

Thank you for taking the time to fill out this form. We use this form to help organize information about your problem. Please fill out as completely as possible.

Name: \_\_\_\_\_ MRN: \_\_\_\_\_ Nickname: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Would you like us to send a copy of this report to another health care provider? (Please give the address.)

Physician: \_\_\_\_\_

### **Present History: Check Correct Item or Fill in Blank(s)**

1. Briefly describe the primary reason you are here to see the doctor:

\_\_\_\_\_  
\_\_\_\_\_

2. When did the present problem start? (month/day/year) \_\_\_\_\_

3. If your problem is pain related, complete the following questions. (If not, go on to question 7, page 2.)

How did the pain start? (Check appropriate box.)

- |   |                                  |   |  |
|---|----------------------------------|---|--|
| <input type="checkbox"/> Suddenly               | <input type="checkbox"/> Fall    | <input type="checkbox"/> Injured at work          | <input type="checkbox"/> Injured during sports |
| <input type="checkbox"/> Gradually              | <input type="checkbox"/> Bending | <input type="checkbox"/> Injured in auto accident | <input type="checkbox"/> No apparent cause     |
| <input type="checkbox"/> Lifting                | <input type="checkbox"/> Pulling | <input type="checkbox"/> Hit from behind          | <input type="checkbox"/> Injured at home       |
| <input type="checkbox"/> Other (specify): _____ |                                  |   |  |

4. What activities make the pain worse?

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Exercise (during)      | <input type="checkbox"/> Standing        | <input type="checkbox"/> Bending Backward | <input type="checkbox"/> At night      |
| <input type="checkbox"/> Exercise (after)       | <input type="checkbox"/> Walking         | <input type="checkbox"/> Coughing         | <input type="checkbox"/> By end of day |
| <input type="checkbox"/> Sitting                | <input type="checkbox"/> Bending Forward | <input type="checkbox"/> Sneezing         |  |
| <input type="checkbox"/> Other (specify): _____ |  |   |  |

5. What reduces the pain?

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Laying down            | <input type="checkbox"/> Walking                   | <input type="checkbox"/> Medication          | <input type="checkbox"/> Brace/Corset |
| <input type="checkbox"/> Sitting                | <input type="checkbox"/> Manipulation              | <input type="checkbox"/> Injections for Pain | <input type="checkbox"/> Nothing      |
| <input type="checkbox"/> Standing               | <input type="checkbox"/> Exercise-Physical Therapy | <input type="checkbox"/> Tens Unit           |                                       |
| <input type="checkbox"/> Other (specify): _____ |  |  |                                       |

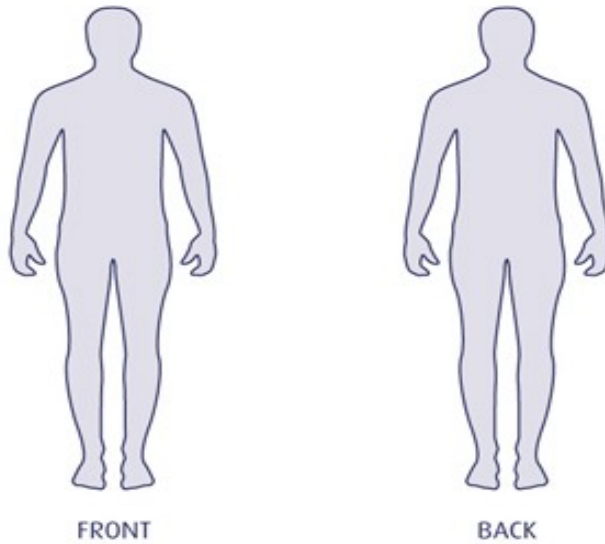
6. May pain is: (Check all that apply)
- Present intermittently (comes and goes)
  - Always present but of variable intensity
  - Improving

- Worsening in that it is:
- Present more often
  - More intense
  - Changing in character
  - Changing in location

**Where is your pain now?**

Mark the areas on your body where you feel the sensations described above, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw your face.

- |                      |                        |                        |                                |                       |                        |
|----------------------|------------------------|------------------------|--------------------------------|-----------------------|------------------------|
| <b>Aching</b><br>△△△ | <b>Numbness</b><br>=== | <b>Tingling</b><br>OOO | <b>Pins and Needles</b><br>+++ | <b>Burning</b><br>XXX | <b>Stabbing</b><br>/// |
|----------------------|------------------------|------------------------|--------------------------------|-----------------------|------------------------|



**Pain Rating Scale**

Please make an "X" on the line that corresponds to the area of your body that you feel pain and its severity. Rate how much pain hurts on an average day by placing the "X" along the line from "No Pain" and on the left to "Worse Pain I Can Possibly Imagine" on the right.

