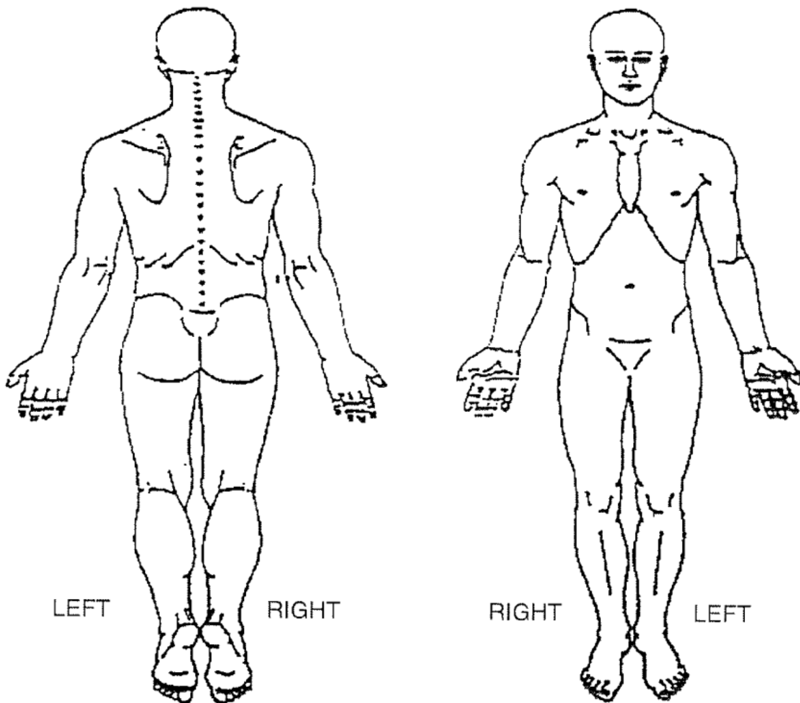
Texas Health Orthopedic Specialists

Dr. Carson Fairbanks

PATIENT NAME:	AGE:	DOB:
DATE OF VISIT:		

Mark these drawings according to where you hurt. If the back of your neck hurts, mark the drawing on the back of the neck, etc. If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

Numbness	Burning	Ache	Pins & Needles	Stabbing
==========	XXXXXXXXXX	^^^^^^^^^^^	0000000000	//////////



How would you describe your current pain ratio? (Please check one box)

Back Pain vs. Leg Pain			Neck Pain vs. Arm Pain		
ü	% Back Pain	% Leg Pain	ü	% Neck Pain	% Arm Pain
	100 %	0%		100%	0%
	75%	25%		75%	25%
	50%	50%		50%	50%
	25%	75%		25%	75%
	0%	100%		0%	100%

HEIGHT:
WEIGHT:
RADIAL PULSE:

Current Pain Intensity

Please circle the number which best describes your current pain level
(0 represents "no pain")

Today	0	1	2	3	4	5	6	7	8	9	10
Best Day	0	1	2	3	4	5	6	7	8	9	10
Worst Day	0	1	2	3	4	5	6	7	8	9	10

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PATIENT NAME:	DOB:

Sex: M or F	Age:	Dominant Hand R or L	Date Your Pain Started:

Which physician referred you to Fort Worth Orthopedics?	Name of Physician ______ Office Address ______
What is the main reason for your visit?	
What are your present symptoms?	______
Describe how the injury occurred?	______
Did you sustain any other injuries at the time of this injury? If yes, please describe.	r Yes r No
Is this injury work related?	r Yes r No r Unsure
Is here any upcoming worker's compensation hearing?	r Yes r No r Unsure
Do you have a lawyer for your injury?	r Yes r No r Unsure
Did an automobile accident cause your pain?	r Yes r No r Unsure
Description of the accident	______ ______
Were you wearing a seatbelt?	r Yes r No
Is there upcoming litigation?	r Yes r No
Do you get leg pain as you walk?	r Yes r No
How far can you walk? (check one box)	r Less than 1 block r 1 block r 5-10 blocks r more than 1 mile
If you sit down after you walk, does your leg pain get better?	r Yes r No
How long have you had your current pain? (check one box)	r Unknown r About 1 Day r About 3 days r About 1 week r About 1 month r About 3 months r About 6 months r About 6 months to 1 year r About 1 to 2 years r About 2 to 3 years r About 3 to 5 years r More than 5 years

