CARY ORTHOPAEDIC
sports medicine specialists
spine specialists

PHYSIATRIST CLINICAL PAPERWORK

Patient Name: ______________________ Account Number: __________ Date: __________

Age: _____ Height: ________ Weight: ________ Occupation: ________________ How Long? __________

Are you: ❑ Right Handed or ❑ Left Handed

Date of last Flu Vaccine ______________ Date of last Pneumonia Vaccine ________________

What is your chief complaint? (describe your problem and any treatment) ______________________

____

____

____

____

The symptoms are mainly in the: ❑ Back ❑ Neck ❑ Legs ❑ Arms

Please rate your pain in the following body parts on a scale of 0-10 with 10 being the worse pain:

Back ________ Neck ________ Legs ________ Arms ________

When did your symptoms begin? ______________________________________

Are your symptoms due to a work injury? ❑ Yes ❑ No

Are your symptoms due to an auto accident? ❑ Yes ❑ No

Have your symptoms changed since they began? ❑ Yes ❑ No

If so, how? ____

Have you ever had any similar symptoms? ❑ Yes ❑ No

Check the following words which best describe your symptoms:

❑ Sharp ❑ Numbness ❑ Dull ❑ Tingling ❑ Electrical

❑ 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 doses:

Medication	Dose	Reason

ALLERGIES

Are you allergic to any medications or food that you know of? ☐ Yes ☐ No

If yes, please list: ____________________

Are you allergic to iodine or contrast dye? ☐ Yes Reaction: ____________________ ☐ No

Are you allergic to shellfish or seafood? ☐ Yes Reaction: ____________________ ☐ No

Are you allergic to latex? ☐ Yes Reaction: ____________________ ☐ No

SOCIAL HISTORY

Education Level: ☐ Elem / Middle School ☐ High School ☐ College ☐ Masters/Doctorate

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Disabled ☐ Modified Duty

Occupation: ____________________ If disabled, for what problem? ____________________

____

Marital Status ____________________

Last date of employment ____________________

What is your caffeine intake each day: ____________________

Have you ever used recreational drugs and/or misused prescription medication? ☐ Yes ☐ No

Do you or did you ever smoke? ____________________ ☐ Yes ☐ No

If yes, how much/how long? ____________________ If previous smoker, when did you stop smoking? ____________________

Do you use alcohol? ☐ Yes ☐ No If so, amount/frequency ____________________

FAMILY HISTORY

	Age	Living	Deceased	Medical Problems
Father	______	☐	☐	____________________
Mother	______	☐	☐	____________________

Siblings ☐ Yes ☐ No How many? ____________________ Ages ____________________

ILLNESSES

Please check the following conditions, illnesses, or problems you have had:

☐ Heart: **Specify** ____________________

☐ Lung: **Specify** ____________________

☐ Kidney: **Specify** ____________________

☐ Cancer: **Specify** ____________________

☐ Stroke: **Specify** ____________________

☐ Mental Illness: **Specify** ____________________

☐ Hepatitis: **Specify** ____________________

☐ Colon/GI: **Specify** ____________________

☐ Bleeding: **Specify** ____________________

☐ Blood Clot: **Specify** ____________________

☐ Liver: **Specify** ____________________

☐ Thyroid: **Specify** ____________________

☐ Asthma

☐ Seizure Disorder

☐ Fibromyalgia

☐ Scoliosis

☐ Vascular disease

☐ Diabetes

☐ HIV/AIDS

☐ Osteoarthritis

☐ Ulcers

☐ Acid Reflux

☐ Anxiety/Depression

☐ High Blood Pressure

☐ Osteoporosis

☐ Lupus

☐ Multiple Sclerosis

☐ Migraines/Headaches

☐ High Cholesterol

☐ Rheumatoid Arthritis

☐ Other ____________________

☐ Anemia

☐ Nerve Disorder

☐ Tuberculosis

SURGICAL HISTORY

Please list any surgeries you have had on the lines provided:

____

____

____

____

Neck Surgery: Type ____________ Date: ________ Performing Physician ____________

Back Surgery: Type ____________ Date: ________ Performing Physician ____________

PROCEDURES/TESTS

Which of the following has been done? If you have had any of these procedures, please bring in the imaging with you.

	When	Where
X-RAYS	________	____________
CT Scan	________	____________
MRI	________	____________
EMG/NCS	________	____________
Spinal Injections	________	____________
Physical Therapy	________	____________
Chiropractic	________	____________

REVIEW OF SYSTEMS

General
- ☐ Fever
- ☐ Chills
- ☐ Weight loss > 10 lbs.
- ☐ Weight gain > 10 lbs.
- ☐ Generally feeling ill
- ☐ Extreme Fatigue
- ☐ Excessive Thirst

Heart
- ☐ Chest Pain
- ☐ Racing Heart

Genito-Urinary
- ☐ Blood in urine
- ☐ Burning with urinations
- ☐ Frequent urination
- ☐ Difficulty controlling urine
- ☐ Loss of urine control with coughing or sneezing
- ☐ Change in menstrual cycle
- ☐ Unusual vaginal bleeding

Vision
- ☐ Blurred Vision
- ☐ Red itchy eyes

Lungs
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ Pleurisy

Musculoskeletal
- ☐ Joint Cramping
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Warm red joints

Psychological
- ☐ Unusual Stress
- ☐ Anxiety
- ☐ Depression

Neurologic
- ☐ Headaches
- ☐ Easily Confusion
- ☐ Seizures / Tremors
- ☐ Poor balance or walking
- ☐ Trouble starting arm or leg motion

ENT
- ☐ Difficulty Swallowing
- ☐ Difficulty Hearing
- ☐ Sinus Trouble
- ☐ Sore Throat

Gastrointestinal
- ☐ Acid Reflux
- ☐ Loss of Appetite
- ☐ Trouble with bowel habits
- ☐ Black tarry stools
- ☐ Ulcer pain
- ☐ Nausea / Vomiting
- ☐ Constipation / Diarrhea

Skin
- ☐ New skin sores
- ☐ New skin lumps
- ☐ Skin discoloration
- ☐ Easy bruising / bleeding
- ☐ Swollen lymph nodes

CARY ORTHOPAEDIC
sports medicine specialists
spine specialists

Pain Diagram

DATE

Patient Name:_______________________________________

- - - - - -	Pins and Needles	z z z z z z	Stabbing	B B B B B B	Burning
x x x x x x	Numbness	/// /// /// /// /// ///	Aching and Cramping	O O O O O O	Other Sensations

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

Right Left Left Right

Please circle where your pain is TODAY

(No Pain) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Worst pain ever)

Please circle where your pain has been on average over the LAST WEEK

(No Pain) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Worst pain ever)