	<u>No Pain</u>									<u>Worst Pain I Can Imagine</u>	
Back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg Pain	0	1	2	3	4	5	6	7	8	9	10
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Arm Pain	0	1	2	3	4	5	6	7	8	9	10

7. What emotional reactions have you had to your current problem? (Check all that apply.)
- I have none
  - I feel nothing matters
  - I feel frustrated/angry
  - I feel like taking my life (suicidal)
  - I feel blue and no good (depressed)
  - Nothing can help me

8. Do you have loss of bowel or bladder control?  Yes  No

If yes, explain: \_\_\_\_\_

9. My weight is:  increasing  decreasing  steady

10. Are there any problems with weak muscles?

none  generally weak  weak in arms  weak in legs

11.  I have no difficulty with sleep OR I have difficulty with sleep:

unable to fall asleep  maintaining sleep  waking frequently because of pain

12. Functional activities: I can comfortably

stand for \_\_\_\_\_ minutes sit for \_\_\_\_\_ minutes walk for \_\_\_\_\_ minutes

I can do the following:

Housework  all  some  none

Leisure activities  all  some  none

Work  all  some  none

13. Have you had any trouble with this problem before?  Yes  No

When was your FIRST time? \_\_\_\_\_

14. Have you seen any other doctors for YOUR CURRENT problem?  Yes  No

List their name and date seen: \_\_\_\_\_

15. Which of the following treatments have you had for this problem?

TREATMENT	DATE	DOCTOR'S NAME	OTHER INFORMATION	
Physical Therapy			What was done? Number of sessions	
Exercise			Are you doing a home exercise program now?	
Brace			What type of brace?	
TENS Unit			Using now?	
Epidural Steroid Injection (Cortisone shot in back)	1 <sup>st</sup>		Helpful?	How long?
	2 <sup>nd</sup>		Helpful?	How long?
	3 <sup>rd</sup>		Helpful?	How long?
Chiropractic Manipulation			Helpful?	How long?

16. Tests I have had for this problem:

	DATE	WHERE	RESULTS(if known)
X-rays			
Myelogram			
CT Scan			
Bone Scan			
Magnet Resonance Imaging(MRI)			
EMG (Nerve Test)			
Discogram			

17. Surgery/surgeries I have had for this problem:

DATE	SURGEON	HELPFUL(YES/NO)	WHAT WAS DONE?

18. Are you currently employed?  Yes  No

Present Employer \_\_\_\_\_

How long have you worked there? \_\_\_\_\_

Present Job/Occupation \_\_\_\_\_

My job duties consist of: \_\_\_\_\_

My present job involves: Hours sitting \_\_\_\_\_ Hours standing \_\_\_\_\_ Lifting \_\_\_\_\_ pounds

19. If unemployed or not currently working:

Retired?  Yes  No

On Medical Leave?  Yes  No Since: \_\_\_\_\_

Laid Off?  Yes  No Since: \_\_\_\_\_

On Total Disability?  Yes  No Since: \_\_\_\_\_

Social Security Disability?  Yes  No Since: \_\_\_\_\_

Is this a Work Related Injury?  Yes  No

Is Lawsuit Pending?  Yes  No

20. I last worked on: \_\_\_\_\_

My employer would allow me to return to work with restrictions:  Yes  No

### Past Medical History

**HEALTH HISTORY:** (Please indicate with a check mark if you have been diagnosed or treated for any of the following)

- AIDS
- Acid Reflux
- Alcoholism
- Anemia
- Arthritis
- Asthma
- Atrial Fibrillation
- Bleeding Disorder
- Other
- Bronchitis
- Cancer
- Chemical Dependency
- CHF
- COPD
- Diabetes
- Emphysema
- Glaucoma
- Goiter
- Gout
- Heart Attack/Heart Disease
- High Blood Pressure
- High Cholesterol/Lipids
- Kidney Disease
- Liver Disease
- Migraines
- Pacemaker/Defibrillator
- Osteoporosis
- Pneumonia
- Seizure Disorder
- Sleep Apnea
- Stroke
- Thyroid
- Ulcer

### CURRENT MEDICATION:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**INFECTIONS:**

Have you ever been diagnosed with **MRSA** (Staph)  Yes  No      Were you treated for **MRSA**  Yes  No

Have you ever been diagnosed with **VRE** (Vancomycin Resistant Enterococcus) Were you treated for **VRE**  Yes  No

**SURGERIES:** (Please list **ALL** surgeries that you have had)

\_\_\_\_\_

\_\_\_\_\_

Have you had breast implant surgery?  Yes  No (This information is necessary for surgeries that may require you to lie on your stomach)

Have you had any problems related to surgery or anesthesia before, during or after surgery?  Yes  No  
(Describe the problem) \_\_\_\_\_

Would you accept blood products or blood transfusions if necessary?  Yes  No

**CARDIAC PROCEDURES:** (Please indicate any cardiac procedures or tests and where and when they were done.)

Heart bypass surgery \_\_\_\_\_

Stents placed in coronary arteries \_\_\_\_\_

Heart catheterizations \_\_\_\_\_

Stress Test(s) \_\_\_\_\_

Pacemaker or Defibrillator devices \_\_\_\_\_

**ALLERGIES:** (Please indicate any allergies, the name of the substance and the type of reaction you experienced.)

Medications \_\_\_\_\_

Iodine \_\_\_\_\_

Foods \_\_\_\_\_

Soaps \_\_\_\_\_

Tapes/Adhesives \_\_\_\_\_

Latex \_\_\_\_\_

NO KNOWN ALLERGIES \_\_\_\_\_

Environmental or Pets \_\_\_\_\_

**TOBACCO USE:**

Never       Quit       Yes       Cigarettes       Chew

How many years have you used tobacco and how much per day \_\_\_\_\_

**ALCOHOL USE:**

No       Yes      # of drinks per week       1-6 per week       6-12 per week       12 or more per week

