PACIFIC
Sports and Spine

Dr. Moore Team ☐ Dr. Phillips Team ☐
Dr. Vora Team ☐ Dr. Peirce Team ☐
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○ 123 Ponderosa Dr. Sutherlin, OR. 97479

APPOINTMENT DATE:_____

CHECK IN TIME:_____

Today's Date: _____

Name: _____ Date of Birth: _____ Social Security #: _____

Sex: ☐ M ☐ F Height_____ Weight_____

Language:_____ Ethnicity: ☐ White ☐ American Indian ☐ African American ☐ Asian ☐ Hispanic/Latino

How were you referred to us?
☐ Physician ☐ Patient/Friend ☐ Workers Comp ☐ Insurance ☐ Internet ☐ TV/Radio
☐ Self ☐ Other:_____

Primary Care Physician: _____ Pharmacy Name/Location: _____

Referring Physician: _____ Specialty: _____

History of Present Illness:

What is your main pain complaint? _____

Which best describes the quality of your current pain complaint?
☐ Sharp ☐ Burning ☐ Throbbing ☐ Shooting ☐ Aching ☐ Stabbing ☐ Dull

☐ Other: _____

Have you missed work because of this pain? ☐Yes ☐No

Pain severity Please rate your pain by circling the one number that describes your average pain:

What is your average daily pain level? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

What is your pain level at its worst? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

What is your pain level at its best? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

How often do you have pain? ☐ Constant ☐ Occasional (several times per week) ☐ Intermittent (several times per day)
☐ Rarely (several times per month)

How long have you had this pain? (weeks/months/years)? _____

How did your current main pain complaint begin? Please give details and dates: _____

_____

_____

Was your pain the result of any of the following? ☐ Work related injury ☐ Auto Accident

☐ Fall or other trauma ☐ Following Surgery ☐ Following Illness ☐ Pain just began

☐ Other: _____

How do the following activities affect your pain?

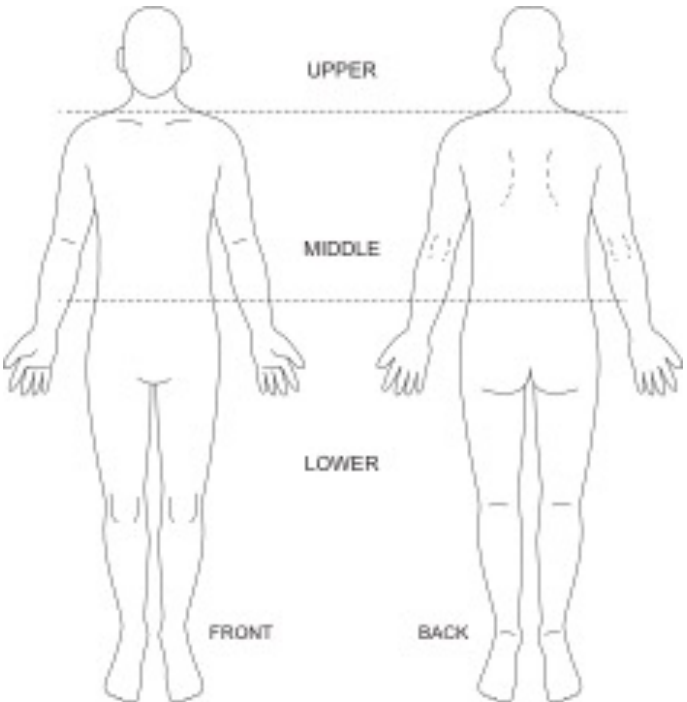
	Aggravates Pain	Relieves Pain	Neither
Exercise	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Bending forward	☐	☐	☐
Bending backward	☐	☐	☐
Lying down	☐	☐	☐
Sleeping	☐	☐	☐
Walking	☐	☐	☐
Sneezing	☐	☐	☐
Coughing	☐	☐	☐
Driving	☐	☐	☐
Other_____	☐	☐	☐

Is your pain associated with other symptoms? ☐ No ☐ Sleep Loss ☐ Sexual Dysfunction
☐ Numbness, where _____ ☐ Muscle weakness, where _____ ☐ Other: _____

Since your present pain began, have you experienced the following?
☐ Urinary incontinence/dysfunction ☐ Bowel incontinence/dysfunction ☐ Neither

Please list your goals for treatment (Hobbies, return to work, etc…)
_____
_____
_____

Please circle the area of pain you are having:



Please list all MEDICATIONS you are currently taking. Include prescription drugs, over the counter (OTC), and herbal supplements:

Medication Strength & Dose (how many times per day you take it):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Taking Aspirin? If so _____mg Last taken: _____ Blood thinner _____ Last taken: _____

Who manages your blood thinner medication? _____ (Provider's Name)

Examples are Warfarin (Coumadin), Apixaban (Eliquis), Rivaroxaban (Xarelto), Dabigatran (Pradaxa), Clopidogrel (Plavix), or Lovenox (Heparin).

