Stony Brook
Orthopaedic Associates

Spine and Scoliosis Center
Nicholas A. Pallotta, MD, MS

TODAY'S DATE: _____

PATIENT NAME: _____ DOB _____ GENDER _____

EMAIL ADDRESS:_____ PRIMARY CARE DOCTOR: _____

PRIMARY LANGUAGE: ENGLISH _____ SPANISH _____ OTHER _____

CAN YOU READ ENGLISH? YES _____ NO ____ DO YOU UNDERSTAND ENGLISH? YES ____ N 0 _____

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

DESCRIBE: _____

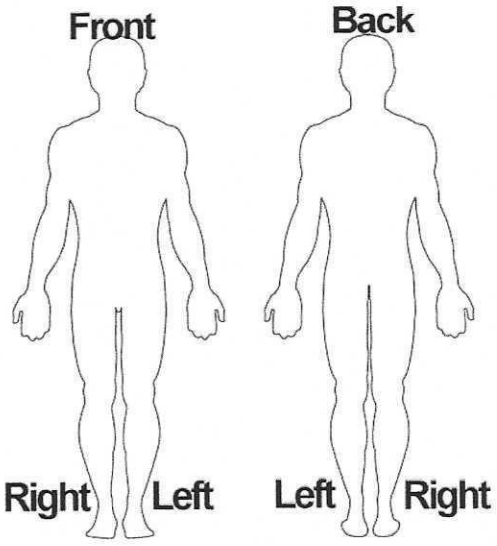
DO YOU HAVE PAIN? YES ___ NO ___ IF YES, PLEASE DESCRIBE: _____

_____

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

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

CULTURAL BELIEFS _____

_____

_____

COMMENTS _____

_____

_____

_____

_____ _____

PATIENT SIGNATURE DATE