SKULL	<input type="checkbox"/> STROKE
<input type="checkbox"/> HIATAL HERNIA	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HEART PROBLEMS
<input type="checkbox"/> INDIGESTION	<input type="checkbox"/> BACK PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE
<input type="checkbox"/> DIABETES	<input type="checkbox"/> CORTISONE THERAPY IN THE PAST YEAR	<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> HEPATITIS (YELLOW SKIN)	<input type="checkbox"/> SWOLLEN/SORE LEGS	<input type="checkbox"/> CHEST PAIN
<input type="checkbox"/> LIVER PROBLEMS	<input type="checkbox"/> POLIO/MENINGITIS	<input type="checkbox"/> MITRAL VALVE PROLAPSE
<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> JAW PROBLEMS/TMJ	<input type="checkbox"/> IMPAIRED HEARING
<input type="checkbox"/> THYROID DISEASE	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> BLACKOUTS/DIZZINESS
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> IMPAIRED VISION	<input type="checkbox"/> READING PROBLEMS
<input type="checkbox"/> SICKLE CELL ANEMIA	<input type="checkbox"/> SKIN RASHES	<input type="checkbox"/> SPEAKING PROBLEMS
<input type="checkbox"/> BRUISE OR BLEED EASILY	<input type="checkbox"/> MOTION SICKNESS	<input type="checkbox"/> EPILEPSY/SEIZURES
<input type="checkbox"/> BLOOD CLOTS	<input type="checkbox"/> CANCER	<input type="checkbox"/> HEADACHES
	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> LUNG PROBLEMS
	<input type="checkbox"/> RADIATION	<input type="checkbox"/> ASTHMA/SOB/INHALER
		<input type="checkbox"/> EMOTIONAL PROBLEMS
		<input type="checkbox"/> SLEEP APNEA

CULTURAL BELIEFS _____

COMMENTS _____

PATIENT SIGNATURE

DATE