SALT LAKE SPINE & SPORTS MEDICINE

NEW EVALUATION

Name: _____ **Date:** _____

Age: _____ **Height:** _____ **Weight:** _____

Are you: ❑Right-Handed ❑Left-handed

Employment: ❑ Full-time ❑ Part-time ❑ Retired ❑Disability

Job: _____

Describe the *MAIN AREA OF PAIN* for which you are being seen today:

What hurts the most? ❑Head ❑Neck ❑Shoulder ❑Arm ❑Hand
❑Back ❑Hip ❑Buttock ❑Pelvis ❑Abdomen
❑Knee ❑Leg ❑Foot

How long have you had your current PAIN? _____

Ever had this before? ❑No ❑Yes → Describe: _____

How did this pain begin? ❑Gradually (unrelated to any specific precipitating factor, trauma, or injury)

❑ Suddenly → Describe any specific injury, trauma, or activity that caused pain:

_____

_____

Overall, is your pain: ❑Getting better ❑Getting worse ❑About the same ❑Constant ❑Intermittent

Any prior injury to this area? ❑No ❑Yes → When? _____ Describe: _____

_____

How would you describe your pain? ❑ Ache/Throb ❑Sharp/Stab ❑Stiff ❑Burn ❑Numb/Tingling

How intense is your pain currently? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

How intense is your pain at its worst? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

How intense is your pain at its best? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Is this a work compensation case? ❑Yes ❑No **Any legal action pending regarding this pain?** ❑Yes ❑No

Do you have a known cancer or tumor? ❑No ❑Yes → Describe:_____

Have you recently taken corticosteroid medications on a regular basis? ❑Yes ❑No

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What makes your pain feel worse? If one activity is worse than all the others, please check the box:

❑Standing ❑Sitting ❑Walking →What distance? _____ ❑Coughing ❑Sneezing ❑Straining
❑Bending forward ❑Bending Back ❑Stairs ❑Reaching overhead ❑Laying on that side
❑Morning ❑Evening ❑In bed at night ❑Sexual intercourse ❑Lifting ❑Twisting

What makes your pain feel better?

❑Standing Still ❑Sitting Down ❑Walking/moving around ❑Lying down ❑Bending forward ❑Bending Back
❑Rest ❑Heat ❑Ice ❑Stretching ❑Medication ❑Nothing makes it better

Have you had any of these symptoms as part of your current symptoms?

❑Yes ❑No Weakness
❑Yes ❑No Fever or chills
❑Yes ❑No Swelling or fluid on the joint
❑Yes ❑No Weight loss
❑Yes ❑No Giveway of your leg, falling down because of pain, locking of your joint
❑Yes ❑No Loss of control of your bladder or bowel
❑Yes ❑No Rash
❑Yes ❑No Numbness or tingling
❑Yes ❑ No Difficulty sleeping

What treatments have you done for your pain? Either mark below, or ☐ I haven't done anything for this pain.

	Yes	No	When?	What was result (effective?)	Are you still using this?
Medications					
Acetaminophen, Tylenol					
Ibuprofen, Advil					
Aleve, Naproxen					
Daypro, Relafen					
Celebrex, Mobic					
Glucosamine, Chondroitin					
Neurontin, Lyrica					
Amitriptyline (Elavil), Nortriptyline (Pamelor)					
Tramadol, Ultram, Ultracet					
Physical Therapy					
Strengthening					
Stretching					
Heat or Ice					
Massage					
Ultrasound					
TENS, Electrical Stimulation					
Traction					
Aerobic Exercise					
Acupuncture					
Manipulation, Chiropractor					
Cane, Walker, or Crutches					
Injection(s) (What was injected?)					
Surgery					
Time Off Work					

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Personal Medical History:

Significant medical conditions:

❑Diabetes ❑Heart Disease ❑High blood pressure ❑Stomach Ulcers ❑Cancer
❑Asthma ❑Other: _____

Past surgeries? _____

What are your current medications? (Use back of page if you need more space)

Medication Dosage How long have you been taking?

_____
_____
_____
_____
_____
_____

Do you have any known Allergies? ❑ No ❑Yes →Describe: _____

Do you have any metal in your body? ❑ No ❑Yes →Describe: _____

Family Medical History

Mother: ❑Diabetes ❑Heart Disease ❑High blood pressure ❑Stomach Ulcers
❑Cancer ❑Asthma ❑Other: _____

Father: ❑Diabetes ❑Heart Disease ❑High blood pressure ❑Stomach Ulcers
❑Cancer ❑Asthma ❑Other: _____

Brothers/Sisters: ❑Diabetes ❑Heart Disease ❑High blood pressure ❑Stomach Ulcers
❑Cancer ❑Asthma ❑Other: _____

Personal Social History

Marital Status? ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

Do you have children? ❑No ❑Yes → Ages? _____

Do you smoke cigarettes or chew tobacco? ❑No ❑Yes → How many packs per day? _____

Do you or have you ever used recreational drugs (cocaine, marijuana, LSD, etc.)? ❑No ❑Yes → Describe: _____

Do you drink alcoholic beverages? ❑No ❑Yes → How much and how often? _____

Have you ever had a history of alcohol abuse? ❑No ❑Yes **Have you ever been to Alcoholics Anonymous?** ❑No ❑Yes

