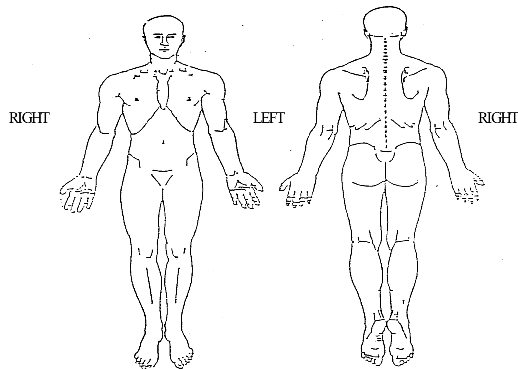
FREEMAN
SPINE & ORTHOPEDIC
MEDICINE

Name: ____ Today's Date: ____________ Age: _______
Last First Middle Initial

Sex: Male Female Date of Birth: ___________ Referred by: ________________________________
(Physician, Family, Friend, etc.)

Pharmacy name: __________________________________ ____________________ ________________
Failure to use this pharmacy is grounds for discharge Location Phone Number

A: PAIN DIAGRAM: (Please indicate where your pain is located using the numbers below.)



Date of onset for your problem: ______________

Pain Level
Place a number on the appropriate locations.
1-2: Mild: interferes with activities of daily living
3-4: Moderate: interferes with working / recreation
5-6: Severe: requires immediate medical attention
7-8: Excruciating; consume all aspects of your life
9-10: Unbearable: Need immediate hospitalization

B: HISTORY OF PRESENT ILLNESS

Mark the box for your neck and / or back pain.

√	Back Pain
	Back pain only; no leg pain
	Back pain worse than leg pain
	Back pain equal to leg pain
	Leg pain worse then back pain
	Leg pain only; no back pain

√	Neck Pain
	Neck pain only; no arm pain
	Neck pain worse than arm pain
	Neck pain equal to arm pain
	Arm pain worse than neck pain
	Arm pain only; no neck pain

Mark the box for your main joint/s for today's pain.

√	Joint
	Shoulder
	Elbow
	Wrist
	Hip
	Knee
	Ankle
	Other:
	Other:

Joint Sensation			
	Discomfort		Warmth
	Locking		Grinding
	Popping		Redness
	Give out		Other:
	Swelling		Other:

Please describe any **decreased strength** you may be experiencing. **None**

Location (body part)	**Cause**	**How does it affect you**	**How Long** (date)
	Due to pain, Pure weakness		

C: PRESENT PAIN CAUSE

√ **Motor Vehicle Accident** (Please √ all appropriate boxes)	√ **Work Injury**	√ **Sports Injury**	√ **Other**
Seat belt: Yes, No . Driver, Passenger, Pedestrian Collision: Head on, Rear-end, Side-impact Your Speed: ____, Hit your head, Knocked unconscious Went to: ER(Self, Ambulance, Helicopter) Home Hospital Course: Sent home that day, Admitted ___days	Fall, Restraining, Lifting, Bending Assault, Driving Notified Supervisor Sent: ER, Home	Clip, Tackle Spear, Kick Throw, Fall Hit, Pivot Fall, Lifting	☐ Unknown ☐ Fall ☐ Bending ☐ Lifting Assault
Brief Description:			

***Do you have an open Motor Vehicle or Worker's Compensation Claims:** Yes, No. ______________________________
Please sign

D: ASSOCIATED PAIN COMPLAINTS:

On a scale of 0 (No pain) to 10 (Need to be hospitalized), please rate your pain intensity levels.

Pain level today	0	1	2	3	4	5	6	7	8	9	10
Lowest level this month	0	1	2	3	4	5	6	7	8	9	10
Highest level this month	0	1	2	3	4	5	6	7	8	9	10
Average pain level this month	0	1	2	3	4	5	6	7	8	9	10

Level 10 represents the need to be in the hospital

Please list which motions affect your symptoms.