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Question				
Have you recently or are you now experiencing numbness and/or tingling in your leg, foot, arm or hand?	r Yes	r No	r Right	r Left
If yes, in which body part?				
Have you recently or are you now experiencing weakness in your arms?	r Yes	r No	r Right	r Left
In your legs?	r Yes	r No	r Right	r Left
Have you experienced any of the following changes in urination?	r Increased frequency	r Inability to hold urine	r Dribbling after voiding	r Cannot pass urine
Have you experienced any of the following changes in your bowels?	r Constipation	r Diarrhea	r Loss of control	
Have you noticed changes in sexual function?	r Yes	r No		
If yes, what?				
Do you have headaches?	r Yes	r No		
Have you recently been depressed because of your pain?	r Yes	r No	r Sometimes	
Does the pain wake you up at night?	r Yes	r No		
How many hours per night do you sleep?				
Is the pain in your back and neck constant or intermittent?	r Constant	r Intermittent		
Is the pain in your leg and arm constant or intermittent?	r Constant	r Intermittent		
Which word in each group best describes your pain?	r Dull r Sharp	r Superficial r Deep	r Burning r Throbbing r Shooting	r Stabbing r Aching
Does the pain keep you from participating in activities you enjoy?	r Yes	r No		
Is your pain severe enough to consider surgery?	r Yes	r No		

Please mark the activities that make your pain worse

r Sitting	r Standing	r Leaning forward	r Walking
r Lying on your side	r Lying on your back	r Lying on your stomach	r Driving
r Coughing/Sneezing	r Lifting	r Getting out of bed	

Please mark the activities that make your pain better:

r Sitting	r Standing	r Leaning forward	r Walking
r Lying on your side	r Lying on your back	r Lying on your stomach	r Driving
r Coughing/Sneezing	r Lifting	r Getting out of bed	

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Please check the boxes next to those treatments you have used for your present condition. Then indicate whether the treatment was helpful or not helpful.

Treatment	Helpful	Not Helpful
r **Physical therapy** If so, how many visits?		
r **Hot packs/ice, massage, muscle stimulation, ultrasound, etc.**		
r **Exercise for proper posture** (stabilization)		
r **Exercise to build strength/endurance** (bike, treadmill, etc)		
r **Back School Education**		
r **Work hardening/conditioning**		
r **Traction**		
r **Chiropractic Adjustment**		
r **Acupuncture**		
r **Epidural Injection** If so, how many visits have you had?		
r **TENS Unit**		
r **Pain Medicine**		
r **Prednisone**		
r **Brace**		

Please mark the following tests you have undergone for your present condition

Test	Date of Testing	Location of Testing (Hospital etc.)	Place a check for those results you will bring or have sent to THC
r **Regular spine x-ray**			
r **CT Scan**			
r **MRI**			
r **Myelogram**			
r **EMG (needle test)**			
r **Discogram**			
r **Bone Scan**			

Have you had back or neck problems before? If yes, describe below. r **Yes** r **No**

Description of Injury	Description of Injury	Months off Work

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Have you had any previous surgeries on or relating to your **neck or back**? r Yes r No

Procedure	Date	Surgeon

What were your symptoms before your last surgery?

r Back pain only	r Neck pain only
r Back pain and right leg pain	r Neck and right arm pain
r Back and left leg pain	r Neck and left arm pain
r Back and pain in both legs	r Neck and pain in both arms

Did you improve after your last surgery?

How long were you better after your last surgery?

r Unknown	r 6 months	r 2-3 years
r 1 day	r 6-12 months	r 3-5 years
r 1 month	r 1 year	r more than 5 years
r 3 months		

What was your work status after your last surgery?

r Returned to same job

r Returned to same job part-time or light duty

r Retrained and worked at a new job

r Never returned to work

List below all the physicians, chiropractors and clinics you have consulted for your present condition.

