ORTHOCENTER

ORTHOPAEDIC SPORTS MEDICINE AND REHABILITATION CENTER, P.A.

NAME: _____ DOB: _____ DATE: _____

PAIN DRAWING

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.(Use los symbolos indicados para demostrar que sensasion siente en el cuerpo. Incluya todas las zonas.)

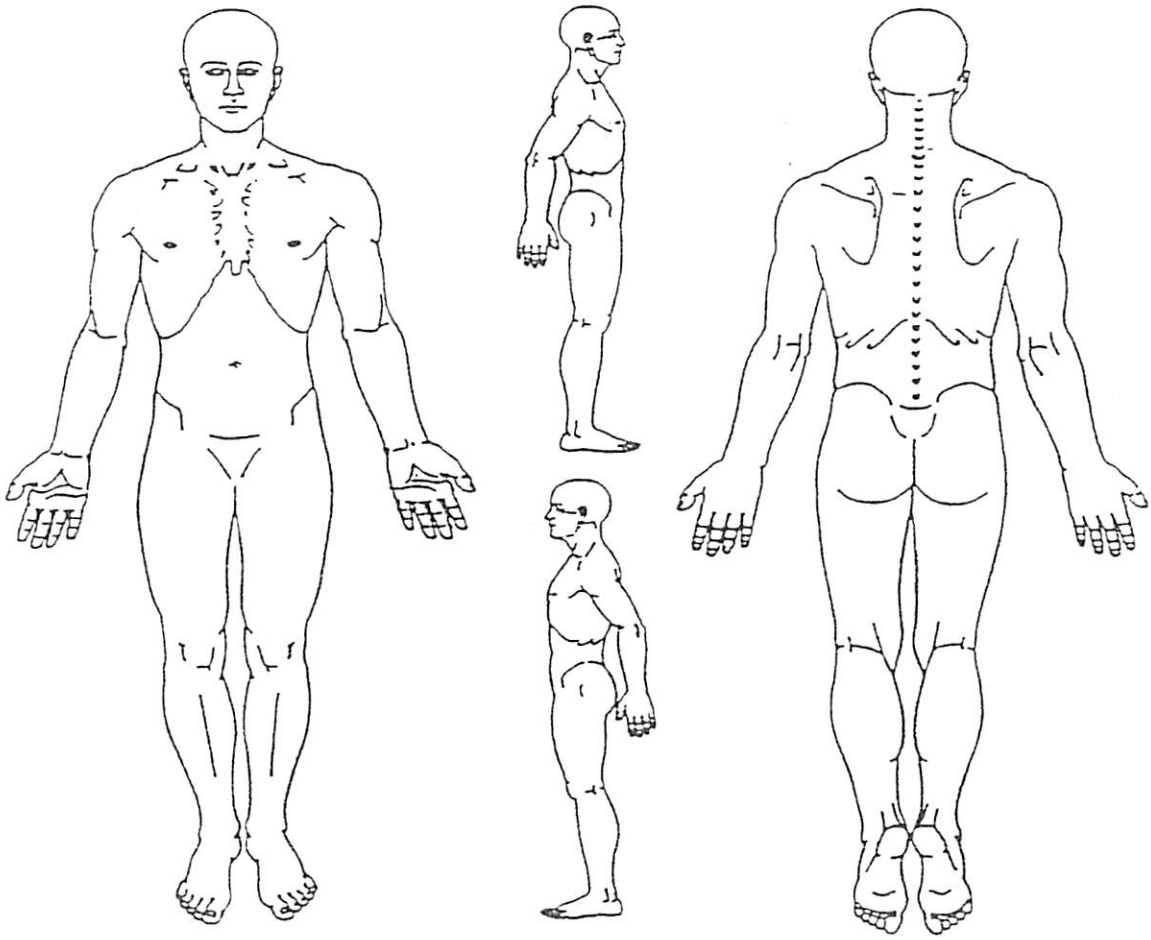
Rate your pain on a scale of 0 (no pain) to 10 (worst pain ever) _____
When did you last take pain medication and/or supplements? _____
If so, please list

_____

_____

Aching (Doloroso)	Numbness (Dormido)	Pins & needle (Pinchasos)	Burning (Ardor)	Stabbing (Punaladas)	Other
Δ Δ Δ	= = =	0 0 0	X X X	/ / /	●●●

(Right Side)



Right Left (Left side) Left Right

Pain since last visit is:	worse	same	less
Pain in arms(s) compared with neck:	worse	same	less
Pain in legs(s) compared with back:	worse	same	less

ORTHOPAEDIC, SPORTS MEDICINE AND REHABILITATION CENTER, P.A.