Increase your pain:	
Decrease your pain:	

Are you experiencing any of the following *new* abnormalities? ☐ **None**

Constitutional Abnormalities	How long / Explain
Incontinence of the bowel or bladder	
Uncontrolled weight loss	
Fever / chills	
Increased pain with lying down that awakens you at night, unrelated to motion	

E: PREVIOUS HISTORY: (Have you had any *prior* problems to the area of *today's* pain?) **None**

Previous History	Month/Year	Explain
Symptoms:		
Injury:		
Surgery:		

F: TREATMENTS FOR YOUR CURRENT CONDITION:

Please list all the doctors, therapists and emergency room visits related to today's visit. ☐ **None**

Name	Specialty	Date	Treatment

Please list diagnostic tests with year, pertaining to today's visit (X-ray, MRI, CT, Ultrasound, etc.). **None**

Please list any recent treatments related to today's visit. ☐ **None**

Treatment	Month/Year	Treatment	Month/Year	Treatment	Month/Year
Physical Therapy		Sacroiliac Injection		Facet Injection	
Epidural Injection		Trigger Point Injection		Other:	

G: CURRENT MEDICATIONS: (Please list **pain** medications /dosage, then **health** medications) ☐ **None**

H: PAST PAIN MEDICATIONS: (Please list medications you have taken in the past.) ☐ **None**

I: ALLERGIES: (Include medications, dyes, shellfish, latex, etc.) **None**

J: MEDICAL HISTORY: (Please list or check off.) ☐ **None**

☐ High Blood Pressure ☐ Diabetes ☐ Congestive Heart Failure ☐ Stroke ☐ Ulcers ☐ Glaucoma ☐Thyroid	
Cancer:	Clotting or Liver Disorder:
☐ Depression ☐ Bipolar Disorder ☐ Anxiety:	Auto-Immune:

K: SURGICAL HISTORY: (Please indicate any other surgeries unrelated to your pain.) **None**

Procedure	Date	Outcome	Procedure	Date	Outcome

L: FAMILY MEDICAL HISTORY **Unknown** ☐ **None**

M: OCCUPATIONAL HISTORY: □ Disabled: Date _____________, □ Retired: Date _____________

1. Current occupations ____
2. Please check your **current** work status, describe your plans to **return** to work if you are not working.
   □ Full Duty, □ Light Duty, □ Off Duty, □ Unemployed.____________________________
3. Job Lifting Requirements: ☐ Heavy (Over 60 pounds), ☐ Medium (30-50), ☐ Light (10-20), ☐ No lifting
4. Who changed your work status if you are not at full duty? ______________________________
5. Reason for disability: ____

N: SOCIAL HISTORY

1. Do you smoke cigarettes? ☐ No, ☐ Yes, number of packs per day ______, for _____years.
2. Do you drink alcohol? ☐ No, ☐ Yes, number of days / week _________, ☐ History of drinking problem.
3. Do you think it is ok to tell stories or lie to get controlled substances? ☐ No, ☐ Yes.
4. Do you think it is ok to get pain medications from more than one doctor at a time? ☐ No ☐ Yes
5. Have you ever been investigated or convicted for street drugs or prescription drug abuse? ☐ No ☐ Yes
6. Are you currently using any illicit or street drugs? ☐ No, ☐ Yes: Drug Name: ________________
7. Does your injury require legal representation? No, Yes, Lawyer's Name: ________________

O: REVIEW OF SYSTEMS: (Please check the appropriate boxes) ☐ **None**

Constitutional: Weight loss, Fever, Chills, Night sweats, Other___________________
Skin: Bleeding, Bruising, Rashes, Moles, Sores ___________, Other_______________
Eyes, Ears, Nose, Throat: Recent changes in: Vision, Hearing, Smell, Taste, Other___________
Respiratory: Shortness of breath, Wheezing, Productive cough, Other_________________
Cardiovascular: Chest pain, Palpitations, Murmur, Feet edema, Other_______________
Gastrointestinal: Nausea/Vomiting, Diarrhea, Constipation, Abdominal pain, Other __________
Genito-Urinary: Bloody urine, Urinary discomfort, Abnormal discharge, Other ______________
Musculoskeletal: Cramps, Joint Pain / Swelling, Morning stiffness Weakness, Other__________
Central Nervous System: Convulsions, Dizziness, Problem sleeping, Other______________
Female: Are you pregnant? No, Yes, Last menstrual period – Date ________, Other______________
Male: Last prostate exam – Date _______, PSA – Date _______, Results ________, Other_____________

(Any missing information is due to patient refusal to provide data.)

Please sign to initiate consultation, thank you.

I certify that I have truthfully answered all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present. In effort to protect myself and the community, I consent to the reporting of any misconduct regarding the controlled substance agreement, to local, state, federal (DEA) authorities, pharmacies, and primary care physicians.

______________________	__________	______________________	__________
Your Signature	Date	Signature of Reviewing Physician	Date