ADVANCED ORTHOPEDICS NEW ENGLAND

Connecticut: Bloomfield • Enfield • Rocky Hill • Vernon
Massachusetts: Springfield

DEMOGRAPHICS INFORMATION FORM

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

STREET ADDRESS

CITY & ZIP CODE

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED**

Please check the box for primary phone number:

☐ HOME PHONE	☐ WORK PHONE	☐ CELL PHONE

EMAIL

PRIMARY CARE DOCTOR

INSURANCE ID NUMBER

SUBSCRIBER NAME & DOB

EMPLOYMENT COMPANY/STATUS

PHARMACY NAME & TOWN

EMERGENCY CONTACT NAME	PHONE NUMBER	RELATION

WHERE DID YOU GET INJURED?

☐ HOME ☐ WORK ☐ MOTOR VEHICLE ACCIDENT ☐ N/A ☐ OTHER: _____

HOW DID YOU HEAR ABOUT US? _____

SIGNATURE: _____ **DATE:**_____

PATIENT HEALTH HISTORY

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Patient Name:_____DOB:___/___/___ **Treating Orthopedic Doctor:**_____

Chief Complaint (why are you here today?): _____

When did the symptoms begin?_____

How did incident occur? ☐ Motor vehicle accident ☐ At work ☐ At School ☐ Home ☐ other: _____

Injury mechanism: ☐ no injury mechanism ☐ direct blow ☐ fall ☐ twisting injury

Height:_____ **Weight:**_____ **Occupation:** _____

Allergies: ☐ No known Allergies _____

ALL current medications (including over the counter): ☐ Not taking any medications _____

_____

_____

PAST MEDICAL HISTORY	YES	NO	PAST MEDICAL HISTORY	YES	NO
Anemia			HIV/AIDS/Hepatitis		
Asthma			Hypo/Hyperthyroidism		
Blood Clot/DVT			Lyme Disease		
Cancer:			Osteoporosis/Osteopenia		
COPD			Peripheral Vascular Disease		
Diabetes Type I/Type II			Psoriasis		
Gout			Renal Failure/Kidney Disease		
Heart Attack/Angina			Rheumatoid Arthritis/Lupus		
Heart Disease/**Pacemaker**			Stroke		
High Blood Pressure			Tuberculosis		
History of Blood Transfusion			Ulcer/Acid Reflux/GERD		
History of Prednisone or Steroid Medication			Other:		

PAST SURGERIES	SURGEON	DATE

FAMILY HISTORY: Please check all that apply ☐ Family History Unknown ☐ Adopted

Relationship	Anesthesia Problems	Arthritis	Blood Clots	Cancer	Diabetes	Heart Disease	High Cholesterol	Hypertension	Rheumatologic Disease	Scoliosis
Mother										
Father										
Sister										
Brother										

ALCOHOL USE: ☐ Yes ☐ No - **Drinks/Week**_____ ☐ wine ☐ beer ☐ liquor **DRUG USE:** ☐ Yes ☐ No

TOBACCO USE	Cigarettes	Cigars	Pipe	Chew	Snuff	Smokeless Tobacco
NEVER						
START DATE						
QUIT DATE						
PACKS/DAY						

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NAME:_____ DOB:____/____/____

If first appointment or new injury, please start here and complete the rest of the form:

How did injury occur? ☐ HOME ☐ WORK ☐ AUTO ACCIDENT ☐ OTHER:_____

For Follow-Up appointments, start here: **Body Part:**_____ **RIGHT** **LEFT** **BILATERAL**

Pain quality:	none	aching		burning		cramping		shooting		stabbing	sharp
Pain Scale:	On average:	0	1	2	3	4	5	6	7	8	9	10
	At its worse:	0	1	2	3	4	5	6	7	8	9	10

Pain Severity:	none	mild	moderate	severe	
Pain frequency:	none	constant	intermittent		
Progression:	same	improving	worsening		
Symptoms:	none	inability to bear weight		loss of motion	loss of sensation
	numbness	tingling	swelling	radiating pain	muscle weakness

Other Symptoms: _____

Aggravated by:	nothing	movement	palpation	weight bearing	lifting
Prior Treatments:	nothing	elevation	heat	immobilization	home exercises
	rest	ice	bracing	cortisone injections	non-weight bearing

Other prior treatments: _____

Physical therapy: YES NO **Start Date:**_____ **For how many weeks:**_____

Improvement on prior treatments: no relief mild relief moderate relief significant relief

Have you taken any pain medications for your condition? (Prescription and/or over the counter)

Medication name:_____ Was it helpful? Yes No Moderate

REVIEW OF SYSTEMS (Please Circle all that apply)

Abdominal pain/discomfort	Abnormal Menstrual periods	Back Pain	Chest Pain
Chills	Constipation	Depression	Diarrhea
Double Vision	Easy Bruising	Environment Allergies	Fatigue
Fever	Glasses	Headaches	Incontinence
Joint Pain (Arthralgia)	Leg swelling/pain	Neck Pain	Neck Stiffness
Nervousness/Anxiety	Numbness	Rash	Shortness of Breath

None of the Above

OFFICE USE ONLY

☐ Images loaded ☐ No disc ☐ No images done ☐ had images, did not bring, where: _____

Date: ___/___/___

Spine Pain Questionnaire

Name: _____ Age: _____

Referring Doctor: _____

Please circle answers when it applies.

