SPAULDING OUTPATIENT CENTER WELLESLEY

Outpatient Services

PATIENT HISTORY & ASSESSMENT

PATIENT INFORMATION				
Patient's last name: First: Middle:			Birth Date: / /	Age:
Home Phone no.: ( )	Cell Phone no.: ( )		Business Phone no.: ( )	
E-Mail Address:				
Height:		Weight:		

PRIMARY CARE PHYSICIAN				
Name	Address		Phone	Fax

REFERRING DOCTOR				
Name	Address		Phone	Specialty

HISTORY OF YOUR PAIN/SYMPTOMS

Describe in your own words the main problem(s) you would like help with:

When did your symptoms originally start? / /

What event(s) led to your original symptoms?

- ❑ Accident
- ❑ Cancer
- ❑ Work Injury
- ❑ No Obvious cause
- ❑ Following an operation
- ❑ Other: _____

Since the time of onset, my symptoms have

- ❑ Remained the same
- ❑ Become more severe
- ❑ Become less severe

What is your ratio of symptoms? (ie: 75% spine, 25% leg)

_____ % back _____ % neck _____ % leg _____ % arm

Previous treatment has included (check all that apply)

- ❑ Medications
- ❑ Physical Therapy
- ❑ Occupational Therapy
- ❑ Injections
- ❑ Chiropractic
- ❑ Massage
- ❑ Acupuncture
- ❑ Pain psychology
- ❑ Other (specify) _____

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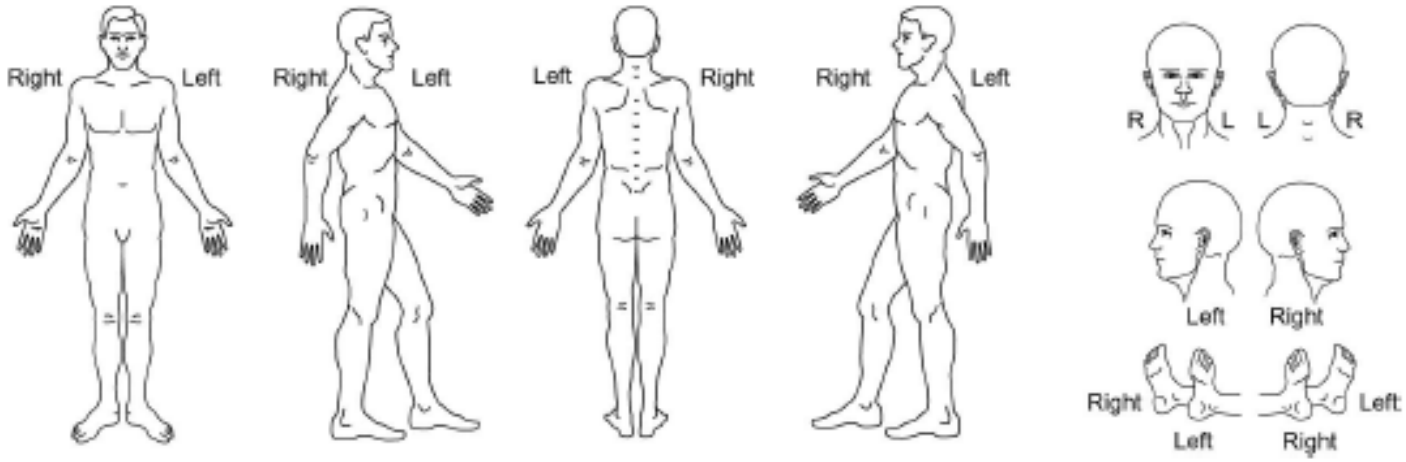
PAIN DIAGRAM

On the body diagram below, Please indicate where your pain is located.



DESCRIPTION OF CURRENT PAIN

Date of current onset

/ /

Pain frequency

- ❑ Constant
- ❑ Comes and Goes

Pain is worse

- ❑ Morning
- ❑ Afternoon
- ❑ Evening
- ❑ Night

Your tolerance to pain

- ❑ Low
- ❑ Average
- ❑ High

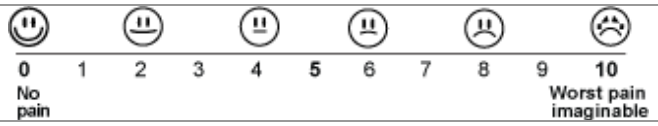
Description of Pain(Check all that apply)

- ❑ Ache
- ❑ Burn
- ❑ Dull
- ❑ Deep
- ❑ Sharp
- ❑ Superficial
- ❑ Sting
- ❑ Swelling
- ❑ Tingle
- ❑ Throb
- ❑ Other (please describe)

What Relieves Pain (Check all that apply)

- ❑ Rest
- ❑ Sleep
- ❑ Cold
- ❑ Heat
- ❑ Relaxation Technique
- ❑ Repositioning
- ❑ Exercise
- ❑ Massage
- ❑ Other (please describe)

On a scale of 0 to 10 with 0 being no pain and 10 being the highest rate your pain now (Circle One)



When I have pain it makes me feel (Check all that apply)

- ❑ Sad
- ❑ Angry
- ❑ Anxious
- ❑ Tired
- ❑ Helpless
- ❑ Other (please describe)

What Makes Pain Feel Worse

What Makes Pain Feel Better

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PAST MEDICAL HISTORY (Please check all that apply)

