

Date: _____ Social Security Number: _____

Patient Name: _____ Sex: _____

DOB: __/__/__ Age: ____ Marital Status: _____ Phone: (____)-____-_____

Street Address: _____ City: _____ ST: ____ Zip: _____ - _____

Insurance: 1. Private Insurance _____

2. Workman's Compensation _____

3. Motor Vehicle Accident _____

How did you Hear about the Salt Lake City Orthopedic Clinic?

1. Referred by Doctor _____

2. Referred by Emergency Room or Hospital Clinic _____

3. Referred by Patient of Salt Lake City Orthopedic Clinic _____

4. Referred by Other _____

5. Self Referred _____

Where are your Symptoms Located?

1. Neck Pain Only _____ 4. Neck and Arm Pain _____ (right ____ left ____)

2. Mid Back Pain _____ 5. Low Back Pain Only _____

3. Low Back and Legs _____ (right ____ left ____)

How Long have you had this Pain?

1. 1-4 Weeks _____ 2. 1-4 Months _____ 3. More than 4 Months _____

Did your pain begin suddenly or with a slow gradual onset? _____

What do you think was the cause of your pain?

1. Household activities i.e. Vacuuming, Raking, Childcare _____

2. Work i.e. lifting, bending sitting _____

3. Motor vehicle accident _____

4. Sports _____

5. Other _____

Have you had similar attacks of pain in the past?

1. No _____

2. 1-2 _____

3. 2-5 _____

4. 5 or more _____

If you have Back Pain Select between 0 and 10 that best describes your level of pain. ____

If you have Leg/Arm Pain, select a number between 0 and 10 that best describes your level of pain. ____

Do you have any of the following symptoms?

1. Numbness or tingling in the legs _____
2. Numbness or tingling in the arms _____
3. Weakness in the legs _____
4. Weakness in the arms _____
5. Pain in the legs with walking _____
6. Bowel or bladder changes _____

Is your Pain aggravated by any of these?

1. Coughing or sneezing Yes _____ No _____
2. Sitting Yes _____ No _____
3. Bending Forward to brush teeth Yes _____ No _____
4. Lying down Yes _____ No _____
5. Walking a distance Yes _____ No _____

Please place a check by any of the following conditions you have had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Gout | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Rheumatic | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Other Heart Disease | <input type="checkbox"/> Allergies (Hay Fever) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Bloodpressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers (peptic,duodenal) |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer |

Do you smoke? Yes _____ No _____

Do you use alcoholic beverages? Yes _____ No _____

Do you have any drug allergies? Yes _____ No _____

If yes what drugs are you allergic to? _____

Please Check ALL Symptoms you are experiencing now:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chills Palpitations | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Excess Sweating | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Swollen Feet/ankles | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Vision Trouble | <input type="checkbox"/> High Bloodpressure | <input type="checkbox"/> Nighttime Urination |
| <input type="checkbox"/> Eye Pain/Redness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Bruise Bleed Easily |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hot Weather Intolerance |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Cold Weather Intolerance |
| <input type="checkbox"/> Throat Discomfort | <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Increased Thirst |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Nausea Vomit | <input type="checkbox"/> Increased Urine Volume |
| <input type="checkbox"/> Sputum | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression | <input type="checkbox"/> Muscle Weakness/paralysis |

Please list any medications that you are presently taking. _____

Do the following activities make you feel better?

- | | | | | |
|-------------------------|-----|-------|----|-------|
| 1. Lying down/resting ? | Yes | _____ | No | _____ |
| 2. Sitting ? | Yes | _____ | No | _____ |
| 3. Standing ? | Yes | _____ | No | _____ |
| 4. Walking ? | Yes | _____ | No | _____ |
| 5. Exercise ? | Yes | _____ | No | _____ |

Have you had Back Surgery before? Yes _____ No _____

If yes, number of Surgeries and Type _____

Have you had any of the following diagnostic procedures don in evaluation of this episode of pain?

1. Bone Scan ? Yes _____ No _____

If yes, where and when: _____

2. CT Scan/myelogram? Yes _____ No _____

If yes, where and when: _____

3. EMG? Yes _____ No _____

If yes, where and when: _____

4. MRI? Yes _____ No _____

If yes, where and when: _____

5. X-Rays? Yes _____ No _____

If yes, where and when: _____

6. Blood Work? Yes _____ No _____

If yes, where and when: _____

What kind of treatments have you received for this current episode of pain?

1. Bed Rest? Yes _____ No _____

If yes, how many days on bed rest: _____

2. Medication (Narcotic)? Yes ___ No ___

If yes, what medication: _____

3. Medication (Non-Narcotic)? Yes ___ No ___

If yes, what medication: _____

4. Brace? Yes ___ No ___

5. Physical Therapy? Yes ___ No ___

If yes, where and when: _____

6. Chiropractor? Yes ___ No ___

7. Acupuncture: ? Yes ___ No ___

8. Back Injections? Yes ___ No ___

9. Other Yes ___ No ___

Do you participate in a general exercise program? Yes ___ No ___

What is your present work status?

- 1. Disabled _____
- 2. Part time/Light duty _____
- 3. Full Duty _____
- 4. Unemployed _____

Employer Name: _____

Occupation: _____ Date Last Worked: __/__/__

If your job requires heavy lifting, what is the average weight of the objects you lift?

- ___ 1-25 lbs.
- ___ 25-50 lbs.
- ___ 50-70 lbs.
- ___ 75-100 lbs.
- ___ 100 lbs. or more

If your job requires heavy lifting, How frequently would you say you lift daily?

- ___ Rarely

- Occasionally
- Frequently
- Constantly

Are you currently receiving?

Workers Compensation: Yes No

Social Security: Yes No

Private Disability: Yes No

Are you involved in a personal law suit?

Yes No