Confluence HEALTH

MUSCULOSKELETAL PATIENT INTAKE INFORMATION

Please indicate current problem: ____________________

When did it start? ____________________

How did this pain begin?

- ☐ Gradually (unrelated to specific trauma or injury)
- ☐ Suddenly. Describe any specific injury or activity that caused pain: ____________________

Current Occupation: ____________________

How would you describe your pain? ☐ Ache / Throb ☐ Sharp / Stab ☐ Stiffness ☐ Numbness / Tingling

What makes your pain worse? *(Check all that apply.)* ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down

☐ Bending forward ☐ Bending backward ☐ Lifting ☐ Coughing/Sneezing ☐ Looking up ☐ Looking down ☐ Twist / Turn

☐ Other ____________________

What makes your pain better? *(Check all that apply.)* ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down

☐ Bending forward ☐ Bending backward ☐ Lifting ☐ Coughing/Sneezing ☐ Looking up ☐ Looking down ☐ Twist / Turn

☐ Other ____________________

Please rate current function level at home: 1 2 3 4 5 6 7 8 9 10

10 = severe impact on function at home; 0 = level of function prior to injury

Does your pain bother/ affect any of these activities of daily living? (please circle)

☐ Walking	☐ Bathing	☐ Getting in /out of a car	☐ Meal preperation
☐ Working	☐ Dressing	☐ Grooming	☐ Dish washing
☐ Driving	☐ Getting in / out of bed	☐ Self care / Hygiene	☐ Vacuuming

PAIN SEVERITY

1. **If 10 is the worst pain imaginable, and 0 is no pain, please note your pain over the last TWO WEEKS:**

   Rate your WORST pain. 0 1 2 3 4 5 6 7 8 9 10

   Rate your LEAST pain. 0 1 2 3 4 5 6 7 8 9 10

   Rate your overall or AVERAGE pain. 0 1 2 3 4 5 6 7 8 9 10

2. **Over an average week, how many days do you have your usual pain?** 0 1 2 3 4 5 6 7

   Over an average day, how many hours do you have your usual pain?"

   ☐ Less than 1 hour ☐ 1-4 hours ☐ 4-8 hours

   ☐ Most daytime hours ☐ Almost 24 hours/day

3. If you have NIGHT pain, does it awaken you at night? ☐ Yes ☐ No

4. Have you had **any of these symptoms** as part of your current symptoms? If yes, check in the box below.

☐ Weakness	☐ Give way of your leg	☐ Difficulty sleeping
☐ Loss of control of your bladder or bowel	☐ Falling down in the last 6 months	☐ Depression
☐ Fever or chills	☐ Numbness or tingling	☐ History of cancer
☐ Night sweats	☐ Weight loss	☐ IV drug use / recreational drug use

PLACE LABEL HERE, IF AVAILABLE
IF NOT, FILL IN FOLLOWING INFORMATION:

PATIENT NAME: ____________________

MRN: ____________________

PATIENT DATE OF BIRTH: ____________________

LOCATION OF SERVICE: ____________________

DATE OF SERVICE: ____________________

TREATMENTS:

Please list anyone who has treated you for this condition (physicians, chiropractors, physical therapist, and/or osteopaths) within the LAST YEAR for your back/neck pain, along with the approximate dates.

Provider's Name	Type of Provider	Approx. Dates

PLEASE CONTINUE ON BACK PAGE.

Any problems with this area prior to this episode? ☐ Yes ☐ No If yes, when? ____________________

Explain: ____________________

If yes, what treatments were used for the prior injury? (Such as: medication, x-rays, injections, surgery, physical therapy and/or chiropractic.)

____

Have you had an MRI of the affected area in the past 3 years? ☐Yes ☐No Where was the study done? ____________________

If you have had surgery on your Back and/or Neck, please fill in the following for each operation:

Date	Type of Surgery and Surgeon	Pain After Surgery: Worse	Same	Better	Explain

Please check the box next to each treatment you have had for your pain in the past or currently.

