EmersonHospital

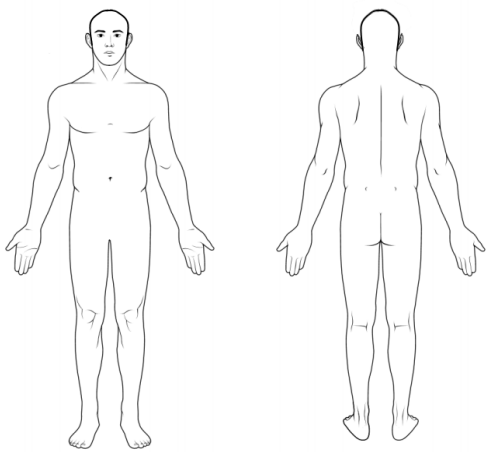
Emerson Spine Program
54 Baker Ave Ext Suite 203
Concord, MA 01742

NEW PATIENT FORM **ROOM#: _____**

NAME: _____ DOB: _____ MRN: _____

____ARTHUR LEE, DO ____JAMES SPINELLI, DO ___FINNERAN, McKAYLA, PA-C ____La MONICA, KRISTIE, PA-C ____GAGNON, REAGAN, PA-C

Where is the Pain? Draw the location of your pain by shading on the diagram below:



Interpreter [ ]Yes [ ]No Language: _____

Workers Compensation [ ]Yes [ ]No

Are you currently working? [ ]Yes [ ]No

Referred by: _____

Chief Complaint (circle):	Upper/Mid/Low Back	Legs/Buttock/ Hip	Shoulder/Elbow
Right/Left/Both	Neck	Arms/Wrist/Hands	Foot/Ankle

History of Present Illness:
The pain is described as: [ ] Constant [ ]Intermittent
Describe your pain: Burning/Sharp-shooting/Tingling/Numbness/Pinprick/Stabbing/Deep-pressure/Tightness/Spasms Other: _____

Rate your <u>USUAL</u> Pain Level (circle):

No Pain 0 1 2 3 4 5 6 7 8 9 10 The Worst Pain Imaginable

What makes the pain worse? _____

What makes the pain better? _____

How long have you noticed pain? _____Days _____Weeks ____Months ____Years

Was there any injury/event that caused your pain? [ ]No [ ]Yes (please describe):

_____

_____

Since the pain started, is it: [ ]Unchanged [ ]Better [ ]Worse, especially for the past:
___days ___ weeks ___months ___years

Any prior back injury or pain before the event above? [ ]No [ ]Yes: what type? _____

***Have you had surgery on your back/neck?** [ ]No [ ]Yes : what type and when? _____

***Have you completed Physical Therapy?** [ ]No [ ]Yes: Where and when?_____

_____

CHECK treatment tried for pain and **CIRCLE** the best treatment to date:

[ ] Injections: where did you have injections and how long ago? _____
[ ] TENS [ ]Heating Pad [ ] Ice [ ]Exercise [ ] Epidural Steroid [ ] Surgery
[ ] Massage [ ]Medications [ ] Acupuncture [ ] Chiropractor

***Evaluations:** [ ]MRI [ ] X-ray [ ]CT Scan [ ]EMG (nerve studies) [ ]Bone Scan [ ]Blood/Lab

How does the pain limit you? _____

What is your goal for coming here today? _____

Please check if you are having the following symptoms:

[ ] Loss of bowel or bladder control
[ ] Leg or arm weakness
[ ] Trouble Walking
[ ] Loss of sensation
[ ] Fevers, chills, sweats, unexplained weight loss
[ ] Increase pain when coughing, sneezing, bowel movement
[ ] Depression
[ ] Trouble sleeping due to pain

Please list other MEDICAL problems:

[ ] Diabetes
[ ] Bleeding Disorder
[ ] High Blood Pressure
[ ] Depression
[ ] Anxiety
[ ] Cancer: _____
[ ] Heart Disease
[ ] High Cholesterol
[ ] Arthritis
[ ] Osteoporosis
[ ] Low Back Pain
[ ] Neck Pain

Past SURGERY:

[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____

FAMILY HISTORY:

Arthritis [ ] Yes [ ] No
_____
Diabetes [ ] Yes [ ] No
Bone Disease [ ] Yes [ ] No
Heart Disease [ ] Yes [ ] No
Cancer [ ] Yes [ ] No

SOCIAL HISTORY:

Where do you live?

What is your marital status?_____
How many children do you have? _____
How do/did you make a living? _____
Alcohol Use ? [ ] No [ ] Yes, how much? _____
Smoker? [ ] No [ ] Yes, #packs/day? _____
Recreational Substance? [ ] No [ ] Yes
Can you dress yourself? [ ] No [ ] Yes

What is your exercise routine? _____
Do you consider yourself overweight? _____

REVIEW OF SYSTEMS: Please fill out **CURRENT** symptom's only

Skin [ ] Normal
[ ] skin rash
[ ] easy bruising/bleeding
[ ] abnormal hair loss
[ ] nail ridging, pitting

Neurological [ ] Normal
[ ] headaches
[ ] incontinence
[ ] seizures
[ ] paralysis

Eyes [ ] Normal
[ ] visual loss
[ ] color blindness
[ ] glaucoma
[ ] glasses/contacts

Lymph Nodes [ ] Normal
[ ] enlargement
[ ] pain

Ears/Nose [ ] Normal
[ ] deafness
[ ] vertigo/dizziness
[ ] hoarseness
[ ] sinusitis
[ ] post nasal drip

Genitourinary [ ] Normal
[ ] blood in urine
[ ] impotence
[ ] painful urination
[ ] kidney stones
[ ] venereal disease

Bone/Joint/Muscles [ ] Normal
[ ] dislocation
[ ] fracture
[ ] muscle wasting
[ ] muscle pain
[ ] muscle weakness

Respiratory Systems [ ] Normal
[ ] breath shortness
[ ] cough
[ ] asthma/bronchitis
[ ] tuberculosis
[ ] pneumonia

Mental Status [ ] Normal
[ ] hallucinations
[ ] nervous breakdown
[ ] depression
[ ]sleep disturbances

Blood System [ ] Normal
[ ] anemia
[ ] bleeding
[ ] bruising
[ ] blood thinners

Endocrine [ ] Normal
[ ] abnormal growth
[ ] goiter
[ ] heat/cold intolerance
[ ] increase thirst

Cardiovascular [ ] Normal
[ ] palpitations
[ ] chest pains
[ ] leg swelling
[ ] arrhythmia

Constitutional [ ] Normal
[ ] fever/chills
[ ] weight loss
[ ] nausea
[ ] vomiting

Allergies [ ] Normal
[ ] dermatitis
[ ] hay fever
[ ] migraine
[ ] sensitivity to pollen

Gastrointestinal [ ] Normal
[ ] appetite changes
[ ] jaundice
[ ] hemorrhoids
[ ] irritable bowel

General [ ] Normal
[ ] poor sleep
[ ] poor energy
[ ] eat too much/little
[ ] tuberculosis

Please list all current medications and allergies:

Allergies:

_____

_____

_____

Medication **Dosage**

_____

_____

_____

_____

_____

_____

_____