Name	Address	Date of 1st visit	Date Last Visit

How many hours of your usual work day do you spend?

Sitting:	Standing:	Walking:	Driving:	Lifting: How Heavy?

Which type of duty are you currently working:	r Light duty	r Heavy duty
Do you want a different job?	r Yes	r No
Do you plan to return to your job?	r Yes	r No

Past Medical History (Please check any of the following problems you have had in the past)

r Diabetes	r Tuberculosis	r Difficulty in Bowel Movements
r Heart Disease	r Arthritis	r Prostatic Problems
r High Blood Pressure	r Hepatitis (Yellow Jaundice)	r Kidney Infections
r Cancer	r Asthma	r Kidney Stones
r Heart Attack	r Stomach Ulcers	r Swelling of Toe or Finger Joints
r Seizure	r Dizziness	r Headaches
r Loss of Consciousness	r Fainting	r Infections
r Unexplained Weight Loss	r Difficulty Swallowing	r Depression
r Night Sweats	r Change in Ability to Pass Urine	r Strokes
r Blood Clots	r Fever	r Other

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Please list **ALL PAST HOSPITALIZATIONS** and **ALL PAREVIOUS SURGERY**. If none, circle: **NONE**

Past Illnesses or Surgeries	Date

Medications

Do you have any allergies to medications? If yes, which ones? r Yes r No

Which medications are you currently using for your back or neck:

Medication	# per day	Medication	# per day

Which medications did you previously use for your back or neck:

Medication	# per day	Medication	# per day

Which medications are you taking for other problems? List all of your medications

Medication	# per day	Medication	# per day

Social History

Are you? r Single r Married r Divorced r Widow/Widower

If married, what is the age, health
And occupation of your spouse? Age: Health: Occupation:

How much schooling have you completed?

r Completed less than high school
r Graduated from high school
r Completed 1 to 3 year of college
r Graduated from a 2 year associate degree program or technical school
r Graduated from college (Bachelor's degree or equivalent)
r Completed post-graduate or professional degree

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Children		Age: Living at home: Age: Living at home: Age: Living at home:
Habits		
Drug Use: r Yes r No	Type:	Amount/day:
Alcohol Use: r Yes r No	Type:	Amount/day:
Tobacco Use: r Yes r No	Type:	Packs/day:
Have you ever had problems with alcohol or drug abuse:	r Yes	r No

Family History

Father: r Alive & Well r Died	Age:	Cause of Death:
Mother: r Alive & Well r Died	Age:	Cause of Death:
Did you have a happy childhood?	r Yes	r No
Is there a history of difficulty with anesthesia? If yes, please describe ______	r Yes	r No
Is there a history of malignant hyperthermia? Is there a bleeding tendency in your family or yourself?	r Yes	r No

Occupational History	
Name of Employer:	
Occupation:	How long?
Date Last Worked:	Previous Employment:

Please mark your current symptoms below. If you have none, please circle: **NONE**

r Weight loss or gain	r Frequent or unusual headache	r Bleeding problems
r Fatigue	r Hearing Loss	r Nausea
r Fever	r Mouth or dental infection	r Vomiting
r Chills	r Loss of vision	r Diarrhea-chronic
r Night sweats	r Shortness of breath	r Incontinence
r Rashes	r Difficulty breathing	r Frequency of urine
r Birthmarks	r Productive cough	r Urgency of urine
r Open wounds or sores	r Chest pain or pressure	r Retention of urine
r Drainage	r Irregular heart beat	r Paralysis
r Multiple joint pain	r Swelling of ankles	r Loss of sensation
r Multiple joint swelling	r Blood clots in legs or lungs	r Depression
r Multiple joint stiffness	r Varicose veins	r Episodes of mania
r Generalized muscle weakness	r Deformity	r Inability to sleep

PATIENT SIGNATURE:	DATE:
History Reviewed By	
	Date:
	Date:
	Date: