Engelen Sports and Orthobiologics

Interventional Sports, Spine, and Regenerative Medicine

Name:_____ SS#:_____ Date of Birth:_____

Who is your primary care physician?_____
Who referred you?_____
What is the reason for today's visit?_____
_____

What are your current symptoms?_____

Precipitating Event?_____ When?_____

Pain at worst on 0-10 Scale_____ Least pain on 0-10 Scale_____

What makes your pain better?_____ What makes it worse?_____

Have you been seen by another physician or therapist for this problem?

NO _____ If YES by whom? _____

Review of systems:
Circle if you have: Fever, Chills, Night sweats, Vision changes, Rashes, Weakness
Chest pain, Shortness of breath, Depression, Anxiety, Swelling in arms or legs
Headache, Numbness, Tingling, Bowel or Bladder changes, Recent weight gain or loss,
Excessive Bruising, Hearing Problems, Heartburn, Constipation, Diarrhea, Seizures, Joint Pain
None of the above

PAIN INTENSITY RATING

On the line below, CIRCLE your AVERAGE PAIN over this last week

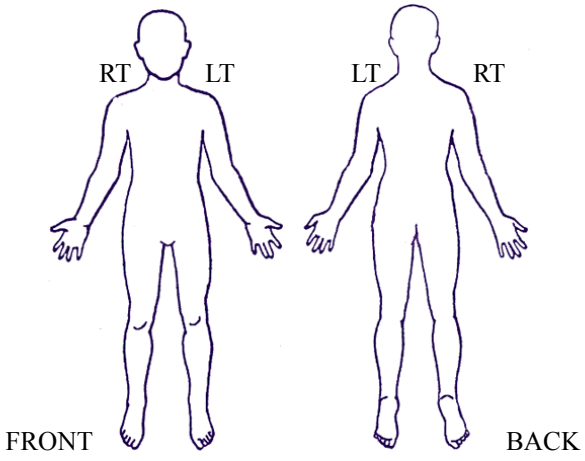
No Pain Worst Possible

0 1 2 3 4 5 6 7 8 9 10

Where is your pain now?

Use appropriate symbols shown below to mark the areas on your body where you feel the described sensations. Include ALL areas affected by your pain and mark the type and area of pain if it radiates or spreads to other areas.

BURNING XXXX	NUMBNESS OOOO	PINS & NEEDLES	STABBING	ACHE



PAST MEDICAL HISTORY

Conditions	Treatment

PAST SURGICAL HISTORY: Please list any previous surgeries or hospitalizations:

Surgery/Hospitalization	Date	Doctor/Surgeon	Hospital	Complication

Have you ever had general anesthesia? YES NO

Have you ever had any problems with anesthesia? YES NO If yes, describe:_____

MEDICATIONS: Please list any medications you are currently taking, including vitamins and herbal supplements:

Medication	Dosage/Frequency	Reason for Medication	Date Medication Started	Who Prescribed Medication?

HAVE YOU EVER TAKEN ANY TYPE OF ANTI-INFLAMMATORY MEDICATION? YES NO

If YES, Please list the medication, when taken, why taken, and any complications or side-effects:

Patient Initials/Date:_____ Patient Name:_____

ALLERGIES: Please list any medications your are allergic to:

_____

_____

SOCIAL HISTORY: Are you employed? YES NO If yes, list your occupation: _____
Retired: YES NO Since when? _____ Previous Occupation: _____
Student: YES NO Where? _____
Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Separated ( ) Divorced
Number of children: _____ List their ages: _____
Who lives at home with you? _____
What regular exercise or sports do you participate in? _____
_____
What are your hobbies? _____

HABITS:

Question	YES	NO	What type?	If yes, how much?	If stopped using, when & how much?
Do you use tobacco in any form?					
Do you drink alcohol?					
Do you have a history of substance abuse?					

FAMILY HISTORY:
What diseases or conditions exist in your immediate family? (mother, father, sister, brother)

_____

_____

Does anyone in your family have cancer?

_____

_____

Exercise and Activity Goals:

- What regular exercise or sports do you participate in?

  _____
- How many times per week do you exercise? _____
- What are your current sports or activity goals?

  _____

_____

Supplements:

- Please list any supplements you are currently taking:

  _____

_____

Hobbies:

_____

Patient Signature: _____ Date: _____

Reviewed/ Updated By:																					
Date:																					