Tahoe Orthopedics & Sports Medicine

Name: _____

DOB: _____

Date: _____

Pain Assessment

Location of Pain (body part):_____

Please circle: LEFT RIGHT BOTH

Severity of Pain: 0 1 2 3 4 5 6 7 8 9 10

Quality of Pain: (Circle all that apply)

Throbbing Sharp Dull Aching Locking

Grinding Popping Cracking Buckling

Symptoms: (Circle all that apply)

Buckling Catching Cracking Crepitus

Giving-Way Grinding Locking Popping

Duration of Pain: (Circle all that apply)

A few minutes A few hours A few days Persistent

Frequency of pain: (Circle all that apply)

Rarely Once a week Several days a week Several times a day

Intermittent Occasional Constant Frequent

Date pain started: _____

Aggravating Factors: (circle all that apply)

Activity Bending Exercise Grasping Gripping Kneeling

Pivoting Reaching Running Sports Squatting Stairs

Straightening Stretching Standing Walking

Limiting Behavior: YES NO

Relieving Factors: (circle all that apply)

Rest Ice Heat Exercise NSAIDS

Result of Injury: YES NO

Work-Related Injury: YES NO

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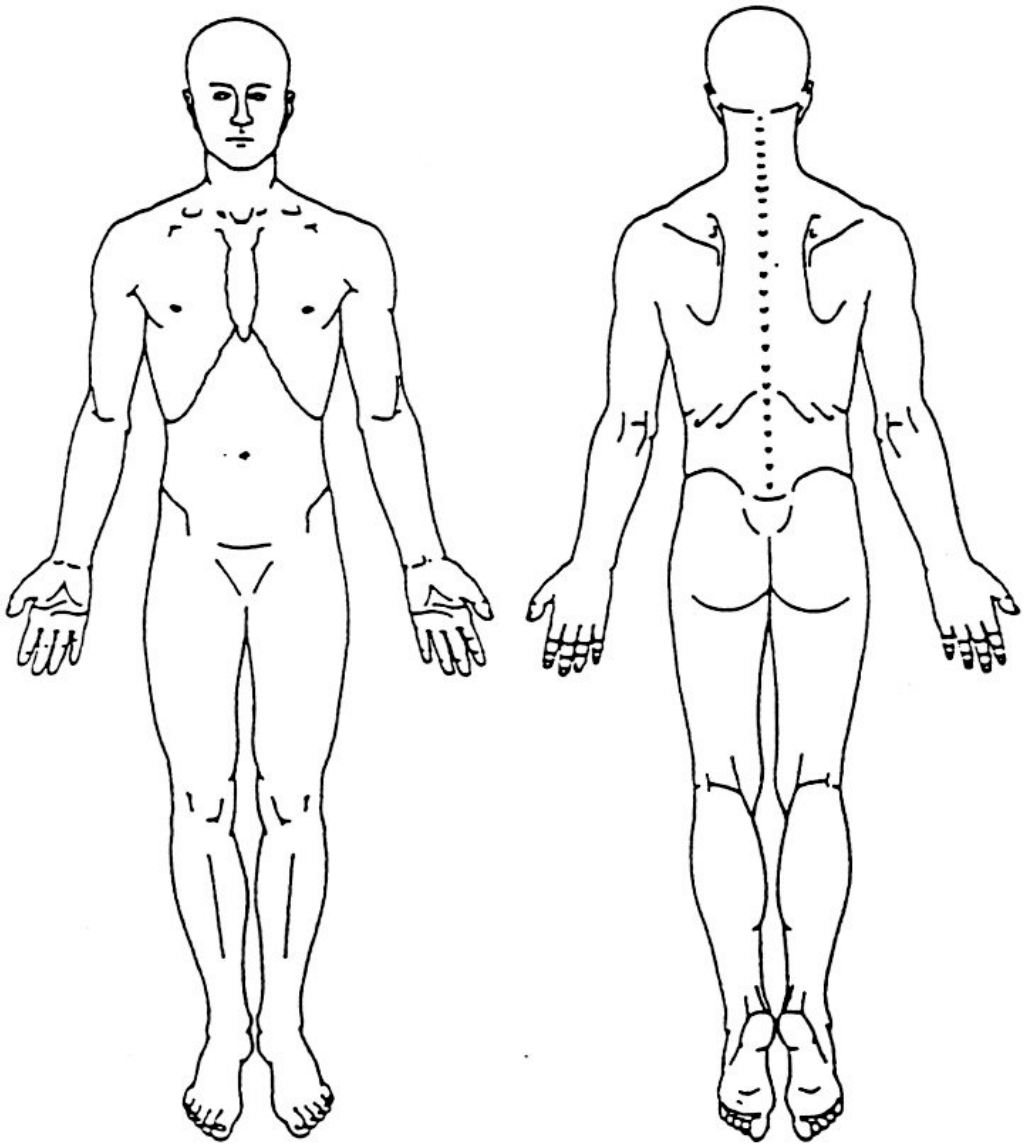
Note the location of your pain on these drawings. (If the back of your neck is painful, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the symbols on the diagrams.