Maximum number of pain pills you take each day? _____

Please list all **PREVIOUS PAIN MEDICATIONS** you have tried and are no longer taking: (Examples)

☐Tramadol (Ultram) ☐Cymbalta(Duloxetine) ☐Neurontin (Gabapentin) ☐Tylenol (Acetaminophen)

☐Ibuprofen/Aleve ☐Lyrica (Pregabalin) ☐Nortriptyline/Amitriptyline

Opiates: ☐Morphine (Ms Contin) ☐Oxycodone (Oxycontin) ☐ Zohydro (Hydrocodone) ☐ Norco ☐Fentanyl ☐Soma

☐ Other:_____

☐ Other medication not listed: _____

Do you have any known **MEDICATION ALLERGIES**? If so, please list:

_____

Other: _____

REACTIONS: _____

_____

Previous Work-Up:

Have you had any of the following tests in relation to your pain, and if so what body part, when, and where was it performed?

☐ X-Ray ☐ CT ☐ MRI ☐ Ultrasound ☐ Myelogram ☐ Bone Scan ☐ EMG

☐ Dexa Scan ☐ Functional Capacity Evaluation (FCE) ☐ Other: _____

Previous Therapies:

Have you had any of the following in relation to your pain, and if so when and where?

☐ PT (Physical Therapy):

-If yes, please list where PT was done and how long therapy lasted: _____

☐ OT (Occupational Therapy)	☐ TENS	☐ Epidural Steroid Inj	☐ Nerve Blocks
☐ Weight loss/Nutrition	☐ SI Belt	☐ Biofeedback	☐ Orthotics
☐ Discogram	☐ Spinal Cord Stimulator	☐ Chiropractic	☐ Pilates

☐ Intrathecal Pain Pump ☐ Vertebroplasty ☐ Acupuncture ☐ Yoga
☐ Joint Injections ☐ Bracing ☐ Psychology/Psychiatry
☐ Naturopathy/Homeopathy ☐ Massage Therapy ☐ Other: _____

Past Medical History (please circle if you have had any of the following):

Anemia	COPD	Hemorrhoids	Parkinson's
Aneurysm	Dementia/Alzheimer's	Hepatitis/liver disease	Pelvic pain
Anorexia/bulimia	Dental problems	Hernia	Pulmonary embolism
Anxiety	Depression	High blood pressure	PVD
Arthritis	Diabetes	High cholesterol	Restless legs
Asthma	Diverticulosis/diverticulitis	HIV or AIDS	Rheumatism
Back problems	DVT	Hypertension	Seizures/epilepsy
Bipolar disorder	Emphysema	Kidney disease	Sleep apnea
Bleeding disorder	Endometriosis	Lung disease	Sleep disorder
Blood clots	Environmental allergies	Multiple sclerosis	Stroke/TIA
Bowel/bladder issues	Fibromyalgia	Muscle/joint/bone issues	Testicular/prostate cancer
BPH	GERD	Neck problems	Thyroid problems
Bronchitis	Gout	Neuropathy	Tremor
CAD/heart disease	Head trauma/injury	Obesity	Tuberculosis
Cancer	Headaches/migraines	Osteoporosis	Ulcers
Chronic fatigue syndrome	Heart arrhythmia	Ovarian cysts	Other _____

Surgical History (circle if you have had any of the following and write date):

_____	AAA repair	_____	Elbow surgery	_____	Mitral valve surgery
_____	AICD	_____	ENT surgery	_____	Neck surgery
_____	Ankle/foot surgery	_____	Eye surgery	_____	Neurosurgery
_____	Aortic valve surgery	_____	Fracture surgery	_____	Oncology surgery
_____	Appendectomy	_____	Gastric bypass	_____	Pacemaker
_____	Arm surgery	_____	Gastrointestinal surgery	_____	Plastic surgery
_____	Atrial septal defect repair	_____	General surgery	_____	Prostatectomy
_____	Back surgery	_____	Genitourinary surgery	_____	Renal surgery
_____	Bladder surgery	_____	Heart surgery	_____	Shoulder surgery
_____	Brain surgery	_____	HEENT surgery	_____	Skin cancer excision
_____	Breast surgery	_____	Hemorrhoidectomy	_____	Spinal surgery
_____	CABG	_____	Hernia repair	_____	Stent
_____	Caesarean section	_____	Hip replacement	_____	Thoracic surgery
_____	Cardiac catheterization	_____	Hip surgery	_____	Thyroid surgery
_____	Cardioversion	_____	Hysterectomy	_____	Tonsillectomy
_____	Carpal tunnel surgery	_____	Interventional radiology	_____	Transplant
_____	Cataract surgery	_____	Joint replacement	_____	Tricuspid valve surgery
_____	Cervical spine surgery	_____	Knee replacement	_____	Tubal ligation
_____	Cholecystectomy	_____	Knee surgery	_____	Vascular surgery
_____	Colectomy	_____	Leg surgery	_____	Wisdom teeth extraction
_____	Congenital heart defect surgery	_____	Lower extremity amputation	_____	Wrist/hand surgery
_____	Coronary artery intervention	_____	Lumbar spine surgery	Other	_____
_____	Craniotomy	_____	Lumpectomy	Other	_____
_____	Dilatation & curettage	_____	Lung surgery	Other	_____