What is your highest level of education? _____

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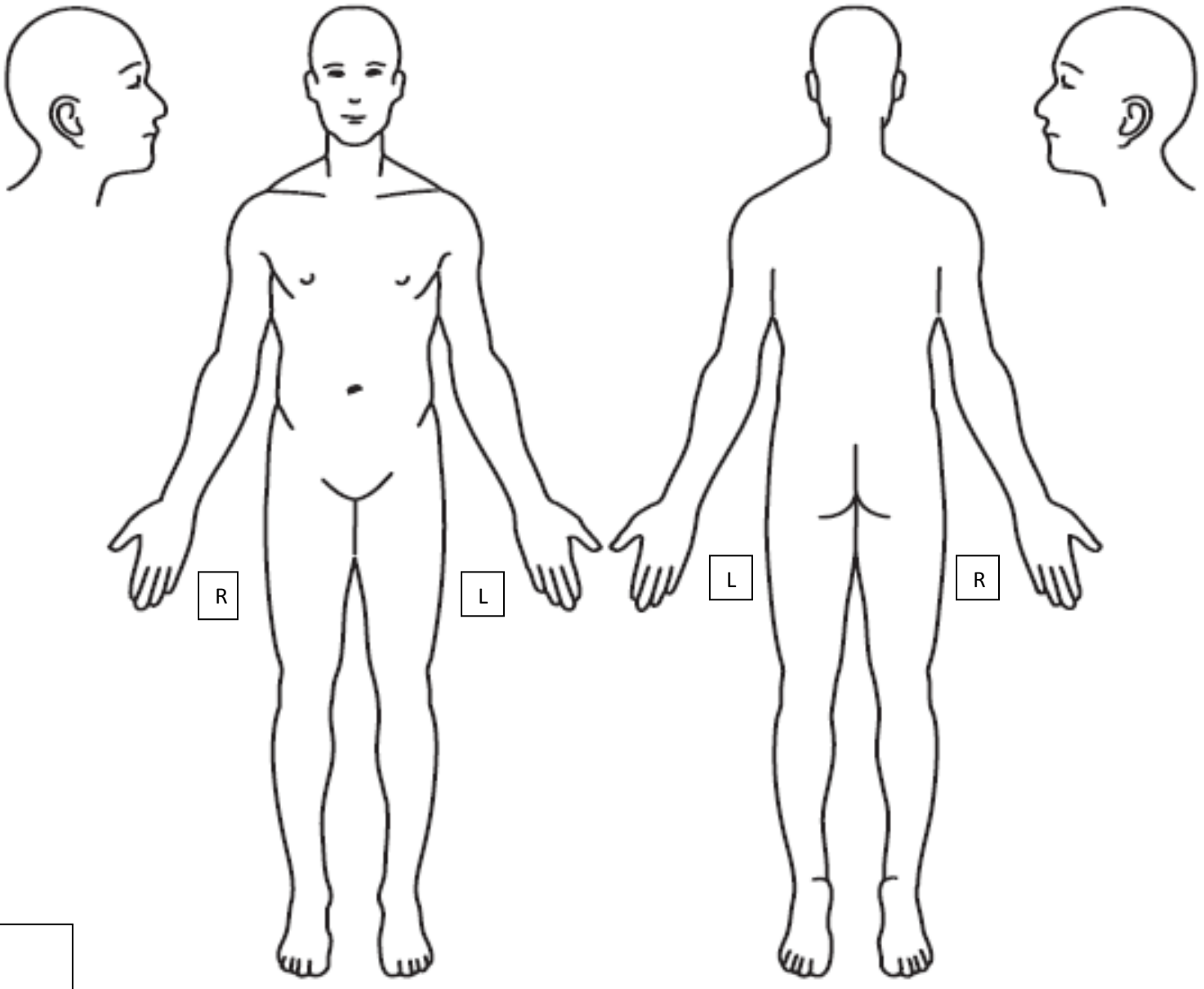
On this diagram, mark where you feel your pain:

Use the following symbols:

">>>>" for aching pain "XXXX" for burning pain "////" for stabbing pain
"OOOO" for numbness/tingling "●●●●" for other, describe _____



Salt Lake Spine and Sports Medicine
5770 South 250 East, Suite 235
Murray, UT 84107
801-314-5115

Brent Bowen, M.D.P.C.
Stephen M. Clements, P.A.-C
Richard W. Hurst, M.D.

Authorization to Release Patient Information to Family Members

Patient Name: _____

Account Number: _____

For Doctor: _____

For my benefit and convenience, I hereby authorize the doctor named above, or members of the staff, to release to the following member(s) of my family any medical information regarding my care at the Utah Joint and Spine Specialists. This release of information must be in person with proof of identification.

Authorized Family Member(s): _____

_____

I understand that the doctor or his staff will make a good-faith effort to assure themselves that they are releasing such information to individual(s) named above, and I release the doctor and his staff from any claim of negligence or HIPAA violation for doing so.

_____ Date: _____
Patient Signature

Salt Lake Spine and Sports Medicine
5770 South 250 East Suite 235
Murray, Utah 84107
801-314-5115

No Show and Cancellation Agreement

for

Brent Bowen, M.D.P.C.
Stephen M. Clements, P.A.-C
Richard W. Hurst, M.D.

There is an increasing number of patients who do not come to their scheduled appointments and do not cancel with reasonable notice. This is obviously disruptive of our work and it reduces the number of patients we can assist.

Consequently, we have established a NO Show/Cancellation Policy: *If you will not be able to keep a scheduled appointment, we ask that you call and give us at least 24 hours notice.*

If you do not come to your appointment, or do not give us sufficient notice, you will be assessed a $30 charge. This charge must be paid prior to your next visit before your doctor or P.A. will see you.

If you have some extenuating circumstances that make it impossible for you to come to your appointment, or to give us notice of your cancellation, please let the staff know of your situation and we will reconsider assessing the "NO Show" charge.

Patient Name: _____ Date: _____

_____ Account: _____
Patient Signature