PLYMOUTH BAY ORTHOPEDIC ASSOCIATES, INC.

41 Resnik Road
Plymouth, MA 02360
Tel. (781)934-2400/Fax (508) 746-3930
www.pbortho.com

Patient Name:_____
DOB:_____

Date:_____
Home Phone (_____) _____-_____ Work Phone (_____) ____-_____ Cell (____) ____-_____
Referred by:_____ PCP:_____
Describe the brief history of the pain problem you were sent here for:_____
_____
_____
_____

How long has pain been present:_____ Work related? □ Yes □ No Legal case? □ Yes □ No
Describe the pain (burning, sharp, dull, etc.)_____
What makes the pain worse?_____
What makes the pain better?_____
How do you spend your day?_____
Do you use: □ Cane □ Crutches □ Walker □ Scooter □ Wheelchair □ None | Handedness □ Left □ Right
Treatment: If you have tried any of these treatments, CIRCLE **↑ if helpful, ↓ if made worse, -- if no difference**

	Current	Past		Current	Past		Current	Past
Physical Therapy (PT)			Heat			Trigger point injection		
Occupational Therapy (OT)			Cold			Spinal injection		
Exercises			Traction			Implanted pump		
Water exercises/aerobics			Acupuncture			Implanted stimulator		
Splints or braces			Chiropractic			Nerve blocks		
Psychological care for pain			Meditation/relaxation			Nerve ablation/burning		
Pain management classes			Massage			TENS unit		

Sleep Do you: □ Have trouble falling asleep? □ Snore? □ Have Restless legs? □ Feel fatigued much of the time?
□ Wake in the middle of the night? □ Have sleep apnea? □ Use CPAP? □ Nap during the day?
Exercise What do you do for exercise?_____
How Often?_____ For how long each time?_____
Mood Describe your current emotional state (*check all that apply*): □ Happy □ Optimistic □ Well-adjusted □ Angry
□ Depressed □ Suicidal □ Anxious □ Confused □ Hopeless □ Indifferent
Do you have a history of: □ Depression □ Anxiety □ Attention deficit □ Bipolar disorder □ Suicide attempt(s)
□ Abuse experiences □ Other problems_____
Are you currently seeing a psychiatrist? □ Yes □ No If yes, name:_____
Are you currently seeing a counselor or psychologist? □ Yes □ No If yes, name:_____
Home/School Who lives with you?_____
Are you: □ Married □ Single □ Engaged □ Divorced □ Separated □ Widowed
If you have children, how many and their ages?_____
How far did you go in school?_____ Have you spent time in the military? □ Yes □ No
Work Do/did you miss work because of pain? □ Yes □ No Do you work outside the home? □ Yes □ No
If yes, what is your job?_____ □ Full-time □ Part-time □ light/limited duty
If no, when did you last work?_____ Why did you stop?_____
What is your source of income?_____ Do you intend return to work? □ Yes □ No

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Medications: Pease bring a complete list of your current medications to your appointment.

What medications have you tried to treat your pain condition? Please circle any you know you have taken.	Helpful	Not Helpful
Vitamins, herbals, glucosamine, other supplements		
NSAID's (Tylenol/acetaminophen, ibuprofen, Aleve, naproxen, Celebrex, others), aspirin		
Opiods/narcotics (oxycodone, hydrocodone, Percocet, Vicodin, morphine, Dilaudid, fentanyl, methadone, Butrans, Suboxone, Kadian, tramadol, Nucynta, others)		
Muscle relaxants (carisoprodal, cyclobenzaprine, Skelaxin, baclofen, tizanidine, others)		
Anti-seizure medications (gabapentin, Lyrica, pregabalin, Topamax, topiramate, others)		
Antidressants (amitriptyline, nortriptyline, Cymbalta, duloxetine, sertraline, escitalopram. Paroxetine, fluoxetine, Salvella, milnacipran, others)		
Sedatives/anti-anxiety (diazepam, lorazepam, clonazepram, others)		
Sleeping aids (Benadryl, diphenhydramine, Ambien, zolpidem, Lunesta, Sonata, others)		
Topicals (Lidoderm patch, lidocaine cream, Ben-Gay, capsaicin, Tiger Balm, Voltaren gel, others)		

Habits □ I have never smoked □ I currently smoke □ I have quit smoking □ I chew tobacco or inhale snuff

Average number of caffeinated beverages per day:_____

Average number of alcoholic beverages per day / week / month (circle one)_____

I have used non-prescribed drugs (check appropriate boxes below):

	Marijuana	Cocaine	Heroin	Amphetamines	Narcotic Pills	Other
Now						
In the past						

□ I have been treated for alcohol or alcohol addiction □ I am in treatment now □ I need treatment

Health History Please check the items that apply to you> Provide details at right.

