7601 West Jefferson Boulevard Fort Wayne, Indiana 46804
P 260.436.8686 800.566.5659 **F** 260.436.8585
fwortho.com

fort wayne ORTHOPEDICS

PLEASE BRING FILMS

(Xray, MRI, CT)

and

ALL RELATED REPORTS

TO APPOINTMENT

DR. SHUGART / DR. RAHN BACK ASSESSMENT

It is very important that you fill out this form as completely as possible before you arrive for your appointment. **If your injury is not work-related, please disregard this page and complete the remainder of the form.**

PATIENT NAME	ACCOUNT NO.

DATE OF VISIT:

Dear Back or Neck Patient:

The questionnaire you have received from Fort Wayne Orthopaedics, LLC will allow your physician to give you the best available treatment for your spinal problem.

If your injury is work-related and has been reported to your employer's worker's compensation carrier, to better facilitate the transfer of information regarding your care, we need you to complete the form below. Please contact your employer to obtain this information prior to your visit.

NAME OF EMPLOYER
EMPLOYER'S ADDRESS
WORKER'S COMPENSATION CARRIER (INSURANCE)
INSURANCE CO. ADDRESS
CASE MANAGER

If you have any other questions, please ask the nurse at the time of your appointment.

Thank you,

Fort Wayne Orthopaedics, LLC

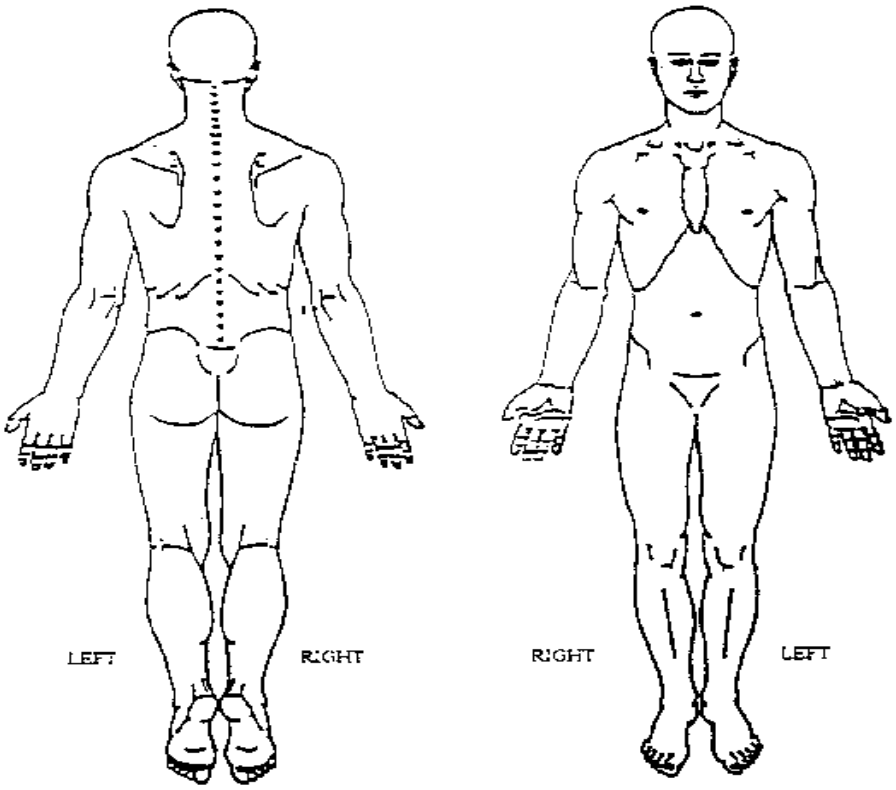
Dr. _____

FORT WAYNE ORTHOPAEDICS – *** **USE ONLY BLACK OR BLUE INK**

PATIENT NAME:	ACCOUNT NO.:
DATE OF VISIT:	DATE OF BIRTH:

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
========	XXXXXX	^^^^^^^^	OOOOO	///////////



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

Back Pain vs. Leg Pain			Neck Pain vs. Arm Pain		
✓	% Back Pain	% Leg Pain	✓	% 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") (10 is "the worst pain you could imagine")

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

FORT WAYNE ORTHOPAEDICS – *** **USE ONLY BLACK OR BLUE INK**

PATIENT NAME:	ACCOUNT NO.:

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

Which physician or physicians referred you to Fort Wayne Orthopaedics?

