

Mark F. Hambly, MD  
Stephen L Mann, MD  
D. Michael Hembd, MD  
Christopher O. Neuburger, MD  
Colleen R. Wight, PA-C  
Rasa S. Sammy, Lac

NCSRA Medical Corporation  
2801 K Street, Suite 410  
Sacramento, CA 95816

### ORTHOPAEDIC PAIN HISTORY FORM

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

1. What date (roughly at least) did your present pain start? \_\_\_\_\_  
Still working? Yes \_\_\_ No \_\_\_ Last day on job? \_\_\_\_\_

2. Mechanism of pain onset:

a. Suddenly	_____	g. Pulling	_____
b. Gradually	_____	h. Injured at work	_____
c. Lifting	_____	i. Auto Accident	_____
d. Twisting	_____	j. Hit from behind	_____
e. Fall	_____	k. Sports	_____
f. Bending	_____	l. No apparent cause	_____

3. What activities make the pain worse?

a. During Exercise	_____	g. Bending backward	_____
b. After exercise	_____	h. Coughing	_____
c. Sitting	_____	i. Sneezing	_____
d. Standing	_____		
e. Walking	_____		
f. Bending forward	_____		

4. What reduces your pain?

a. Lying down	_____	h. Injections	_____
b. Sitting	_____	i. Muscle relaxants	_____
c. Standing	_____	j. Aspirin or anti-inflammatories	_____
d. Walking	_____	k. Physical Therapy Exercises	_____
e. Manipulation	_____	l. Nothing	_____
f. Physical therapy	_____	m. Other	_____
g. Pain pills	_____		

5. How long have you had this pain? \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks.  
How long have you had similar pain? \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks.

6. Have you had any diagnostic x-rays? YES NO

a. Have you had a CAT scan?	YES	NO	
b. Have you had a myelogram?	YES	NO	Date _____
c. Have you had an EMG?	YES	NO	Date _____
d. Have you had a discogram?	YES	NO	Date _____
e. Have you had an MRI?	YES	NO	Date _____
f. Have you had arthrogram/sonogram? YES	NO	Date	_____
g. Have you had diagnostic injections?	YES	NO	Date _____

7. Have you been in the hospital for your pain problem? YES NO

\_\_\_\_\_Number of Times \_\_\_\_\_Dates

8. Have you had surgery for this problem? YES NO

\_\_\_\_\_ Number of Times \_\_\_\_\_ Dates

9. Have you been in the hospital with other medical problems? YES NO

10. Please list current medications: \_\_\_\_\_  
\_\_\_\_\_

11. Do you take antacids? YES NO

12. General medical problems:

- |                                      |       |                   |       |
|--------------------------------------|-------|-------------------|-------|
| a. Stomach problems<br>(ulcers, etc) | _____ | g. Cancer         | _____ |
| b. Diabetes                          | _____ | h. Heart          | _____ |
| c. Arthritis                         | _____ | i. Epilepsy       | _____ |
| d. Gout                              | _____ | j. Loss of Weight | _____ |
| e. Sexual Difficulties               | _____ | k. Other          | _____ |
| f. Bowel or Bladder                  | _____ |                   |       |

13. Allergies YES NO Please List: \_\_\_\_\_  
\_\_\_\_\_

14. Do you smoke? YES NO How much: \_\_\_\_\_

15. Do you drink alcoholic beverages? YES NO How much: \_\_\_\_\_

16. What other types of doctors or health care providers have you seen for this condition?  
\_\_\_\_\_  
\_\_\_\_\_

17. Do you have any additional information which would be helpful to understand your problem?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Please fill in last grade completed in school: \_\_\_\_\_

19. To be sure paperwork is completed correctly, please check appropriate:

- |                                                                  |       |
|------------------------------------------------------------------|-------|
| a. On Workers Compensation                                       | _____ |
| b. Receiving Disability Income                                   | _____ |
| c. Legal proceeding pending                                      | _____ |
| d. Report should be sent to referring physician or family doctor | _____ |
| e. Report sent to any other party                                | _____ |

20. Do you plan to be at your regular job in six months? YES NO

Patient Name:				Date:		
Private Insurance: Yes No			Workers Comp: Yes No			
Current Medications:						
VS:	T:	P:	R:	B/P:	HT:	WT:

How bad is your pain now? Please place a mark on the line showing where your pain level is:

No Pain (0) ----- (5) ----- (10) Worst Possible

Where is your pain now? Mark the areas on your body (diagram below) where you feel the described sensations. Use the appropriate symbol. Mark the areas where your pain radiates. Include all affected areas. Just to complete the picture, please draw in your face.

**Aching:** ^^^^ **Numbness:** 00000 **Pins & Needles:** ..... **Burning:** xxxxx **Stabbing:** \\\

