FALMOUTH ORTHOPAEDIC CENTER

<u>*Please Fill Out This Side ONLY!!!</u>**

Name:____________________________Date:______________

Onset:___Gradual___Sudden___Recurrent

❒ **Nature of Injury:**__________________

____
____
____
____
____
____
____

Back Pain ❒

Neck Pain ❒

Do you have problems walking? No ❒ Yes ❒

Do you have problems with balance or coordination? No ❒ Yes ❒

❒ **Pain is**

When:	Better	Worse	None		Better	Worse	None
Lay	☺	☹	O	Cough	☺	☹	O
Side	☺	☹	O	Sit	☺	☹	O
Walk	☺	☹	O	Sneeze	☺	☹	O
Drive	☺	☹	O	Stand	☺	☹	O

Other_______________________________________

<u>Function:</u>

❒ Change in Daily Function: __ None __ Sleeping
__ Household Activities __ Sex __ Recreation
__ Walking __ Sitting __ Lifting __ Reclining

❒ Work: __Full/Same __Part/Light __Unemployed
__Disabled: Last worked?: __/__/__
Months since work: __<1 __1-3 __>3

	<u>Yes</u>	<u>No</u>
Prior neck Pain:	❒	❒
Prior Neck Surgery:	❒	❒

When:______________________

Where:_______________________________

Date: ____________________

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Notes: ____________________________________
____
____
____

Radicular Pain: Yes No R L BILAT
__Intermittent __Constant __Night
____

Non-radicular Pain: Yes No R L BILAT
__Intermittent __Constant __Night
____

Numbness: Yes No R L BILAT
__Intermittent __Constant __Night
____

Paresthesias: Yes No R L BILAT
__Intermittent __Constant __Night
____

Weakness: Yes No R L BILAT
__Intermittent __Constant __Night
____

	<u>Yes</u>	<u>No</u>
Saddle Anesthesia:	❒	❒
Bowel Changes:	❒	❒
Bladder Changes:	❒	❒

Describe:____________________
____
____
____

❒ **Prior Neck Surgery:**

1.__/__/__ __HNP __Decomp __NI Fus __Ins Fus
__Other__________________

2.__/__/__ __HNP __Decomp __NI Fus __Ins Fus
__Other__________________

3.__/__/__ __HNP __Decomp __NI Fus __Ins Fus
__Other__________________

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Procedures:	Yes	No
X-rays	☐	☐
MRI Scan	☐	☐
CAT Scan	☐	☐
CTMYELOGRAM	☐	☐
MYELOGRAM	☐	☐
Bone Scan	☐	☐
Nerve Studies	☐	☐
Blocks	☐	☐
Epidural Steroids	☐	☐
Therapies:		
Anti inflammatories	☐	☐
Narcotics	☐	☐
Muscle Relaxants	☐	☐
Antidepressants	☐	☐
Oral Steroids	☐	☐
Chiropractor	☐	☐
Occup Rehab	☐	☐
Exercise	☐	☐
Physical Therapy	☐	☐
Brace	☐	☐
Tens Unit	☐	☐
Pain Program	☐	☐
Back School	☐	☐

Past Medical History: Circle all that apply

None	Hypertension
Diabetes	Cancer
CVA (stroke)	Lung Disease
Heart Disease	Obesity
Vascular Disease	Weight Loss
Fatigue	

Prior Surgeries(Non spine) ______________

____

Allergies__None__No known drug allergies__

Drug:__________Reaction:______________

Drug:__________Reaction:______________

Drug:__________Reaction:______________

Drug:__________Reaction:______________

Medications__ None

1._______________for _________________

2._______________for _________________

3._______________for _________________

Please circle the appropriate selection

Social History: Married Single Divorced Widowed

# of children: 0 1 2 3 4 or more

Smoke: Yes / No

Alcohol intake: Yes/No

Height:___________Weight:__________

Family History: None____

Date: _________________

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Result of Procedures:

X-ray ____________________________________

MRI scan ________________________________

CAT scan ________________________________

CT/MYELOGRAM__________________________

MYELOGRAM ____________________________

Bone Scan _______________________________

Nerve Studies_____________________________

Blocks __________________________________

Epidural Steroids__________________________

NSAIDS__________________________________

Narcotics_________________________________

Muscle Relax ______________________________

Antidepress _______________________________

Oral Steroids______________________________

Exercise__________________________________

Physical Therapy___________________________

____

Brace ____________________________________

Tens Unit _________________________________

Pain Program_______________________________

Manipulations ______________________________

Back School________________________________

Occup Rehab________________________________

ROS__

Chest Pain __	Abdominal Pain__
Head Aches__	Shortness of breath__
Weight Loss__	Fatigue__
Night Sweats__	

PAIN DRAWING

Name:________________________________ Date:___________________

Please circle the one pain level which best describes your current pain level.

Pain Level	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	(No Pain)										(Severe Pain)

Please mark these drawings according to where you have pain (if the back of your neck hurts, mark the drawing on the back of the neck). If you feel any of the following symptoms, please indicate which sensations you feel by placing the marks shown below.

▲ ▲ ▲ Aching	x x x Burning
0 0 0 Pins & Needles	/ / / Stabbing
v v v Numbness	● ● ● Other

Front

Right

Left

Back

Right