Which is your dominant hand? Right / Left

When did you first notice your current pain? (Date, Month, Year)

Is there anything that I haven't asked that you feel will help me understand your problem better?
Yes / No. If yes, please explain.

Previous Spine Surgery

Please fill in the following if you have had previous spine surgery. "Pain free interval" means the period of time you felt well after the surgery before you felt the pain again. "Results" means your perception of how you did after the surgery. Please list additional spine operations in the back of this form.

Operation: Date:	Surgeon: Time off of work:	Pain free interval: Results:
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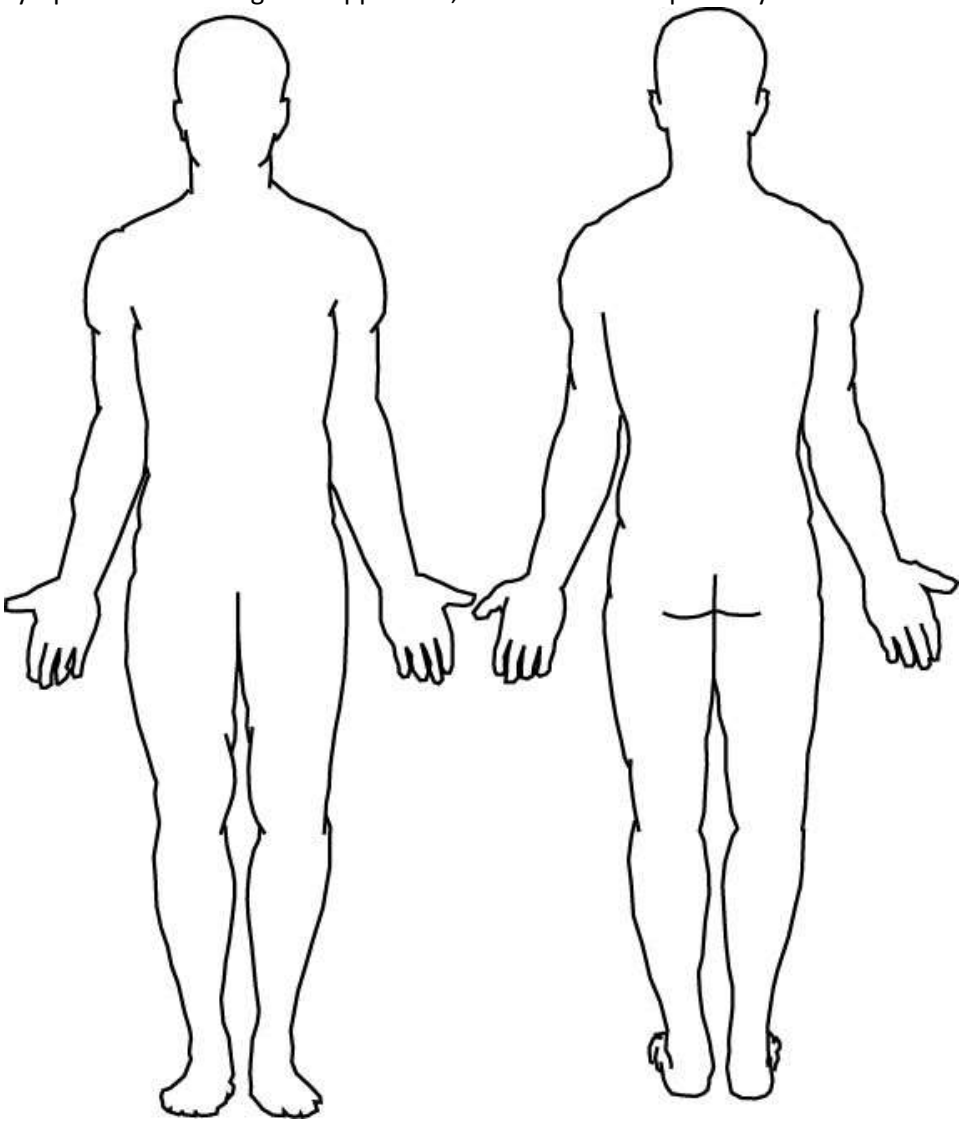
Pain Drawings

Mark these drawings according to where your pain is. (If the back of your neck hurts, mark the drawing on the back of the neck, etc.) If you feel any of the symptoms in the **key**, indicate where you feel them by placing the symbol shown with the symptom. If markings not applicable, indicate areas of pain in your own words.



Symptom Key:

Numbness:
= = = = =

Pins and Needles:
O O O O O

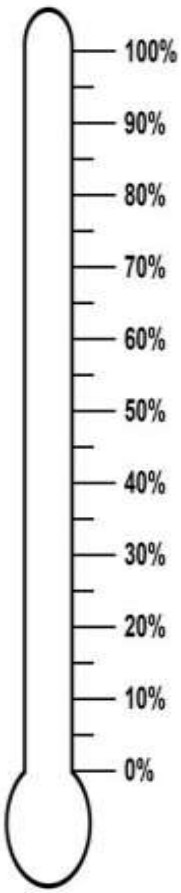
Burning:
X X X X X

Stabbing:
/ / / / /

Aching:
^ ^ ^ ^ ^

Comfort Thermometer

Please put a "**B**" on the thermometer to note your **BACK** pain and an "**L**" on the thermometer to note your **LEG** pain. 100% being the worst possible pain and 0% being the most comfortable.



Pain Scale

Please put a "**B**" on the scale to note your **BACK** pain and an "**L**" on the scale to note your **LEG** pain.