Name of Physician _____

Office Address _____

OCCUPATIONAL HISTORY:

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

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? ☐ Light duty ☐ Regular duty ☐ Off Work
Do you want a different job? ☐ Yes ☐ No
Do you plan to return to your job? ☐ Yes ☐ No

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. _____

Is this injury work related?	❑ Yes	❑ No	❑ Unsure
Is there an upcoming worker's compensation hearing?	❑ Yes	❑ No	
Do you have a lawyer for your injury?	❑ Yes	❑ No	
Did an automobile accident cause your pain?	❑ Yes	❑ No	Date of Accident:

Description of the accident _____

PATIENT NAME:	ACCOUNT:

Were you wearing a seatbelt?	❑ Yes	❑ No		
Is there upcoming litigation?	❑ Yes	❑ No		
Do you get leg pain as you walk?	❑ Yes	❑ No		
How far can you walk? (check one box)	❑ Less than 1 block	❑ 1 block	❑ 5-10 blocks	❑ more than 1 mile
If you sit down after you walk, does your leg pain get better?	❑ Yes	❑ No		
How long have you had your current pain? (check one box)	❑ Unknown ❑ About 1 Day ❑ About 3 days ❑ About 1 week ❑ About 1 month ❑ About 3 months		❑ About 6 months ❑ About 6 months to 1 year ❑ About 1 to 2 years ❑ About 2 to 3 years ❑ About 3 to 5 years ❑ More than 5 years	
Have you recently or are you now experiencing numbness and /or tingling in your leg, foot, arm, or hand?	❑ Yes	❑ No	❑ Right	❑ Left
If yes, in which body part?				
Have you recently or are you now experiencing weakness in your arms?	❑ Yes	❑ No	❑ Right	❑ Left
In your legs	❑ Yes	❑ No	❑ Right	❑ Left
Have you experienced any of the following changes in urination?	❑ Increased frequency	❑ Inability to hold urine	❑ Dribbling after voiding	❑ Cannot pass urine
Have you experienced any of the following changes in your bowels?	❑ Constipation	❑ Diarrhea	❑ Loss of control	
Have you noticed changes in sexual function?	❑ Yes	❑ No		
If yes, what?				
Do you have headaches?	❑ Yes	❑ No		
Have you recently been depressed because of your pain?	❑ Yes	❑ No	❑ Sometimes	
Does the pain wake you up at night?	❑ Yes	❑ No		
How many hours per night do you sleep?				
Is the pain in your back or neck constant or intermittent?	❑ Constant	❑ Intermittent		
Is the pain in your leg or arm constant or intermittent?	❑ Constant	❑ Intermittent		

FORT WAYNE ORTHOPAEDICS – *** **USE ONLY BLACK OR BLUE INK**

PATIENT NAME:	ACCOUNT NO:

Which word in each group best describes your pain?	❑ Dull ❑ Sharp	❑ Superficial ❑ Deep	❑ Burning ❑ Throbbing ❑ Shooting	❑ Stabbing ❑ Aching
Does the pain keep you from participating in activities you enjoy?	❑ Yes	❑ No		
Is your pain severe enough to consider surgery?	❑ Yes	❑ No	❑ Maybe	

Please mark the activities that make your <u>pain worse</u>

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

Please mark the activities that make your <u>pain better</u>

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

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
❑ **Physical therapy** If so, how many visits?_____		
❑ **Hot packs/ice, massage, muscle stimulation, ultrasound, etc.**		
❑ **Exercises for proper posture (**stabilization)		
❑ **Exercises to build strength/ endurance** (bike, treadmill, etc.)		
❑ **Back School education**		
❑ **Work hardening/conditioning**		
❑ **Traction**		
❑ **Chiropractic Adjustment**		
❑ **Acupuncture**		
❑ **Epidural Injection** If so, how many have you had?_____		
❑ **TENS Unit**		
❑ **Pain Medicine**		
❑ **Prednisone**		
❑ **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 FWO
❑ **Regular spine x-ray**			
❑ **CT Scan**			
❑ **MRI**			
❑ **Myelogram**			
❑ **EMG (needle test)**			
❑ **Discogram**			
❑ **Bone Scan**			

FORT WAYNE ORTHOPAEDICS – *** **USE ONLY BLACK OR BLUE INK**

PATIENT NAME:	ACCOUNT NO.:

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

Description of Injury	Date of Treatment	Months off Work

Have you ever had any previous injuries at work? If yes, describe below. ❑ Yes ❑ No

Description of Injury	Date of Treatment	Months off Work

If you had previous episodes, did they cause any of the following?

❑ Back or neck pain only			
❑ Leg or arm pain only	❑ Right	❑ Left	❑ Both
❑ Back pain and leg pain	❑ Right	❑ Left	❑ Both
❑ Neck pain and arm pain	❑ Right	❑ Left	❑ Both

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

Name	Address	Date 1st Visit	Date Last Visit

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

Procedure	Date	Hospital / Facility	Surgeon

Please list any surgery you have had OTHER THAN SPINE SURGERY.

Type of Surgery Date

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

FORT WAYNE ORTHOPAEDICS – *** **USE ONLY BLACK OR BLUE INK**

PATIENT NAME:	ACCOUNT NO.:

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

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

REVIEW OF SYSTEMS (Please mark *current* symptoms)

Constitutional ☐ **Normal**
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night sweats

Integumentary ☐ **Normal**
- ☐ Rashes
- ☐ Birthmarks
- ☐ Open wounds or sores
- ☐ Drainage

Musculoskeletal ☐ **Normal**
- ☐ Multiple joint pain
- ☐ Multiple joint swelling
- ☐ Multiple joint stiffness
- ☐ Generalized muscle weakness
- ☐ Deformity

ENTM ☐ **Normal**
- ☐ Frequency of unusual headache
- ☐ Hearing loss
- ☐ Mouth or dental infections

Eyes ☐ **Normal**
- ☐ Loss of vision

Respiratory ☐ **Normal**
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Productive cough

Cardiovascular ☐ **Normal**
- ☐ Chest pain or pressure
- ☐ Irregular heart beat
- ☐ Swelling of ankles
- ☐ Blood clots in legs or lungs
- ☐ Varicose veins

Hematologic ☐ **Normal**
- ☐ Bleeding Disorders

Gastrointestinal ☐ **Normal**
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea-Chronic

Genitourinary ☐ **Normal**
- ☐ Incontinence
- ☐ Frequency of urine
- ☐ Urgency of urine
- ☐ Retention of urine

Neurological ☐ **Normal**
- ☐ Paralysis
- ☐ Loss of sensation
- ☐ Headaches

Psychiatric ☐ **Normal**
- ☐ Depression
- ☐ Episodes of mania
- ☐ Inability to sleep

Endocrine ☐ **Normal**
- ☐ Diabetes
- ☐ Thyroid Disorder

Family History

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

Social History

Drug Use: ❑ Yes ❑ No	Type:	Amount/day:	
Alcohol Use: ❑ Yes ❑ No	Type:	Amount/day:	
Tobacco Use: ❑ Yes ❑ No	Type:	Packs/day:	
Have you ever had problems with alcohol or drug abuse?		❑ Yes	❑ No

PATIENT NAME:	ACCOUNT NO.:

MEDICATIONS (Bring a copy of your medication list to the appointment)

Please list all medication you take including prescription, nonprescription, herbal and vitamins.

❑ I do not take any medication

Medication	Reason taken	Dose & How often	Doctor

Any ALLERGIES to medications, foods, tape, latex or iodine/betadine? ❑ No ❑ Yes

If yes, please list and describe reaction._____

_____

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

PATIENT NAME:	ACCOUNT NO.: