HC HIGHLAND CLINIC

DATE: _______________
MD you are seeing today
____

HIGHLAND CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE

PCP/REFERRING MD
____

PATIENT HISTORY FORM

Name:____DOB:________________________Age:_________

Reason for Visit:____

Past Medical History:
Do you have?
- ☐ None
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Diabete
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Thyroid Disease
- ☐ Other______________________________
- ☐ Cancer
- ☐ Depression
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Gout
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure

Ortho Surgery
- ☐ Bone or Joint

Type:______________
____
____
____
____

Past Surgical History:
Have you had?
- ☐ Thyroid
- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Wisdom Teeth
- ☐ Gallbladder
- ☐ Tonsillectomy
- ☐ Other________________
- ☐ None

***Allergies: ☐ NONE or list each allergy____

Medications: *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)* ☐ None

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Family History:
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Other________________
- ☐ Cancer
- ☐ Depression
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Fibromyalgia
- ☐ None

Social History:

Occupation:__________________________
Dominant Hand: R L
Tobacco Use ☐ current ☐ former ☐ never
Type__________________ ________amt/day
☐ Alcohol Use Yes No
Height_________ Weight_________

Review of Systems: ***Do you have?***
- ☐ Fatigue
- ☐ Chills
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight loss
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Skin Rash
- ☐ Skin Lesion
- ☐ Chronic Headache
- ☐ Constipation
- ☐ Reflux
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Seizures
- ☐ Asthma
- ☐ Depression
- ☐ Bruising
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Painful Urination
- ☐ Frequent Urination

HIGHLAND CLINIC ORTHOPAEDICS

FACTORS OF COMPLAINT

What do you want to happen as a result of this visit?

____
____
____
____
____
____

How and when did you problem begin? (Please mark each answer that applies to your neck/back pain.)

- □ I don't know how it began.
- □ It comes and goes.
- □ I've had it a long time. (_____years)
- □ Injury (date of injury _____) On the job? □ yes □ no

Please explain how the injury happened.

____

Are you currently in litigation with regards to your backs pain? □ yes □ no

Have you been laid off from your job? □ yes □ no

How bad is your pain? Place an "X" (-----X-----) on each of the lines below to indicate you pain.

How bad is your **low back** pain?

No pain---Worst possible

How bad is your **leg** pain

No pain---Worst possible

How bad is your **middle back** pain?

No pain---Worst possible

How bad is your **neck** pain?

No pain---Worst possible

How bad is your **arm** pain?

No pain---Worst possible

NEW PATIENTS ONLY COMPLETE THE FOLLOWING:

Do you have any of the following problems? (please check your answers)

Is you pain worse at night?	□ yes	□ no
Does your pain awaken you from sleep?	□ yes	□ no
Does coughing affect your pain?	□ yes	□ no
Do your legs tire/hurt if you walk too far?	□ yes	□ no

If YES, how far can you walk?

□Less than 1 block □ 1-3 blocks □more than 3 blocks

Is this relieved by resting you legs?	□ yes	□ no
Is this relieved by bending forward?	□ yes	□

Bladder Control (urine):

- □ No problem
- □ Can't empty bladder
- □ Loss of urine (accidents)

Bowel Control:

- □ No Problem
- □ Constipation
- □ Loss of control (accidents)

How does each of the following affect your pain? (check your answers)

Sitting	□ Better	□ Worse	□ No change	
Standing	□ Better	□ Worse	□ No change	
Walking	□ Better	□ Worse	□ No change	
Lying down	□ Better	□ Worse	□ No change	
Rising from chair	□ Better	□ Worse	□ No change	
Physical activity	□ Better	□ Worse	□ No change	
Heat	□ Better	□ Worse	□ No change	□ Don't know
Cold	□ Better	□ Worse	□ No change	□ Don't know

Patient's Initials______ Date__________

HIGHLAND CLINIC
ORTHOPAEDICS

Please fill out these forms completely!

We know that filling out these forms can he difficult - but please complete them carefully. Your accurate responses will give us a better understanding of you 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 helping us to know you better!

PAIN DIAGRAM

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

Ache
^ ^ ^ ^ ^
^ ^ ^ ^ ^
^ ^ ^ ^ ^

Numbness
OOOO
OOOO
OOOO

Pins & Needles
= = = =
= = = =
= = = =

Burning
XXXX
XXXX
XXXX

Stabbing
/ / / / /
/ / / / /
/ / / / /

RIGHT LEFT LEFT RIGHT

FRONT BACK

Patient's initials_______ Date_______

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.

	<6mo	<12 mo
X-rays	☐	☐
MRI scan	☐	☐
CT scan	☐	☐
Myelogram	☐	☐
Discogram	☐	☐
EMG/NCV (nerve test)	☐	☐

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 ☐ worse?

2) Type of Surgery__________________________
Date_______________________________________
Surgeon____________________________________
Did it make your pain ☐better ☐ worse?

3) Type of Surgery__________________________
Date_______________________________________
Surgeon____________________________________
Did it make your pain ☐better ☐ worse?

Effect of your back/neck pain on your lifestyle.

I describe my home setting as supportive of me during this time.	☐ yes	☐ no
I describe my work setting as supportive of me during this time.	☐ yes	☐ no
My pain has affected my interaction with my family and friends.	☐ yes	☐ no
The changes in my lifestyle due to my problem have been difficult for me.	☐ yes	☐ no

Has your pain affected your ability to do your job or any other daily activities? ☐ **yes** ☐ **no**
If YES, please
explain____
____
____

Is there anything we have failed to ask that you believe is important for us to know? ☐ yes ☐ no
If YES, please
explain____
____
____
____

Patient's initials______Date_______