PERFORMANCE SPINE & SPORTS PHYSICIANS, P.C.

INITIAL EVALUATION FORM

PATIENT INFORMATION

Name: _____ Date: ____/____/____

Date of Birth: ____/____/____

Family Dr.: _____ Referring Doctor: _____

Pharmacy: _____ Phone Number: _____

Date of Injury: ____/____/____ Location: (home, work, auto, etc.) _____

Is this a worker's comp case? ❑ Yes ❑ No Auto? ❑ Yes ❑ No Litigation? ❑ Yes ❑ No

Chief Complaint: _____

_____

Description and duration of problem or accident: _____

_____

_____

_____

What makes your pain worse?: _____

_____

What makes your pain better? _____

Other Physician/s seen for this problem: _____

Have you had any treatments for this condition? (e.g. epidurals, physical therapy, etc.) _____

_____

_____

Did your treatments help? _____

Past medical history: (e.g. diabetes, high blood pressure, acid reflux disease, asthma, GI bleed.) _____

_____

Past surgical history: _____

_____

Name: _____ Date: ____/____/____

Date of Birth: ____/____/____

Medication allergies: _____

_____

Are you allergic to: X-Ray Dye? ❑ Yes ❑ No Shellfish? ❑ Yes ❑ No Iodine? ❑ Yes ❑ No

Food Allergies: _____

Pain Medications: _____

Other Medications: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Family History: ❑ DM ❑ Heart Disease ❑ Spine Disorder ❑ Arthritis ❑ CTS ❑ Thyroid

Social History: ❑ Single ❑ Married Children: ❑ Yes ❑ No

Education (years and degree): _____

Living status: ❑ Alone ❑ With _____

Hobbies / Sports / Other Activities: _____

Do you Smoke: _____ If yes, how many per day: _____

Do you drink alcoholic beverages? _____ If yes, how much per week: _____

Have you had any problems with substance abuse? ❑ Yes ❑ No If yes, please explain: _____

_____

Employment History: _____

What type of work do you do now? Please describe: _____

_____

Present employer and length of time: _____

Are you working: ❑ Full-time ❑ Part-time ❑ Modified duty

If you are not currently working, date last worked: _____

Do you have problems with:

	❑ Weight Loss	❑ Weight Gain	❑ Eyes / Ears
❑ Heart	❑ Lungs	❑ Bowel	❑ Headache
❑ Bladder	❑ Skin	❑ Stroke	❑ Balance problems
❑ Depression	❑ Bleeding disorder	❑ Anemia	❑ Ulcer Disease

Diagnostic Studies: ❑ X-Ray ❑ MRI ❑ EMG ❑ CT/Bone Scan ❑ Other _____

List dates, facility where done, part of body, and results: _____

_____

Name: _____ Date: _____/_____/_____

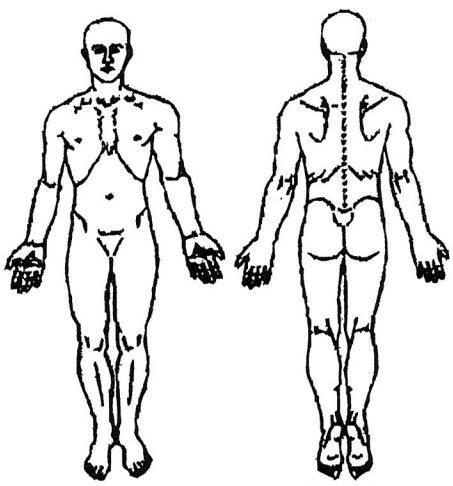
Date of Birth: _____/_____/_____

*If your visit **TODAY** is a follow-up from a procedure, please provide the following information:

What percent of relief did you have immediately after the procedure? _____ (0% - 100%)

What percent of relief do you have **TODAY**? _____ (0% - 100%)

Pain Diagram: Please mark your area of pain using the diagram and legend below.



right/left

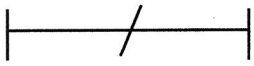
left/right

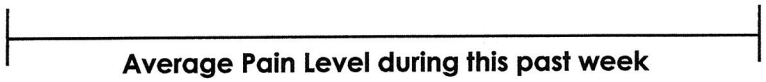
left side

right side

// Stabbing
XX Burning
== Numbness
++ Aching
00 Pins and Needles

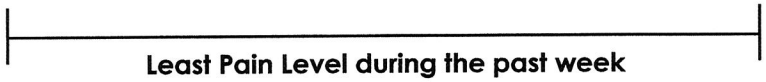
Visual Analog Score: Place a mark on the line that best reflects how much pain you have

EXAMPLE 



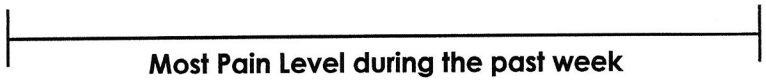
Average Pain Level during this past week

No Pain



Least Pain Level during the past week

Most Pain Imaginable
(Your leg is being amputated without anesthesia)



Most Pain Level during the past week

Please Circle:

1. What relieves your pain: Sitting, Standing, Walking, Laying down, Bending forward, Bending backwards
   Other: _____
2. What worsens your pain? Sitting, Standing, Walking, Laying down, Bending forward, Bending backwards
   Other: _____
3. Did you receive a flu shot during this current flu season? YES NO
   If NO, were you offered the vaccine and declined? YES NO