Spine and Pain Service

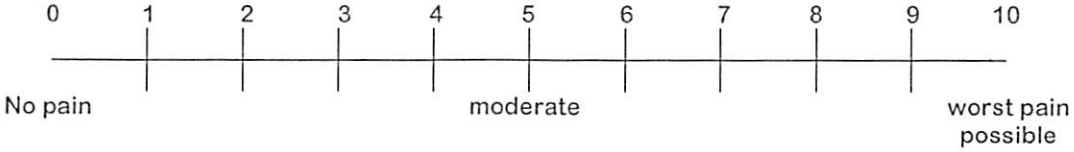
Name: _____ Age: _____ Date: _____
Who referred you to us? _____
Would you like your notes sent there? Y N

When did you first feel symptoms? _____
Have you had episodes like this in the past? Y N
When and how often? _____
Was it related to an accident? Y N
Work related? Y N Motor Vehicle Accident? Y N
Please describe the accident, if any: _____
Are you claiming workers compensation? Y N
Comments: _____
Are you in litigation regarding your accident? Y N
Comments: _____

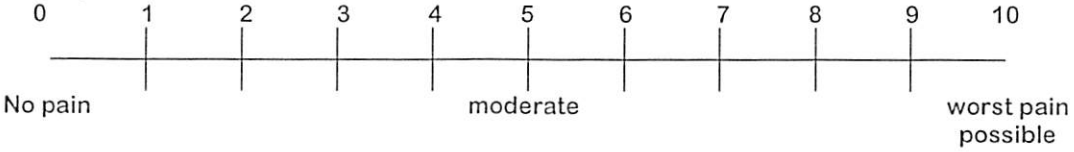
Do you have neck/back pain? Y N
Is one side of your neck/back worse? Right Left Equal
Is your neck/back pain present now? Y N
Has your neck/back pain been getting Better Worse Same
How long have you had neck/back pain? _____

Do you have arm or shoulder/leg or buttock pain? Y N
Is one side worse? Right Left Equal
Is your arm/leg pain present now? Y N
Has your arm/leg pain been getting Better Worse Same
How long have you had arm/leg pain? _____

My worst pain has been:



My pain today is:



What percentage of your pain is in your neck/back? _____%
What percentage of your pain is in your arms/legs? _____%
My pain feels better when I: _____
My pain feels worse when I: _____

Have you had unexplained weight loss recently? Y N
Do you suffer with fever, chills or night sweats? Y N
Do you have a history of cancer? Y N
Do you have trouble sleeping because of your symptoms? Y N
Do you have bowel problems because of your symptoms? Y N
Do you have urinary problems because or your symptoms? Y N
Do you feel off balance because of your symptoms? Y N
Have you had problems with coordination such as writing, buttoning shirts or tying shoes? Y N
Comments: _____

Have you seen any other physicians for these symptoms?
_____

Have you had?	Have you tried?	Have you done?
□x-rays	□NSAIDS (i.e. Advil)	□Physical Therapy
□MRI	□Muscle relaxants	□Massage Therapy
□CT scan	□Steroids	□Chiropractic Care
□Discogram	□Narcotics	□Epidural Injections
□EMG	□Lyrica / Neurontin	□Other Injections
□Other tests	□Other medications	

What medicines or treatments have helped your symptoms?
_____
_____

Have you had back or neck surgery? Y N
When and with whom? _____

What type of work do you do? _____
Do you enjoy your work? _____
Have you missed work because of your current symptoms? _____
Date Last Worked: _____

What activities do you enjoy? _____
Do you smoke? Y N Packs per day? _____ For how long? _____
Do you drink alcohol? Y N Drinks per week? _____ For how long? _____

What would you like your doctor to do for you today?
_____
_____