

Please fill out these forms completely!

We Know that filling out these forms can be difficult – but please complete them carefully. Your accurate responses will give us a better understanding of your and your problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes and fill in the blanks where indicated.

Thank you for your helping us to know you better!

Date: _____

Patient Name: _____
(Please print)

Gender: Male Female

Date of Birth: _____
Month/Day/Year

Current Age: _____

Height: _____ Weight: _____

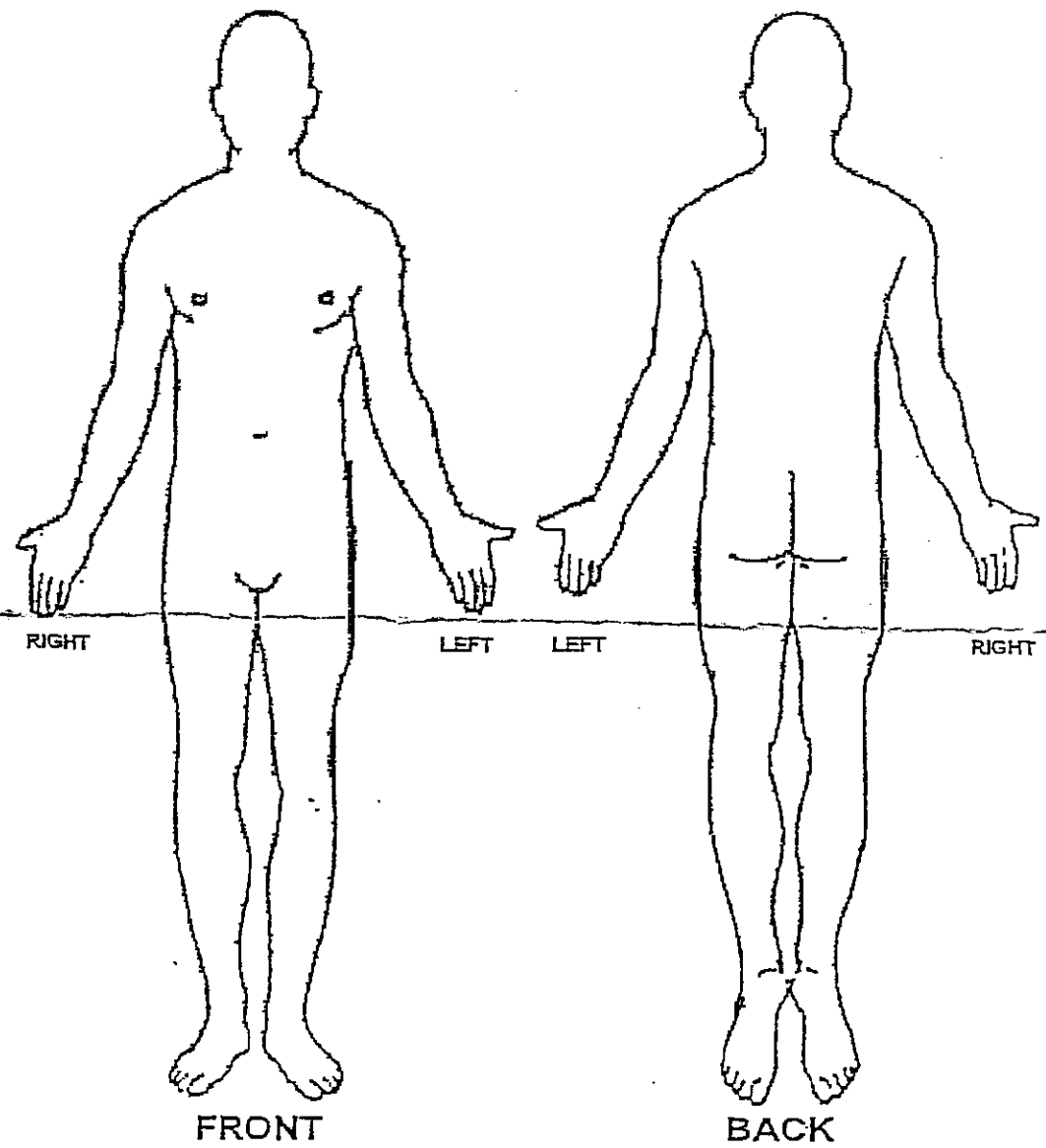
Referring Physician: _____

Primary Care Physician: _____

PAIN DIAGRAM

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

- Ache**
AAAAA
AAAAA
AAAAA
- Numbness**
NNNN
NNNN
NNNN
- Pins & Needles**
PPPP
PPPP
PPPP
- Burning**
BBBB
BBBB
BBBB
- Stabbing**
SSSS
SSSS
SSSS





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PREVIOUS TREATMENT

We need to know about the treatments you have already received for your current back/neck pain. If YES, did it make your condition better or worse?

Have you had:

- Chiropractic care better worse
- Physical therapy better worse
- Injections better worse
- Psychological consultation better worse
- Other: _____ better worse

For your current back/neck pain, please mark the boxes for the timeframe that any tests were done.

	<6 mo	<12 mo
X-rays	<input type="checkbox"/>	<input type="checkbox"/>
MRI scan	<input type="checkbox"/>	<input type="checkbox"/>
CT scan	<input type="checkbox"/>	<input type="checkbox"/>
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>
Discogram	<input type="checkbox"/>	<input type="checkbox"/>
EMG/NCV (nerve test)	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had surgery on your back or neck?

yes no If YES, complete the following:

1) Type of surgery _____
 Date _____
 Surgeon _____
 Did it make your pain better or worse?

2) Type of surgery _____
 Date _____
 Surgeon _____
 Did it make your pain better or worse?

3) Type of surgery _____
 Date _____
 Surgeon _____
 Did it make your pain better or worse?

GENERAL MEDICAL HISTORY

Check all the conditions below that you have currently or have had in the past. If NONE check

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Colon Problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Enlarged prostate | <input type="checkbox"/> ALS |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer: type | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis | <i>Have you used:</i> |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Multiple Sclerosis (MS) | <input type="checkbox"/> Immuno-suppression? |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Visual Changes | <input type="checkbox"/> Corticosteroids |
| <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Degenerative arthritis | <input type="checkbox"/> Frequent pneumonia | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Duodenal problems | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anemia (low blood count) | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Sexual difficulty | <input type="checkbox"/> Dizziness | |

List any major surgery you have had, other than on your back or neck.

Type of surgery	Year
1. _____	_____
2. _____	_____
3. _____	_____

Are you allergic to any medications?

yes no If YES, list the medications.

Are you allergic to metal? yes no

Do you take any medications, including herbal, over-the-counter, and prescription?

yes no If YES, list all medications you are taking.

Medication	Reason taken	How often taken	Doctor (if prescribed)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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REVIEW OF SYSTEMS

Do you have any allergies other than to medications (such as to latex, shellfish, etc.)?
yes no If YES, describe.

Do you have any of the following?

General:

Recent weight loss of more than 10 pounds? yes no
Recent weight gain of more than 10 pounds? yes no
Fever? yes no
Chills? yes no
Night sweats? yes no

Have you seen your primary care physician in the past year? yes no

Cardiac:

Chest pain yes no
Shortness of Breath yes no

Respiratory:

Wheezing yes no
Pneumonia yes no
Chronic cough yes no

Gastrointestinal:

Abdominal pain yes no
Nausea yes no
Vomiting yes no
Diarrhea yes no
Liver problems yes no

Skin:

Open sores yes no
New moles yes no
Poor healing yes no
Skin infection yes no

Hematologic/Oncologic:

Easy bruising yes no
Blood thinning medications yes no
Blood transfusion yes no
Organ transplant yes no

Bones/Joints:

Shoulder pain yes no
Wrist/hand pain yes no
Hip pain yes no
Knee pain yes no
Lupus yes no
Muscle weakness yes no
Fibromyalgia yes no

Genitourinary:

Abnormal kidney function yes no
Pain with urination yes no
Frequent urinary infections yes no

Nervous System:

Headaches yes no
Tremors yes no
Poor speech yes no
Changes in vision yes no

Mental Health:

Sleep disturbances yes no
Feeling of hopelessness yes no

Endocrine:

Thyroid problems yes no

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NECK PAIN QUESTIONNAIRE

If you have NECK pain- complete this page.

Please Read: This questionnaire has been designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please just mark the one choice which most closely describes your problem right now.

Section 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help everyday in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

Section 5 – Headaches

- I have no headache at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7 – Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

Section 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

- I am able to engage in all of my recreational activities with no neck pain at all.
- I am able to engage in all of my recreational activities with some pain in my neck.
- I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.