Stony Brook Orthopaedic Associates

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SPINE AND SCOLIOSIS CENTER

TODAY'S DATE: _____

PATIENT NAME: _____ DOB: _____ Gender____

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 THE INJURY:

_____

WHEN DID THE PAIN/SYMPTOMS BEGIN? DATE__/__/___

HOW DID THE PAIN START? _____

WHERE IS THE PAIN LOCATED? NECK___ MID-BACK___ LOW-BACK___ ARM___ LEG___

DESCRIBE _____

DOES THE PAIN AWAKEN YOU FROM SLEEP? YES ___ NO ___

ARE YOUR SYMPTOMS: IMPROVING___ WORSENING___ STAYING THE SAME OVER TIME ___

WHAT AGGRAVATES YOUR PAIN? _____

WHAT HELPS YOUR PAIN? _____

DO YOU EXPERIENCE WEAKNESS IN YOUR ARMS OR LEGS? YES ____ NO____

IF YES PLEASE DESCRIBE: _____

_____

DO YOU HAVE BOWEL / BLADDER INCONTINENCE? YES____ NO ____

HAVE YOU HAD TREATMENT FOR YOUR CONDITION? YES____ NO ____

PHYSICAL THERAPY ____ CHIROPRACTOR ____ EPIDURAL STEROID ____ ACUPUNCTURE ____

TRIGGERPOINT INJECTIONS ____ MEDICATIONS ____ SURGERY____ OTHER_____

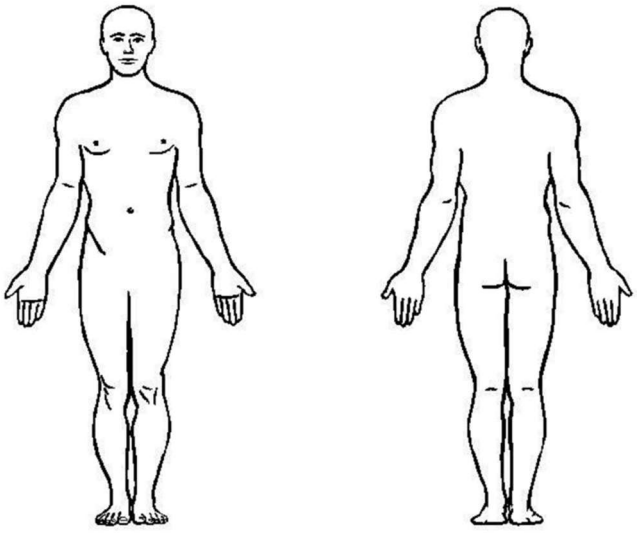
PLEASE RATE PAIN ACCORDING TO THE SCALE BELOW

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

WHERE IS YOUR PAIN?

PLEASE USE THE SYMBOLS ON THE LEFT TO MARK THE LOCATION AS ACCURATELY AS POSSIBLE ON THE BODY DRAWING:

PAIN	**X X X X**
BURNING TINGLING	~~~~
NUMBNESS	**O O O O**



MEDICAL HISTORY:

DIABETES? YES____ NO ____ HEART ATTACK OR STROKE? YES____ NO ____
BLOOD CLOT? YES____ NO ____ KIDNEY DISEASE? YES____ NO ____

PLEASE DETAIL ADDITIONAL PAST MEDICAL HISTORY: _____
_____
_____
_____

PLEASE DETAIL PAST SURGICAL HISTORY: _____
_____
_____
_____

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

DRUG DOSE FREQUENCY
_____
_____
_____
_____

PLEASE LIST ANY ALLERGIES: _____

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 ____
IF NOT WORKING, WHEN DID YOU STOP? ___/___/___

DO YOU SMOKE? YES ____ NO ____ CIGARETTES _____ CIGARS _____ PIPE _____ OTHER _____
DO YOU DRINK? YES ____ NO _____ IF YES HOW OFTEN _____ HOW MANY _____

DO YOU HAVE ANY SIGNIFICANT FAMILY MEDICAL HISTORY? FOR EXAMPLE, BLOOD CLOTS, CANCER, KIDNEY DISEASE, HEART DISEASE

DESCRIBE: _____
_____
_____
_____

REVIEW OF SYSTEMS

(CHECK ALL THAT APPLY)

□ CHEST PAIN
□ COUGH
□ DEPRESSION
□ EAR PAIN
□ FAINTING
□ FEVER
□ MANIA
□ SKIN RASH
□ VOMITING
□ CONSTIPATION
□ COLD HANDS/FEET
□ LOSS OF APPETITE
□ MUSCLE WEAKNESS
□ IMPOTENCE
□ BALANCE PROBLEMS
□ SEIZURES
□ SKIN ULCERS
□ STOMACH PAIN
□ ABNORMAL BLEEDING
□ GROWTH DISTURBANCE
□ RUNNY NOSE
□ NUMBNESS OF FEET
□ NUMBNESS OF HANDS
□ SHORTNESS OF BREATH
□ SORE THROAT
□ WHEEZING
□ WEIGHT GAIN
□ ABNORMAL MENSTRUAL CYCLE
□ INCONTINENCE OF BOWEL
□ INCONTINUENCE OF URINE
□ SLEEP DISTURBANCE
□ SPUTUM PRODUCTION
□ VISUAL DISTURBANCE
□ SWELLING IN THE LEGS
□ UNEXPLAINED WEIGHT LOSS
□ OTHER_____

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE