SWEDISH
MEDICAL GROUP

Patient Label Here

Spine, Sports & Musculoskeletal Medicine

Last Name • **First Name** • **Middle Initial** • **SSN / ID # / L&I #** • **Date** • **Ref. Doctor**

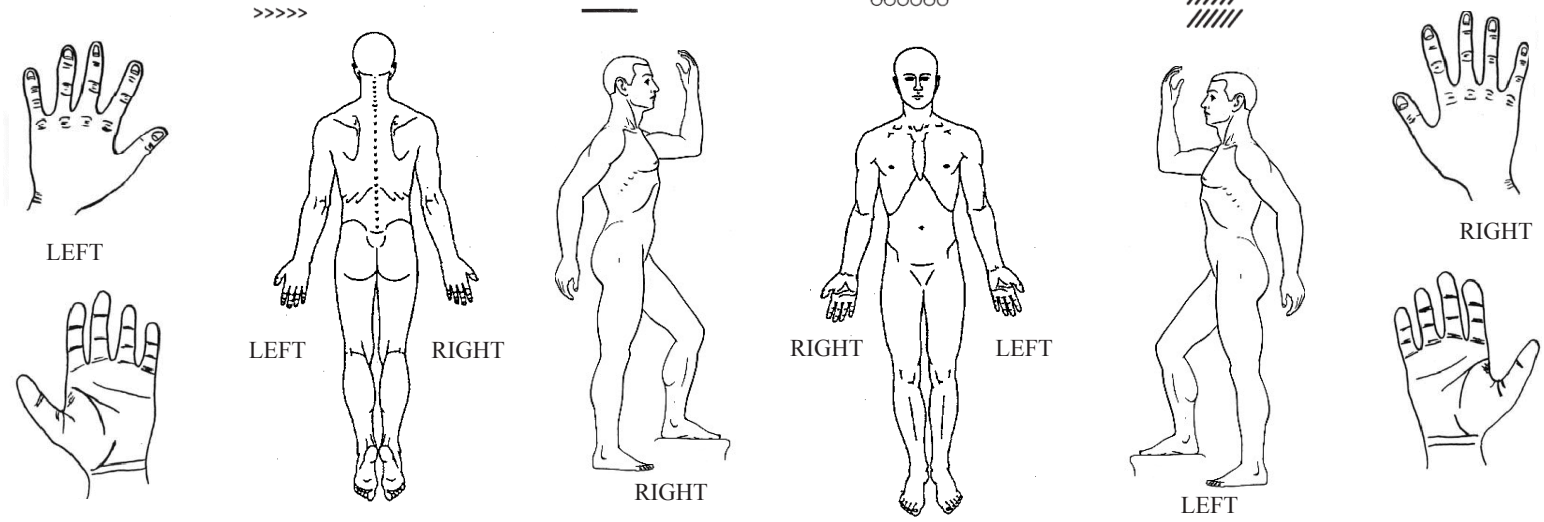
Age: _____ • Single / Domestic Partner / Married / Widowed / Divorced / Separated • Caucasian / Black / Asian / Middle Eastern / Hispanic / Other

Dominant Hand: Right / Left / Both • Sex: Male / Female

PERSONAL HEALTH HISTORY

Mark the areas on your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below.

ACHE >>>>> >>>>> >>>>> NUMBNESS ═══ ═══ ═══ PINS & NEEDLES ○○○○○○ ○○○○○○ ○○○○○○ STABBING ////// ////// //////



What problem/issue brings you here today? _____

How long has it been bothering you? What would you like to accomplish? _____

Have you had a previous injury to this area? _____

What makes it worse? _____

What makes it better? _____

Please mark on the line below to describe the level of pain/discomfort you are having today.

No pain _____ Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

Your pain feels like:
Dull / Achy / Burning / Stabbing / Numbness / Tingling / Pulling / Cramping / Tightness

Please describe the timing of your pain:
Constant / Comes and Goes / Getting Worse / Getting Better / Awakens Me at Night

OFFICE USE ONLY

Which of the following have you had for your low back / mid-back / neck?					Did the treatment make you:		
	Low Back	**Mid-Back**	**Neck**	**Other**	**Better**	**No Change**	**Worse**
Physical Therapy							
Occupational Therapy							
Chiropractic / Osteopathic							
Massage							
Brace							
Biofeedback							
Acupuncture							
Herbs							
Injections:							
Trigger Point							
Epidural / Facet							
Nerve Root							
Regular X-rays					Patient Label Here		
MRI Scan							
Myelogram							
CT Scan							
Bone Scan							
EMG / NCV							

Check all of those that apply to you:

1. Bowel Function: ___ Normal ___ Loss of control or accidents ___ Constipation
2. Bladder Function: ___ Normal ___ Loss of control or accidents ___Difficulty starting or stopping urination ___ Sense of urgency
3. Leg / Foot: ___ Normal ___ Weakness (Right / Left)
4. Arm / Hand: ___ Normal ___ Weakness (Right / Left)

It is normal for patients faced with daily pain to experience emotional reactions such as worry, frustration and sadness. Please circle the appropriate number to indicate the extent that you are troubled by the following:

	NONE										**SEVERE**
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10

Yes | No | Was this a problem for you prior to having the pain for which you are seeing us today?