Numbness ======== Pins and needles oooooooooo Ache ^^^^^^^^^^

Burning XXXXXXXX Stabbing //////////////



_____ _____ _____ _____

Patient's Signature Date Physician's Signature Date

Which of the following have you had?					Did the treatment make you:		
	Other	Low Back	Mid Back	Neck	Better	No Change	Worse
Physical Therapy							
Occupational Therapy							
Chiropractic / Osteopathic							
Acupuncture							
Regular X-rays							
MRI Scan							
CT Scan							
EMG / NCV							

Any changes to the following since your last visit?		
Medications:	YES	NO
If yes, what? _____		
Allergies:	YES	NO
If yes, what? _____		

Any new hospitalizations or surgeries since your last visit?	YES	NO
If yes, what? _____		
If yes, where? _____		
If yes, when? _____		

Any new medical problems or issues since your last visit?	YES	NO
If yes, what? _____		

Review of Systems

Patient Name: _____ **Date of Birth:** _____

General (Circle all that apply. If none apply, circle "none"):
Fever Chills Diaphoresis/Sweats Weight Loss Malaise/Fatigue Weakness
None Other:_____

Skin (Circle all that apply. If none apply, circle "none"):
Rash Itching None Other: _____

Head, Ears, Nose, Throat (Circle all that apply. If none apply, circle "none"):
Headaches Hearing Loss Tinnitus/Ringing in Ears Ear Pain Ear Discharge Nosebleeds Congestion Stridor Sore Throat
None Other: _____

Eyes (Circle all that apply. If none apply, circle "none"):
Blurred Vision Double Vision Photo phobia/Light Sensitivity Eye Pain Eye Discharge Eye Redness
None Other: _____

Cardiovascular (Circle all that apply. If none apply, circle "none"):
Chest Pain Palpitations Orthopnea/Shortness of Breath Claudication/Leg Weakness/Limp Leg Swelling
PND(Paroxysmal Nocturnal Dyspnea) None Other: _____

Respiratory (Circle all that apply. If none apply, circle "none"):
Cough Hemoptysis/Coughing Blood Sputum Production Shortness of Breath Wheezing
None Other: _____

Gastrointestinal (Circle all that apply. If none apply, circle "none"):
Heartburn Nausea Vomiting Abdominal Pain Diarrhea Constipation Blood in Stools Melena/Black stools
None Other: _____

Genitourinary (Circle all that apply. If none apply, circle "none"):
Dysuria/Painful Urination Urgency Increase Frequency Hematuria/Blood in Urine Flank pain
None Other: _____

Musculoskeletal (Circle all that apply. If none apply, circle "none"):
Myalgia/Muscle pain Neck Pain Back Pain Joint Pain Falls
None Other: _____

Endocrine/Hematologic/Lymphatic (Circle all that apply. If none apply, circle "none"):
Easy to Bruise/Bleed(Anemia) Environmental Allergies Polydipsia/Excessive Thirst
None Other: _____

Neurological (Circle all that apply. If none apply, circle "none"):
Dizziness Tingling Tremor Sensory ChangeSpeech Change Focal Weakness Seizures Loss of Consciousness
None Other: _____

Psychiatric (Circle all that apply. If none apply, circle "none"):
Depression Suicidal Ideas Substance Abuse Hallucinations Nervousness/Anxious Insomnia Memory Loss
None Other: _____