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fort wayne ORTHOPEDICS

DR WINTERS' BACK FORM

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,

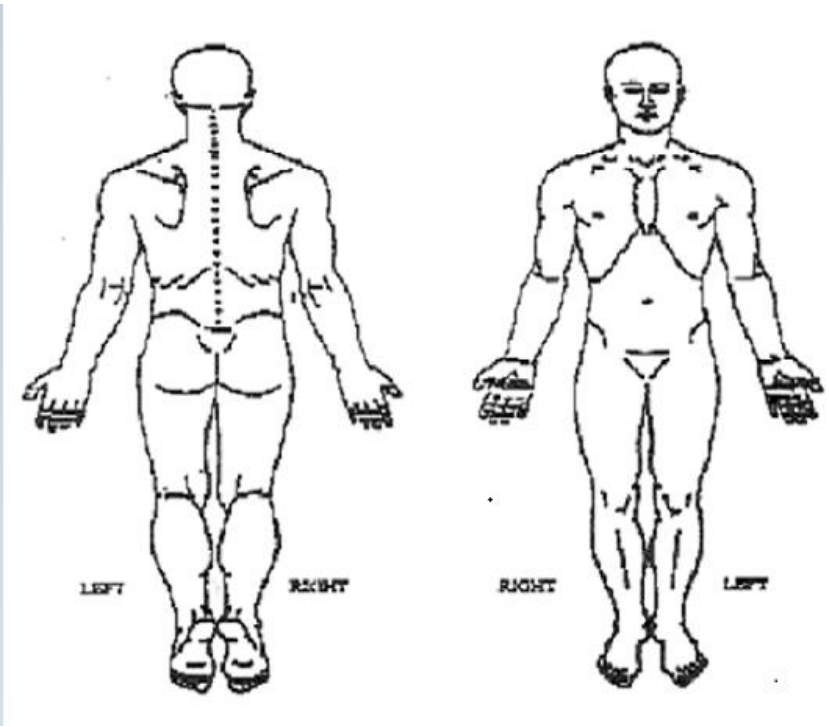
Fort Wayne Orthopaedics, LLC

Dr. Winters

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

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:

PAIN ASSESSMENT SCALE

Please circle the number from 0 to 10 that best describes your pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Possible Pain

Describe your reason for your visit:_____
_____

When did the problem start? _____
_____

Was there an injury that caused the problem? If yes please describe.
_____
_____

Was the injury work related?_____
What symptoms are you currently experiencing?
_____
_____
_____

Mark the activities that make your pain worse:

☐ Sitting	☐ Walking	☐ Lying On Your Back	☐ Reaching overhead
☐ Standing	☐ Leaning Forward	☐ Coughing / Sneezing	☐ Other_____

What activities or treatments make your pain better *(including medications)*: _____
_____

What activities or treatments have you tried that were NOT helpful *(including medications)*: _____

Have any diagnostic studies been performed on this area? Please list study (xray, CT, MRI, etc..), location and approximate date

Study	Location	Date

If you have provided your health history information with our staff via the phone or completed your health history on the computer, you do not need to procced with the next page.

If you have not completed your health history through one of methods, you MUST complete the following page.

Dominant Hand (Check correct box): Right Handed ☐ Left Handed ☐ Ambidextrous ☐

MEDICAL HISTORY:

☐ Eye Disease	☐ AIDS/HIV	☐ Cerebral Palsy	☐ Lupus	☐ Mental Disability
☐ Hearing Loss	☐ Anemia	☐ Migraines	☐ Osteoarthritis	☐ Presription Drug Abuse
☐ Asthma	☐ Bleeding Disorder	☐ Multiple Sclerosis	☐ Osteoporosis	☐ Schizoprenia
☐ COPD	☐ Blood Clots	☐ Parkinsons	☐ Rheumatoid Arthritis	☐ Diabetes
☐ Tuberculosis	☐ MRSA	☐ Peripheral Neuopathy	☐ Hepatitis _____	☐ Thyroid Disease
☐ Sleep Apnea	☐ Alzheimer's Disease	☐ Polio	☐ Liver Disease	☐ Malignant Hyperthermia
☐ Atrial Fibrillation	☐ Obesity	☐ Stroke	☐ ADD/ADHD	
☐ Heart Disease	☐ Bowel Disease	☐ Back Problems	☐ Alcohol Abuse	☐ Other_____
☐ Heart Attack	☐ Acid Refulx	☐ Fibromyalgia	☐ Anxiety	
☐ High Cholesterol	☐ Hiatal Hernia	☐ Muscular Disease	☐ Bipolar Disorder	☐ Other_____
☐ Hypertention	☐ IBS	☐ Scoliosis	☐ Depression	
☐ Heart Failure	☐ Kidney Disease	☐ Gout	☐ Drug Abuse	☐ Other_____

List **ALL** previous surgeries:

_____

_____

_____

_____

List any allergies to medicines: _____

_____

List all medicines and dosages that you are currently using:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY HISTORY: (please check if for Mother, Father, Sibling(s), Daughter, Son)

☐Adopted/Unknown family history	Mother	Father	Sibling(s)	Daughter	Son
Alcohol Abuse					
Malignant Hyperthermia					
Bleeding Disorder					
Cancer					
Diabetes					
Heart Disease					
Kidney Disease					
Lung Disease					

SOCIAL HISTORY:

Tobacco Use: ☐ Current _____ packs/per day ☐ Former ☐ Never

Alcohol Use: ☐ Yes ☐ No Amount _____

Caffeine Use: ☐ Yes ☐ No Amount cups per day_____ OR Amount ounces per day_____