BATON ROUGE ORTHOPAEDIC CLINIC

Initial Patient Evaluation — Dr. Jason Smith

Name:_____ Chart # (office use) _____

MD Referral: _____ DOB: _____

Family Doctor: _____ Age:_____

1. Main Problem Today: _____

_____

Was there an Injury? _____

Did the Injury happen at work? Yes No

Brief Description of MVA/accident (if applicable): _____

_____

2. Date THIS problem started: _____

3. If your problem is pain related, complete the following questions (If not, go to question 8).

How did the pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ Other (specify)
- ☐ Fall
- ☐ Bending
- ☐ Pulling
- ☐ Injured at work
- ☐ Injured in auto accident
- ☐ Hit from behind
- ☐ Injured during sport
- ☐ No apparent cause
- ☐ Injured at home

4. What activities make the pain worse?

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Other (specify)
- ☐ Standing
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backward
- ☐ Coughing
- ☐ Sneezing
- ☐ At night
- ☐ By end of day

5. What reduces the pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Other (specify)
- ☐ Standing
- ☐ Walking
- ☐ Manipulation
- ☐ Exercise or Physical Therapy
- ☐ Medication
- ☐ Injections for Pain
- ☐ Tens Unit
- ☐ Brace/Corset
- ☐ Nothing

What medications are you/have you taken for this problem? _____

6. My pain is: (Check all that apply)

- ☐ Present intermittently (comes and goes)
- ☐ Always present but of variable intensity
- ☐ Improving

Worsening in that it is:

- ☐ Present more often
- ☐ More intense
- ☐ Changing in character
- ☐ Changing in location

7. Rate your Pain: 0 (no pain) to 10 (worst pain that you can imagine)

Neck Pain: 0 1 2 3 4 5 6 7 8 9 10 Arm Pain: 0 1 2 3 4 5 6 7 8 9 10

Back Pain: 0 1 2 3 4 5 6 7 8 9 10 Leg Pain: 0 1 2 3 4 5 6 7 8 9 10

Chart#_____

Where is your pain now?

Mark the areas on your body where you feel the sensations described above, using the appropriate symbol.
Mark areas of radiation. Mark all affected areas including your facial area.

Aching	Numbness	Tingling	Pins and Needles	Burning	Stabbing
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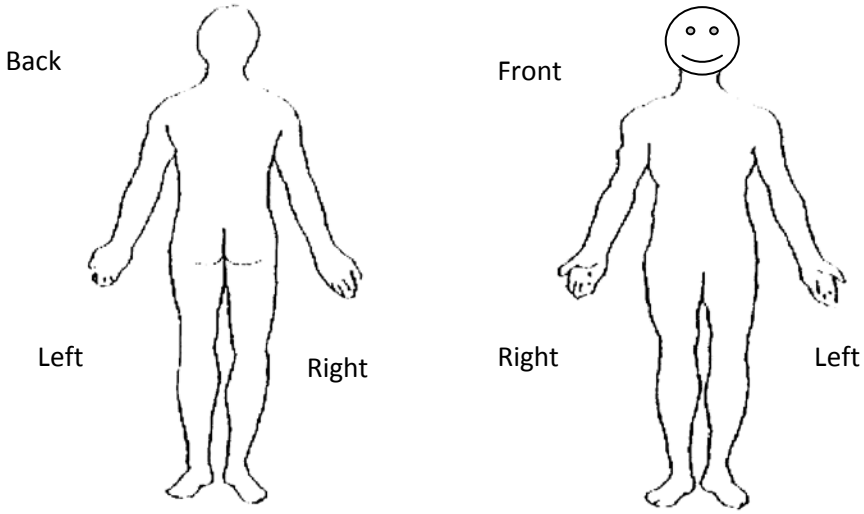

8. Do you have loss of bowel or bladder control (no urge felt): Yes No

9. More than 15 pounds of weight loss or gain in last 6 months?: Yes No

10. I feel Weakness in: ☐ Arms ☐ Legs ☐ All Over (generalized)

11. The pain can: ☐ Make it hard to fall asleep ☐ Wake me up in the middle of the night

12. I can comfortably:
Stand for _____ minutes Walk for _____ minutes Sit for _____ minutes

13. Have you had THIS problem in the past? Yes No If yes, When?: _____

14. Have you seen other doctors for THIS current problem? Yes (Who?) No
_____

15. What types of treatments have you had for this problem?

Treatment	Date(s)	Was it helpful? (Yes or No)
Physical Therapy (_____# of sessions.)		
Exercise		
Brace		
TENS Unit		
Epidural Steroid Injections (____#)		
Chiropractic manipulation		

16. Tests done for CURRENT problem with date if known: _____
☐ Xrays ☐ Myelogram ☐ CT Scan ☐ Bone Scan
☐ MRI ☐ EMG (Nerve conduction study) ☐ Discogram

Chart#_____

17. Surgery/Surgeries I have had for <u>THIS CURRENT</u> problem:

Date	Surgeon	Helpful (Yes/No)	What was done?

18. What type of work do you do? _____

☐ Heavy Labor ☐ Light Labor ☐ Sedentary ☐ Professional
☐ Homemaker ☐ Retired ☐ Unemployed

19. Last day worked? _____

20. Alcohol Use:

☐ No ☐ 1-6 per week ☐ 6-12 per week ☐ 12-18 per week ☐ >18 per week

21. Tobacco Use:

☐ No ☐ Smokeless Packs per Day _____ Number of years Smoked_____

I have reviewed and fully completed all pages (three pages total) to the best of my ability. I understand the above statements and agree.

Patient Signature: _____ Date: _____