❑ High blood pressure ❑ Heart disease ❑ High cholesterol ❑ Asthma ❑ Sleep apnea	❑ Bleeding problems ❑ Diabetes ❑ Thyroid disease ❑ Liver disease ❑ Kidney disease	❑ Seizures ❑ Osteoporosis ❑ Autoimmune disorder (specify) _____	❑ Cancer (specify) _____ ❑ Psychiatric disorder (specify) _____ ❑ Other (specify) _____

SURGICAL PROCEDURES

Date	Describe	Hospital Performed	Doctor

CURRENT MEDICATIONS (or attach current medication list)
(Please include prescribed, over-the-counter, herbs and vitamins)

Medication Name	Dose/Frequency	Started	Prescribing MD

ALLERGIES
(Please include medication, food, environment and latex)

Allergy	Reaction

FAMILY HISTORY

Relative	Medical Problem

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SOCIAL HISTORY					
What is your **occupation**?					
Working Status: ❑ Full Time ❑ Part Time (___ hours per week) ❑ Homemaker ❑ Retired ❑ Unemployed ❑ Due to pain?					
How would you classify your occupation? ❑ Sedentary ❑ Light ❑ Medium ❑ Heavy/Physical					
Are you on Disability? ❑ Yes ❑ No	Date Started	Reason			
Marital Status ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Separated					
Do you have any children? If so what ages:	❑ No	❑ Yes			
Who do you live with? ❑ Alone ❑ Spouse/Partner ❑ Children ❑ Roommate(s) ❑ Pets					
Please briefly describe your current **living situation** (e.g. Apartment with an elevator, or House with 2 floors; stairs)					
Have you experienced significant **stress** this past year? If yes, please explain:	❑ No	❑ Yes			
Do you have any pending health related litigations?	❑ No	❑ Yes			
BEHAVIORAL HEALTH					
Do you smoke? If yes how much?	❑ No	❑ Yes			
How many drinks do you have during a typical week?	_____ drinks / week				
Do you use recreational drugs?	❑ No	❑ Yes			
FALL RISK ASSESSMENT					
Have you **fallen** in the last (6) months (not a slip or a trip)?	❑ No	❑ Yes			
Are you feeling weak, dizzy, or lightheaded today?	❑ No	❑ Yes			
Do you need help to walk or change your clothes?	❑ No	❑ Yes			
Have you ever experienced lightheadedness when having blood drawn or an IV?	❑ No	❑ Yes			
FUNCTIONAL STATUS					
Do you use: ❑ Cane ❑ Walker ❑ Braces ❑ Wheelchair ❑ None of these					
Do you **exercise** regularly?	❑ No	❑ Yes			
What type of exercise do you do?					
How many days per week do you exercise?					
For how long do you exercise each time (approximately)? For running and cycling, please include weekly mileage.					

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REVIEW OF SYSTEMS *(Please check all that apply)*

Constitutional
- ❑ **Weight loss**
- ❑ **Loss of appetite**
- ❑ **Fatigue**
- ❑ **Fever**
- ❑ **Chills**
- ❑ **Night sweats**
- ❑ **Recent Infections**

Eyes
- ❑ Blurred vision
- ❑ Double vision
- ❑ Eye pain or irritation
- ❑ Dry eyes

Ears, Nose Mouth and Throat
- ❑ Difficulty hearing
- ❑ Ringing in Ears
- ❑ Dry mouth
- ❑ Difficulty swallowing
- ❑ Frequent sore throat
- ❑ Frequent nose bleeds
- ❑ Sinus trouble or congestion

Cardiovascular
- ❑ Heart murmur
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of Breath
- ❑ Swollen ankles
- ❑ Passing out

Endocrine
- ❑ Cold hands
- ❑ Cold feet
- ❑ Excessive thirst
- ❑ Excessive urination

Respiratory
- ❑ Cough
- ❑ Wheezing

Gastrointestinal
- ❑ Nausea or vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Abdominal pain
- ❑ Ulcers
- ❑ Heartburn
- ❑ Jaundice (yellow skin)
- ❑ Black or Bloody Stools

Genitourinary
- ❑ **Bladder incontinence**
- ❑ **Incomplete bladder emptying**
- ❑ **Genital numbness**
- ❑ Frequent or hesitant urination
- ❑ Pain with urination
- ❑ Blood in urine
- ❑ Kidney infection
- ❑ Frequent bladder infections
- ❑ Erectile dysfunction

Musculoskeletal
- ❑ Back pain
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Muscle stiffness

Skin
- ❑ Rash/sores
- ❑ Eczema
- ❑ Psoriasis
- ❑ Itching

Neurological
- ❑ Headaches
- ❑ Loss of strength
- ❑ Weakness
- ❑ Numbness
- ❑ Fainting spells
- ❑ Dizziness/vertigo

Psychiatric
- ❑ Difficulty sleeping
- ❑ Anxiety
- ❑ **Depression**
- ❑ Mood swings
- ❑ Memory Loss

Hematological
- ❑ Excessive bruising or bleeding
- ❑ Enlarged glands

Gynecologic
- ❑ Painful periods
- ❑ Painful intercourse
- ❑ Pregnant
- ❑ Post-menopausal
- ❑ Last Menstrual Period

  Date: _____

Patient signature / Person Completing Form **Date:** **Time:**