ORTHOPAEDIC SPECIALISTS OF AUSTIN

Name: _____ Date of birth: _____/_____/_____ Age: _____

Height: _____'_____' Weight: _____lbs. Pharmacy Name/Phone Number: _____

Referring Physician Name: _____

Please describe problem(s) you are here for today: _____

_____

How long have you had the problem? _____

If an injury, where did it occur? ❒ Home ❒ School ❒ Auto ❒ Other _____ Date of Injury: ___/____/____

Where is the majority of your pain? ❒ Leg Pain Rt / Lt / Both ❒ Back { %} Leg { %} Back

❒ Arm Pain Rt / Lt / Both ❒ Neck { %} Arm { %} Neck

Pain Scale (Check One Number): MILD MODERATE SEVERE

❒ None ❒ 1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

Onset of Pain: ❒ Sudden ❒ Chronic ❒ Gradual Worsening

Duration of Pain: ❒ Occasional ❒ Intermittent ❒ Frequent ❒ Constant

Describe Pain: ❒ Sharp ❒ Aching ❒ Stabbing ❒ Burning ❒ Numbness ❒ Cramping

What makes it feel better? ❒ Bending Forward ❒ Sitting ❒ Standing ❒ Bending Back ❒ Walking ❒ Lying Flat

What makes it feel worse? ❒ Bending Forward ❒ Sitting ❒ Standing ❒ Bending Back ❒ Walking ❒ Lying Flat

Is your pain activity related? ❒ Yes ❒ No Does the pain wake you from your sleep? ❒ Yes ❒ No

What does the pain keep you from doing? _____

_____

_____

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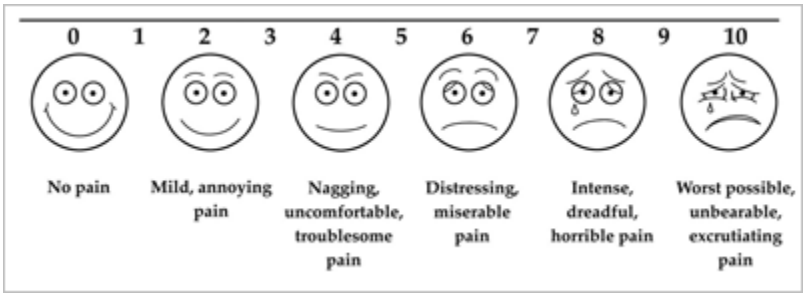
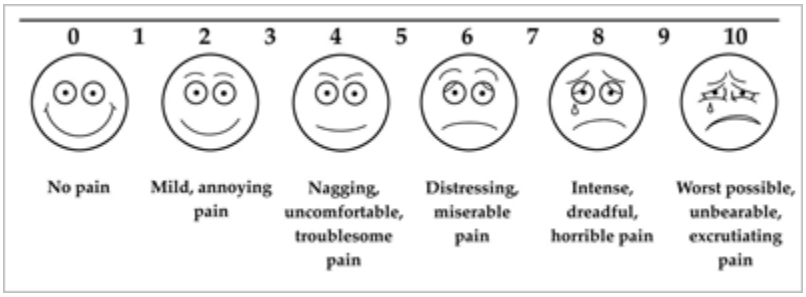
What is your level of Back or Neck Pain?

Please circle only **ONE**



What is your level of Leg or Arm Pain?

Please circle only **ONE**



PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing (Please list name of facility and date of service):
❒ CT _____
❒ MRI _____
❒ EMG _____
❒ X-Ray _____
❒ Other _____

Anti-Inflammatories: ❒ Helpful ❒ Not Helpful Name of Anti-Inflammatory: _____

Injections: ❒ Helpful ❒ Not Helpful Type of Injection(s) and Date of Injection: _____

Physical Therapy: ❒ Helpful ❒ Not Helpful Name of PT Facility and Duration of PT: _____

Chiropractics: ❒ Helpful ❒ Not Helpful Name of Facility and Duration of treatment: _____