Yes | No | If so, is it worse since developing this pain?

Yes | No | Do you currently take medication for anxiety or depression?

Yes | No | Have you received counseling for anxiety or depression?

Yes | No | Do you have a history of psychological disease? (ie: ADD, Obsessive Compulsive Disorder, Bipolar, Schizophrenia)

Please specify: _____

PRIOR MEDICAL HISTORY

List **ALL allergies** to medications:

MEDICATION	REACTION	MEDICATION	REACTION

List **ALL** medications **(prescription and non-prescription)** you currently take:

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

List all medications **previously** taken for your pain _____.

Gastrointestinal: ☐ Do you have ulcers? ____ Yes ____ No Has your ulcer bled? ____ Yes ____ No
☐ Do you have reflux, hiatal hernia or GERD? ____ Yes ____ No

Alcohol / Drugs: What is your approximate weekly use of alcoholic beverages?

____ I don't drink alcohol

____ Less than 1-2 drinks a week

____ 3-6 drinks a week

____ Drink some alcohol on a daily basis

Patient Label Here

Have you or a parent ever had a problem with:
Alcoholism: ____ You ____ Parent ____ No • Drug Abuse: ____ You ____ Parent ____ No

Tobacco: What is your approximate daily use of tobacco?

____ I don't smoke ____ 1 pack per day ____ More than 2 packs per day

____ ½ pack per day ____ 1-2 packs per day

OB/GYN: (Women Only)

Date of last period: _____ ____ Normal ____ Abnormal ____ Hysterectomy / Postmenopausal/Premenopausal

Date of last pelvic exam: _____ ____ Normal ____ Abnormal

Date of last PAP Smear: _____ ____ Normal ____ Abnormal

____ Yes ____ No Pregnant or possibly pregnant • ____ Yes ____ No Breast-feeding

CURRENT MEDICAL PROBLEMS: Please list

1) _____ 4) _____ 7) _____

2) _____ 5) _____ 8) _____

3) _____ 6) _____ 9) _____

PRIOR SURGERY: Please list

TYPE	DATE	TYPE	DATE

FAMILY HISTORY:

	Living (Yes / No)		Present health issues or cause of death
Father	Yes	No	
Mother	Yes	No	
Spouse	Yes	No	
Brothers	# Living ____		
	# Deceased ____		
Sisters	# Living ____		
	# Deceased ____		
Children	# Living ____		
	# Deceased ____		

Please Turn Over ——▶

Review of Systems: Please put an "X" next to any of the symptoms you have had during the past year.

____ Nausea
____ Vomiting
____ Chills
____ Problems with sexual function
____ Loss of sensation around groin or buttocks
____ Unexplained fevers
____ Night sweats
____ Weight loss of 10 pounds or more
____ Loss of appetite
____ Excessive fatigue
____ Problems with depression
____ Difficulty sleeping
____ Dizziness
____ Decreased Concentration
____ Memory Difficulties

____ Unusual stress in home life
____ Unusual stress in work life
____ Any lumps in neck, armpits or groin
____ Chest pain or tightness
____ Persistent or unusual cough

____ Trouble breathing with exercise
____ Trouble breathing lying flat
____ Stomach pain
____ Swollen ankles
____ Joint pain or swelling
List joints: _____
____ Muscle tenderness
____ Generalized morning stiffness
____ Easy bruising
____ Excessive bleeding

____ Change in bowel habits
____ Persistent diarrhea
____ Excessive constipation
____ Dark black stools
____ Blood in stools

____ Pain or burning when urinating
____ Blood in urine
____ Need to urinate more at night

____ Persistent eye redness
____ Dry eyes or mouth
____ Skin rashes

Work: Employer: _____ Your job title: _____ Date last worked: _____

Work status at the time of:	Injury Onset	Currently
On disability	____	____
Regular: full-time	____	____
Regular: part-time	____	____
Permanent light duty	____	____
Temporary light duty	____	____
Temporarily totally disabled (not working)	____	____
Retired	____	____

How physically demanding is your job?
____ Very heavy (frequently lifting > 100 pounds)
____ Heavy (frequently lifting > 60 pounds)
____ Moderate (frequently lifting > 30 pounds)
____ Light (frequently lifting < 30 pounds)
____ Sedentary (essentially no lifting)

How satisfied are you with your job?
____ Very satisfied
____ Satisfied
____ Dissatisfied
____ It is the worst job I've ever had

Social: What are some of your usual recreational activities that you had participated in the **YEAR BEFORE** your current problem? **Place an "X" in front of those you currently cannot perform.**

(____) _____ (____) _____
(____) _____ (____) _____

Education: (Circle highest level attained) Did Not Finish High School / High School / College / Post Graduate

Attorney: Does an attorney assist you with your injury claim? ___ Yes ___ No Name: _____

Primary Care Physician: Name: _____
Address: _____

Please inform me if any portion of the physical examination that I will perform causes you pain. Please do not perform any motion that causes your symptoms to worsen. An initial evaluation will occasionally increase your symptoms since painful structures are being evaluated.

Please sign and date this form.

_____ _____
Patient's signature Date

Patient Label Here