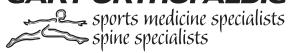
CARY ORTHOPAEDIC



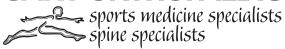
PHYSIATRIST CLINICAL PAPERWORK

Patient Name:	A	Date:					
Age:Weight:	Occupation	on:	HowLong?				
Are you: ☐ Right Handed	or 🖵 Le	eft Handed					
Date of last Flu Vaccine Date of last Pneumonia Vaccine							
What is your chief complaint? (describe y	our problem an	d any treatment)					
			·				
The symptoms are mainly in the:	aalz 🗀 Naalz		200				
Please rate your pain in the following bod		<u> </u>					
BackNeckLegs_	• 1		ing the worse pain.				
When did your symptoms begin?							
		□ No					
Are your symptoms due to a work injury?							
Are your symptoms due to an auto accide		□ No					
Have your symptoms changed since they		□ No					
If so, how?							
Have you ever had any similar symptoms?	?	□ No					
Check the following words which best des	scribe your sym	ptoms:					
☐ Sharp ☐ Numbness ☐ Du	ıll 📮 Ti	ingling	ical				
□ Burning □ Spasms □ Aching □ Skin Sensitivity							
☐ Weakness ☐ Erectile Dysfunction							
☐ Incontinence ☐ Changes to your bowel/bladder pattern							
☐ If yes, please specify:							
Which factors make the pain BETTER :							
☐ Sitting ☐ Standing ☐	Lying Down	☐ Flexing Forward	☐ Overhead Activity				
☐ Extending Backwards ☐ Walking ☐	Reaching	☐ Neck Motion					
Which factors make the pain WORSE :							
☐ Sitting ☐ Standing ☐	Lying Down	☐ Flexing Forward	☐ Overhead Activity				
☐ Extending Backwards ☐ Walking ☐	Reaching	☐ Neck Motion					

MEDICATIONS Please list all current medications and dos	ses.	
Medication	Dose	Reason
Medication	Dose	TORION I
ALLERGIES		
Are you allergic to any medications or foo	od that you know of?	□ Yes □ No
If yes, please list:	•	
Are you allergic to iodine or contrast dye		□ No
Are you allergic to shellfish or seafood?		□ No
Are you allergic to latex?		□ No
	La res Reaction.	
SOCIAL HISTORY Education Level: □ Elem / Middle So	ahaal Duigh Sahaal	College Masters/Desterate
	_	☐ College ☐ Masters/Doctorate
Employment Status:		
Occupation:	If disabled, for what p	roblem?
Marital Status		
Last date of employment		
What is your caffeine intake each day:		
Have you ever used recreational drugs an	d/or misused prescription	on medication? ☐ Yes ☐ No
Do you or did you ever smoke?	□ Yes	□No
If yes, how much/how long?	If previous smo	oker, when did you stop smoking?
Do you use alcohol? ☐ Yes	□ No If so, a	amount/frequency
FAMILY HISTORY		
Age Living	Deceased	Medical Problems
Father		Wiedled Froeigns
Mother		
		Ages
ILLNESSES		
Please check the following conditions, illr ☐ Heart: Specify		
☐ Heart: Specify ☐ Lung: Specify	_	s: Specify GI: Specify
☐ Kidney: Specify		
☐ Cancer: Specify		Clot: Specify
☐ Stroke: Specify		Specify
☐ Mental Illness: Specify	Thyroid	: Specify
☐ Asthma ☐ Diabetes	☐ Anxiety/Depression	n □ Migraines/Headaches □ Anemia
☐ Seizure Disorder ☐ HIV/AIDS		re
☐ Fibromyalgia ☐ Osteoarthritis	☐ Osteoporosis	☐ Rheumatoid Arthritis ☐ Tuberculosis
☐ Scoliosis ☐ Ulcers	☐ Lupus	☐ Other
☐ Vascular disease ☐ Acid Reflux	☐ Multiple Sclerosis	

SURGICAL HISTORY		
Please list any surgeries you have ha	nd on the lines provided:	
Neck Surgery: Type	Date:	Performing Physician
Back Surgery: Type	Date:	Performing Physician
PROCEDURES/TESTS		
<u> </u>		procedures, please bring in the imaging with you.
Wh	en	Where
X-RAYS		
MRI		
EMG/NCS		
Spinal Injections		
Physical Therapy Chiropractic		
Cintopractic		
REVIEW OF SYSTEMS General	Lungs	ENT
☐ Fever	Lungs ☐ Shortness of Breath	ENT ☐ Difficulty Swallowing
□ Chills	☐ Chronic Cough	☐ Difficulty Hearing
\square Weight loss > 10 lbs.	☐ Wheezing	☐ Sinus Trouble
☐ Weight gain > 10 lbs.	☐ Pleurisy	☐ Sore Throat
☐ Generally feeling ill☐ Extreme Fatigue	Musculoskeletal	Gastrointestinal
☐ Excessive Thirst	☐ Joint Cramping ☐ Joint Stiffness	☐ Acid Reflux
Heart	☐ Joint Swelling	☐ Loss of Appetite ☐ Trouble with bowel habits
☐ Chest Pain	☐ Warm red joints	☐ Black tarry stools
☐ Racing Heart	Psychological	☐ Ulcer pain
Genito-Urinary	☐ Unusual Stress	□ Nausea / Vomiting
□ Blood in urine	☐ Anxiety	☐ Constipation / Diarrhea
☐ Burning with urinations☐ Frequent urination	☐ Depression	Skin □ New skin sores
□ Difficulty controlling urine	Neurologic	□ New skin lumps
□ Loss of urine control with	☐ Headaches ☐ Easily Confusion	☐ Skin discoloration
_coughing or sneezing	☐ Seizures / Tremors	☐ Easy bruising / bleeding
□ Change in menstrual cycle	☐ Poor balance or walking	☐ Swollen lymph nodes
☐ Unusual vaginal bleeding	☐ Trouble starting arm or	leg motion
Vision		
☐ Blurred Vision		

CARY ORTHOPAEDIC



spine specialists	DATE
Patient Name:	

Pins and Needles	Z Z Z Z Z Z	Stabbing	BBB BBB	Burning
x x x Numbness x x x		Aching and Cramping		Other Sensations

Mark the location(s) of your pain on the body outlines using the symbols