Other Treatment: _____

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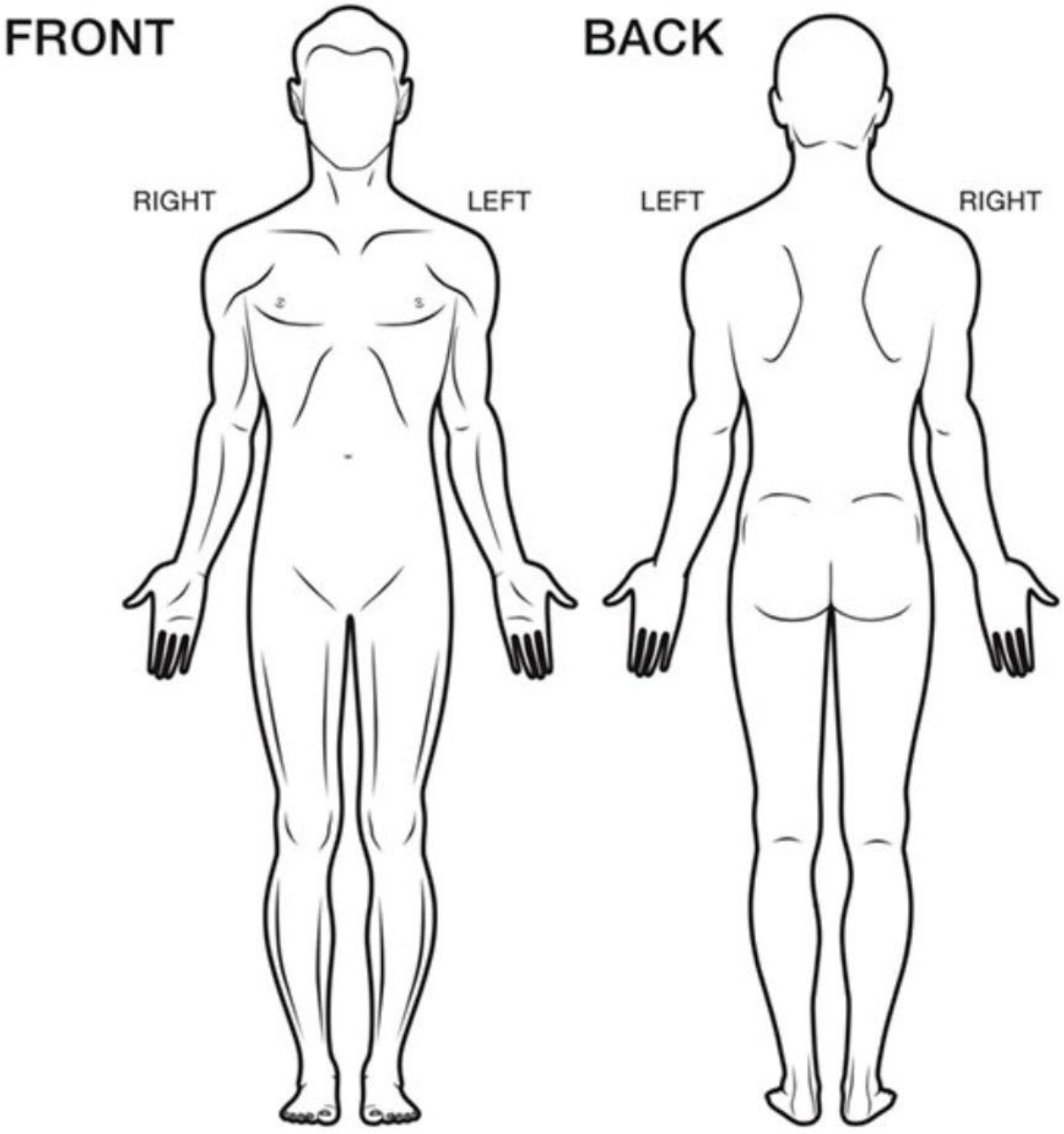
Using these symbols, mark the drawing below to describe the pain that you are having.

Numbness	= = = = = = = = = = = =	Aching	^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^	Pins and Needles	o o o o o o o o o o
Stabbing	/ / / / / / / / / / / / / / / / / / / /	Burning	x x x x x x x x x x x x x x x x	Cramping	+ + + + + + + + + +



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MEDICAL HISTORY *Check the boxes that correspond to diagnoses you have been given in the past*

ADD/ADHD		Diabetes Mellitus		Inflammatory Bowel Disease	
Allergies		Eating Disorder		Liver Disorder	
Anemia		Emphysema		Nerve/Muscle Disease	
Anxiety		Genitourinary Disease		Obesity	
Arthritis		GERD		Osteoporosis	
Asthma		Glaucoma		Pneumonia	
Bleeding Disorder		Headaches		Seizures	
Cancer		Hearing Loss		Skin Disease	
Congestive Heart Failure		Heart Disease		Stroke	
COPD		Hepatitis		Substance Abuse	
Coronary Artery Disease		HIV/AIDS		Thyroid Disease	
Dementia		Hyperlipidemia		Ulcers (GI)	
Depression		Hypertension		Vision Problems	

SURGICAL HISTORY *Check the boxes that correspond to surgeries you have had in the past*

Abdomen Surgery		Eye Surgery		Spine Surgery	
Adenoidectomy		Gallbladder Surgery		Stent	
Appendectomy		Heart Surgery		Tonsillectomy	
Breast Surgery		Hernia Repair		Tubal Ligation	
CABG (Bypass Surgery)		Hysterectomy		Upper GI Endoscopy	
Colonoscopy		Joint Replacement		Valve Repair	
Cosmetic Surgery		Orthopedic Surgery		Weight Loss Surgery	
C-Section		Sinus Surgery			

FAMILY HISTORY *Check the boxes that correspond to your family history* ❒ Adopted

	Arthritis	Asthma	Cancer	Depression	Diabetes	Early Death	Heart Disease	High Cholesterol	Hypertension	Stroke
Mother										
Father										
Sister										
Brother										
Grandfather										
Grandmother										

MEDICATIONS *List your medication name, strength and frequency*

Name of Drug	Strength	Frequency	Name of Drug	Strength	Frequency

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ALLERGIES ❒ NKDA *List your allergies and reactions*

Medication Allergy	Reaction

SOCIAL HISTORY

Alcohol	Do you drink alcohol? ❒ Yes ❒ No If yes, how many drinks per week? _____
Tobacco	Do you use tobacco? ❒ Yes ❒ No
	❒ Cigarettes: ___ packs per day ❒ Dip: ___ # per day ❒ E-Cig/Vape
	❒ Pipe: ____ # per week ❒ Cigars: ____ # per week
	How many years have you used tobacco? _____ What year did you quit? _____ ❒ Currently Smoking
Drugs	Do you currently use recreational or street drugs? ❒ Yes ❒ No
	If yes, what kind?

REVIEW OF SYSTEMS *Check the boxes that correspond to any symptoms you are **CURRENTLY** experiencing.*

SKIN		**CARDIOVASCULAR**		**ENDOCRINE**	
Rash		Heart Attack		Diabetes	
Psoriasis		Irregular Heartbeat		Thyroid	
EYES		Chest Pain		**HEMATO-IMMUNOLOGIC**	
Vision Loss		Chest Pressure		Bleeding Tendencies	
Double Vision		**GASTROINTESTINAL**		Bruise Easily	
EARS		Weight Loss		Recurrent Infections	
Decreased Hearing		Weight Gain		**PSYCHIATRIC**	
Ringing in Ears		Abdominal Pain		Depression	
NOSE		Liver Disease		Hallucinations	
Sinus Problems		Constipation		Anxiety	
Breathing Problems		**GENITOURINARY**			
THROAT		Kidney Stones			
Sore Throat		Bladder Infections			
Hoarseness		Blood in Urine			
Snoring		**MUSCULOSKELETAL**			
RESPIRATORY		Osteoporosis			
Shortness of Breath		Rheumatoid Arthritis			
Asthma		Gout			
Bronchitis		**NEUROLOGICAL**			
Pulmonary EMB/DVT		Seizures			
Cough		Headaches			

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INJURY ADDENDUM

CIRCUMSTANCES OF INJURY

Date of Injury: _____

Make and Model of YOUR car: _____

How did the accident happen? (Ran red light, etc.): _____

Make and Model of OTHER car: _____

How fast were YOU moving? _____

How fast was the OTHER car moving? _____

Description of Accident: ❒ Passenger Side ❒ Driver Side ❒ Frontal ❒ Rear

How much did it cost to repair YOUR car? _____

Were you wearing a seatbelt? ❒ Yes ❒ No

Were you: ❒ Driving ❒ Passenger

Comments: _____

PREVIOUS TREATMENT FOR THIS PROBLEM

Have other doctors seen you for this condition? ❒ Yes ❒No If yes, who? _____

_____

Have you ever had this type of pain before? ❒ Yes ❒ No

Have you ever had back or neck pain before? ❒ Yes ❒ No

Have you ever had an MRI of your back or neck? ❒ Yes ❒ No If yes, at what facility? _____