**EXERCISE/PHYSICAL ACTIVITY:** \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:** (Please indicate with a check mark any diseases that run in your family)

Diabetes       Rheumatoid Arthritis       Bleeding Disorders       Heart Disease

Osteoporosis       Osteoarthritis       Blood Clots       High Blood Pressure

Problems with anesthesia \_\_\_\_\_

**REVIEW OF SYSTEMS** (Check ALL that apply)

<b>Constitutional</b>	<b>Skin</b>	<b>Eyes</b>	<b>Ears/Nose/Throat</b>	<b>Neuro</b>
<input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> sweats <input type="checkbox"/> fatigue <input type="checkbox"/> weight loss <input type="checkbox"/> no complaints	<input type="checkbox"/> rashes <input type="checkbox"/> lesions <input type="checkbox"/> scars <input type="checkbox"/> no complaints	<input type="checkbox"/> double vision <input type="checkbox"/> blurry vision <input type="checkbox"/> glasses/contacts <input type="checkbox"/> no complaints	<input type="checkbox"/> deafness <input type="checkbox"/> sinusitis <input type="checkbox"/> hoarseness <input type="checkbox"/> vertigo/dizziness <input type="checkbox"/> no complaints	<input type="checkbox"/> stroke <input type="checkbox"/> seizures <input type="checkbox"/> headaches <input type="checkbox"/> dizziness <input type="checkbox"/> numbness <input type="checkbox"/> visual changes <input type="checkbox"/> no complaints
<b>Cardiovascular</b>		<b>Respiratory</b>	<b>Hematologic</b>	<b>Mental Health</b>
<input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> swelling in hands, feet, ankles <input type="checkbox"/> varicose veins <input type="checkbox"/> no complaints	<input type="checkbox"/> short of breath when laying flat <input type="checkbox"/> short of breath with daily activity <input type="checkbox"/> no complaints	<input type="checkbox"/> shortness of breath <input type="checkbox"/> cough <input type="checkbox"/> coughing blood <input type="checkbox"/> asthma/wheeze <input type="checkbox"/> no complaints	<input type="checkbox"/> anemia <input type="checkbox"/> bruise easily <input type="checkbox"/> bleeding <input type="checkbox"/> blood clots <input type="checkbox"/> no complaints	<input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> hallucinations <input type="checkbox"/> sleep problems <input type="checkbox"/> mood swings
<b>Stomach/GI</b>	<b>Reproductive</b>	<b>Urology</b>	<b>Musculoskeletal</b>	<b>Endocrine</b>
<input type="checkbox"/> heartburn <input type="checkbox"/> trouble swallowing <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> abdominal pain <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> blood in stool <input type="checkbox"/> no complaints	<input type="checkbox"/> sexual dysfunction <input type="checkbox"/> erectile dysfunction <input type="checkbox"/> no complaints	<input type="checkbox"/> pain/burning with urination <input type="checkbox"/> incontinence <input type="checkbox"/> hesitancy <input type="checkbox"/> blood in urine <input type="checkbox"/> no complaints	<input type="checkbox"/> fractures <input type="checkbox"/> sprains <input type="checkbox"/> swelling <input type="checkbox"/> arthritis <input type="checkbox"/> stiffness <input type="checkbox"/> no complaints	<input type="checkbox"/> excessive thirst <input type="checkbox"/> frequent urination <input type="checkbox"/> heat intolerance <input type="checkbox"/> cold intolerance <input type="checkbox"/> increased appetite <input type="checkbox"/> decreased energy <input type="checkbox"/> hair/growth change <input type="checkbox"/> no complaints

**I have reviewed and fully completed these 5 pages to the best of my ability. I understand this information will become part of my permanent medical record at Commonwealth Orthopaedic Centers.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

MD Signature \_\_\_\_\_ Date \_\_\_\_\_

# Commonwealth

Orthopaedic Centers

Dear \_\_\_\_\_,

We would like to thank you for choosing Commonwealth Orthopaedic Centers to participate in your spine care needs. Attached is the Initial Patient Evaluation paperwork that Dr. Kakarlapudi will use to help organize information about your medical history. Please fill out as completely as possible.

Your appointment is scheduled for \_\_\_\_\_ @ \_\_\_\_\_ at our 7388 Turfway Road location in Suite 101. Please arrive at least 5 minutes early for your scheduled visit. Please bring your completed paperwork along with your insurance cards, driver's license, and any co-payments that are typically due.

If you have any questions, please don't hesitate to call our office at 859-301-2663. Thank you for taking the time to fill out these forms.

Thank you,  
Commonwealth Orthopaedic Centers