

West Bay Orthopedic Associates  
120 Centerville Road  
Warwick, RI 02886

Date \_\_\_\_\_

Name \_\_\_\_\_

Age \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Referred by Dr. \_\_\_\_\_

Marital Status \_\_\_\_\_

Primary Care Dr. \_\_\_\_\_

**Where are your symptoms located?** Circle

Neck pain    Neck/Arm    Right    Left

Mid Back Pain

Low back    Back and leg    Right    Left

**On a scale of 0 to 10, how would you rate your pain?**

0 = no pain    10= excruciating pain

Pain Level \_\_\_\_\_

**How long have you been having pain?** \_\_\_\_\_ days

\_\_\_\_\_ weeks

\_\_\_\_\_ months

\_\_\_\_\_ years

**How did your pain start?**

Suddenly

Slow gradual onset

other \_\_\_\_\_

**What do you think was the cause of your pain?**

Circle

Work related injury

Motor vehicle accident

Slip and fall

Sports

House work/Yard work

Assault

Old age

Unknown

Other

**Briefly describe how this episode of pain started** \_\_\_\_\_

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**Have you had similar pain like this before?**

No

Yes

If yes, how often? \_\_\_\_\_

**Does the pain wake you up at night?**

No

Yes

**Do you have any of the following symptoms?**

Numbness/tingling in the leg/legs

No

Yes

Right

Left

Both legs

Weakness in the leg/legs

No

Yes

Right

Left

Both legs

Pain with walking

No

Yes

Numbness/tingling in the arm/arms

No

Yes

Right

Left

Both arms

Difficulty with Bowel or Bladder?

No

Yes

Bowel or bladder changes

No

Yes

**Is your pain aggravated by any of the following?**

Coughing or sneezing	No	Yes
Sitting	No	Yes
Bending forward	No	Yes
Lying down	No	Yes

**Do any of the following make you feel better?**

Lying down	No	Yes
Sitting	No	Yes
Standing	No	Yes
Walking	No	Yes
Exercise	No	Yes

**Have you had previous surgery on your low back?**      No      Yes      Year \_\_\_\_\_

Dr. \_\_\_\_\_

**Have you had previous surgery on your neck?**      No      Yes      Year \_\_\_\_\_

Dr. \_\_\_\_\_

**Please list any other surgery you have had and the year performed**

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**Have you had any testing related to your back or neck?**      No      Yes (please list)

MRI      Where \_\_\_\_\_      When \_\_\_\_\_

X-ray      Where \_\_\_\_\_      When \_\_\_\_\_

Ct-Scan      Where \_\_\_\_\_      When \_\_\_\_\_

EMG      Where \_\_\_\_\_      When \_\_\_\_\_

Myelogram      Where \_\_\_\_\_      When \_\_\_\_\_

**Have you had any treatment?**      No      Yes

Physical therapy      When? \_\_\_\_\_ Where? \_\_\_\_\_

Epidural Steroid Injections      When? \_\_\_\_\_ Where? \_\_\_\_\_

Chiropractic      When? \_\_\_\_\_ Where? \_\_\_\_\_

Acupuncture      When? \_\_\_\_\_ Where? \_\_\_\_\_

Bed Rest      How Long? \_\_\_\_\_

**Do you participate regularly in an exercise program?**      No      Yes (please circle)

Running    walking      Yoga    Stretching      weight lifting    sports      other \_\_\_\_\_

**Please circle any of the following you currently have or have had**

Heart murmur	heart attack	other heart disease	high blood pressure	Rheumatic fever
Gout	phlebitis	venereal disease	nervous disorder	blood transfusion
Pneumonia	emphysema	asthma	seasonal allergies	epilepsy
Tuberculosis	tumor	glaucoma	jaundice	hepatitis
Arthritis	diabetes	cancer	kidney problems	anemia
Ulcer (peptic, duodenal)				

**List any other medical problems you have that are not listed** \_\_\_\_\_

\_\_\_\_\_

**Other than your primary care doctor, are you under the care of any other physician?** No Yes

**Please list the names of other treating physicians** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please circle any symptoms you have now**

Fever/chills	fatigue	excess sweating	vision trouble	eye pain/redness
Nose bleeds	cough	sore throat	sputum	wheezing
Chest pains	heart burn	nervousness	palpitations	swollen feet/ankles
Jaundice	nausea	vomiting	vomiting blood	stomach pain
Black stools	diarrhea	depression	fainting	nighttime urination
Bruise easily	bleed easily	hearing trouble	shortness of breath	muscle weakness
Muscle paralysis	tremors	weight loss	increased thirst	difficulty swallowing
Hot weather intolerance		cold weather intolerance		

**Do you smoke?** No Yes How much \_\_\_\_\_

**Do you use alcoholic beverages?** No Yes How often? \_\_\_\_\_ or socially \_\_\_\_\_

**Are you allergic to any medications?** No/Unknown Yes

Please list \_\_\_\_\_

**Are you currently taking any medications?** No Yes

Please list \_\_\_\_\_  
\_\_\_\_\_

**What is your present work status?**

Full time/full duty    Part time/light duty    Retired    Unemployed  
Medically disabled    Not working currently due to pain    Student    Other

**If your job requires heavy lifting, what is the average weight you lift?**

1-25 lbs    25-50 lbs    50-70 lbs    70-100 lbs    100 lbs or more

Last date you worked \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

How long employed? \_\_\_\_\_

<b>Are you presently receiving</b>	Workers compensation	No	Yes
	Social security	No	Yes
	SSI	No	Yes
	Private disability	No	Yes
	RI TDI	No	Yes

**Name of your attorney (if applicable to this injury)**

\_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_