Review of Systems: **Mark all that apply to your problems/symptoms**

□ Recurrent fevers, chills, sweats
□ Recent weight changes
□ Loss/changes of vision
□ Chronic sinus problems
□ Voice changes
□ Chest pain
□ Irregular heart rhythm
□ Chronic cough
□ Shortness of breath
□ Coughing up blood
□ Abdominal pain
□ Abnormal mole
□ Vomiting blood
□ Frequent diarrhea
□ Heat or cold intolerance
□ Severe heart burn
□ Lack of bladder control
□ Excessive urination
□ Burning with urination
□ Constipation
□ Change in sexual function
□ Weakness
□ Difficulty walking
□ Rash
□ Numbness/tingling sensation
□ Seizures
□ Headaches
□ Enlarged lymph nodes
□ Depression
□ Nervousness
□ Extreme fatigue
□ Excessive thirst
□ Easy bruising
□ Frequent bleeding
□ Environmental allergies

Have you ever had mental health treatment? ☐ Yes ☐ No If yes, please describe: _____
Have you ever been treated for cancer? ☐ Yes ☐ No If yes, what type? _____
Have you or any family members had any problems with anesthesia? ☐ No ☐ Yes

Social History:

Current Occupation:_____ Employer: _____
Present employment status: ☐ Fulltime ☐ Part time ☐ Retired ☐ Disability ☐ Worker's Comp
How would you describe your work? ☐ Sedentary (lift less than 10 lbs) ☐ Light (lift 10-25 lbs)
☐ Light to medium (lift 25-50 lbs) ☐ Medium (lift 50-75 lbs)
☐ Medium to heavy (lift 75-100 lbs) ☐ Heavy (lift more than 100 lbs)
Do you have physical work restrictions? ☐ Yes ☐ No ☐ N/A

If not currently working, what was your last job? _____

How long have you been out of work? _____

Are you: ☐Right-handed ☐Left-handed ☐ Ambidextrous

What is your highest education level? ☐ High school ☐ Vocational degree ☐ College ☐ Advanced Degree
☐ Other: _____

Marital Status: ☐ Single ☐ Married-Name of Spouse: _____ ☐ Divorced ☐ Widowed
Do you have children? ☐ Yes ☐ No If yes, how many? _____ What are their ages? ___ ___ ___ ___ ___ ___ ___

Exercise level: ☐occasional ☐moderate ☐heavy
Do you use caffeine: ☐occasional ☐moderate ☐heavy
Do you use tobacco? ☐ Never ☐ Yes _____ packs per day ☐ Former User, quit: _____
Do you use alcohol? ☐ Never ☐ Regularly ☐ Rarely
Have you used recreational drugs in the last 5 years? ☐ Yes ☐ No If yes, please list: _____
Do you have a history of Alcoholism, drug abuse, or addiction? ☐ Yes ☐ No

What is your current living situation? ☐ Alone ☐ with _____

What are your living accommodations? ☐ Apartment ☐ House ☐ Assisted Living ☐ Nursing Home ☐ Homeless ☐ Other: _____

Do you have an application pending or do you intend to apply for workers compensation or disability? ☐ Yes ☐ No

Do you have a pending lawsuit for your pain or injury? ☐ Yes ☐ No Name of attorney: _____

Family History:

Are you adopted? ☐ **Yes** ☐ **No**

Please indicate the age and status of the following family members (if deceased, please indicate age at time of death and cause of death):

	Alive	Deceased
Age of Father	_____	_____
Age of Mother	_____	_____
Ages of Brothers	_____	_____
Ages of Sisters	_____	_____
Ages of Children	_____	_____

Using the key below, please indicate if any of your immediate relatives have any of the following:

F= Father M= Mother B= Brother S= Sister MGF= Maternal grandfather MGM= Maternal grandmother PGF= Paternal grandfather PGM= Paternal grandmother

_____ Addiction	_____ History of back problem	_____ Brain tumor
_____ Alzheimer's Disease	_____ History of musculoskeletal issues	_____ Osteoarthritis
_____ Blood coagulation disorder	_____ Hypertensive disorder	_____ Osteoporosis
_____ Stroke	_____ Malignant hypertension	_____ Rheumatoid Arthritis
_____ Diabetes	_____ Cancer	_____ Seizure
_____ Disorder of neck	_____ Migraine	_____ Tuberculosis
_____ Heart disease	_____ Multiple sclerosis	_____ Other: _____

I attest that information provided here is true and correct to the best of my knowledge.

Signature: _____ Date: _____