System	**Problems**	**Details or other problems**
General	□ Fatigue □ Fevers/Chills □ Weight loss or gain □ night sweats □ "Hot flashes"	
Head/Neck	□ Poor vision □ Poor hearing □ TMJ syndrome □ Head/neck cancer □ Swollen glands/nodes	
Blood/Immune	□ Easy bruising or bleeding □ Anemia □ Lymphoma or leukemia □ Transfusions □ Transplant	
Bones/Joints	□ Broken bones □ Joint swelling □ Stiff joints □ Osteoarthritis □ Very flexible joints □ Morning stiffness □ Lupus □ Rheumatoid	
Skin	□ Rashes □ Sores/ulcers □ Scars □ Eczema □ Skin cancer	
Lungs/Chest	□ Shortness of breath □ Cough □ Asthma □ Emphysema/COPD □ Pneumonia □ Lung cancer □ Lung surgery	
Heart	□ Chest pain (from heart)/Angina □ High blood pressure □ Heart attack □ Low blood pressure □ Irregular heartbeat □ Valvular disease □ Swollen legs/arms □ Aneurysm □ Cold hands/feet	
Spine	□ Scoliosis □ Disc problems □ Fracture □ Neck injury □ Back injury □ Spinal arthritis □ Spine surgery □ Spinal tumor	
Endocrine	□ Diabetes □ Goiter □ Thyroid disease □ Low testosterone/estrogen □ Pancreatic disease	
Genital/Urinary and Pelvic	□ Kidney stones □ Kidney failure □ Kidney cancer □ Prostate problems □ Urinary infection □ Problems controlling urine □ "Fallen bladder" □Painful intercourse □ Erectile dysfunction □ Prostate/bladder cancer Menstrual problems □ Pelvic pain □ Ovarian/uterine/cervical cancer	

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System	Problems	Details or other problems
Abdomen/GI	□ Heartburn, GERD, hiatal hernia □ Peptic ulcer □ Gallstones □ Hepatitis □ Diarrhea □ Constipation □ Irritable bowel □ Ostomy □ Crohn's □ Ulcerative colitis □ Cancer □ Gastric bypass □ Problems controlling bowels □ blood in stool	
Neuro-muscular	□ Headache □ Vertigo (spinning) □ Lightheadedness □ Stroke □ Seizures/epilepsy □ Tremor □ Falls □ Balance problems □ Weakness □ Muscle pain □ Fibromyalgia □ CRPS/RSD □ Brain tumor □ Parkinson's □ Multiple sclerosis □ Double vision □ Peripheral neuropathy □ Chronic fatigue □ Spinal cord injury □ Muscular dystrophy or myopathy □ Head injury/concussion	
Other	□ Currently pregnant □ Currently breastfeeding □ Planning pregnancy □ HIV/AIDS □ Artificial joint or disc □ Pacemaker, defibrillator, stents, artificial heart valve	

Other medical history:_____

_____

_____

_____

_____

Surgical history:_____

_____

_____

_____

Family Medical History:

Family Member	Medical Problem(s)	Family Member	Medical Problem(s)
Father		Child	
Mother		Child	
Sister/Brother		Other	
Other		Other	

Signature of Patient/Representative:_____ Date:_____ Time:_____

If signed by someone other than patient, print name and state relationship and authority to do so.
Print name:_____ Relationship:_____

Patient is: □ Minor □ Incompetent/Incapacitated
Legal Authority: □ Legal Guardian □ Parent
□ Health Care Agent □ Other_____

Reviewed by:_____ Date:_____ Time:_____