TREATMENT	Currently Using	EFFECT OF TREATMENT: Helped	No Change	Increased Pain
☐ Home exercise program	Yes	☐	☐	☐
☐ Bed rest	Yes	☐	☐	☐
☐ Hot packs/ice	Yes	☐	☐	☐
☐ TENS unit for home use	Yes	☐	☐	☐
☐ Back brace	Yes	☐	☐	☐
☐ Physical therapy	Yes	☐	☐	☐
☐ Massage	Yes	☐	☐	☐
☐ Chiropractic treatment	Yes	☐	☐	☐
☐ Radiofrequency Ablation (Rhizotomy)	Yes	☐	☐	☐
☐ Epidural injections	Yes	☐	☐	☐
☐ Facet injections	Yes	☐	☐	☐
☐ Local (trigger point) injections	Yes	☐	☐	☐
☐ Other ____________	Yes	☐	☐	☐

What treatments have you done for pain?

MEDICATIONS	HAVE TAKEN	CURRENTLY TAKING	DOSE	FREQUENCY	EFFECTIVE?
Acetaminophen (Tylenol)					
Ibuprofen (Advil)					
Naproxen (Aleve)					
Neurontin (Gabapentin)					
Lyrica (Pregabalin)					
Amitriptyline (Elavil)					
Nortriptyline (Pamelor)					
Tramadol (Ultram)					
Narcotics: Hydrocodone (Vicodin) Oxycodone (Percocet)					
Flexeril (Cyclobenzaprine)					
Robaxin (Methocarbamol)					
Other: ____________					

Do you have **any of the following illnesses or conditions?**

☐ Pacemaker ☐ Metal clips in your head
☐ Blood thinner medication (COUMADIN, PLAVIX)
☐ Allergy to local anesthesia ☐ None of these

Do you have any allergies to medicines? ☐ Yes ☐ No

Please list: ____________________

Have you had any of these medical problems?

☐ Osteoporosis
☐ Cancer, type: ____________
☐ Diabetes
☐ High Blood Pressure
☐ Heart Disease
☐ Kidney Disease
☐ Arthritis
☐ Stroke
☐ Ulcer

Has anyone in your family ever had any of these conditions?

☐ Osteoporosis
☐ Arthritis
☐ Cancer, type: ____________
☐ Diabetes
☐ Disability
☐ Stroke

How is your current pain, compared to when this pain episode first started?

☐ Much improved
☐ Somewhat improved
☐ No change
☐ A little worse
☐ Much worse

How much change do you expect in your pain 6 months from now?

☐ Total relief
☐ Marked improvement
☐ Some improvement
☐ No change
☐ Worse

Do you use any of the following?

☐ Tobacco If yes, how many packs/day? _____ Years of smoking? _____
☐ Alcohol If yes, how many drinks/day? _____
☐ Do you have, or have you had a problem with chemical dependency/addiction?

Do you have any of these symptoms? If yes, check in the box below.

☐ Bleeding Problems
☐ Cataracts
☐ Depression
☐ Anxiety
☐ Panic
☐ Bipolar Disease
☐ Sleep Apnea
☐ Heartburn
☐ Stomach Ulcer
☐ Are you pregnant?
☐ Weight Gain
☐ Chest Pain
☐ Irregular Heartbeat

☐ Bloody Urine
☐ Bowel or Bladder Problems
☐ Burning with Urination
☐ Frequent Headaches
☐ Double Vision
☐ Shortness of breath
☐ Joint Swelling
☐ Muscles Aches
☐ Stomach Pain
☐ Rash
☐ Thyroid Problems
☐ Diabetes

PLACE LABEL HERE, IF AVAILABLE
IF NOT, FILL IN FOLLOWING INFORMATION:

PATIENT NAME: ____________________

MRN: ____________________

PATIENT DATE OF BIRTH: ____________________

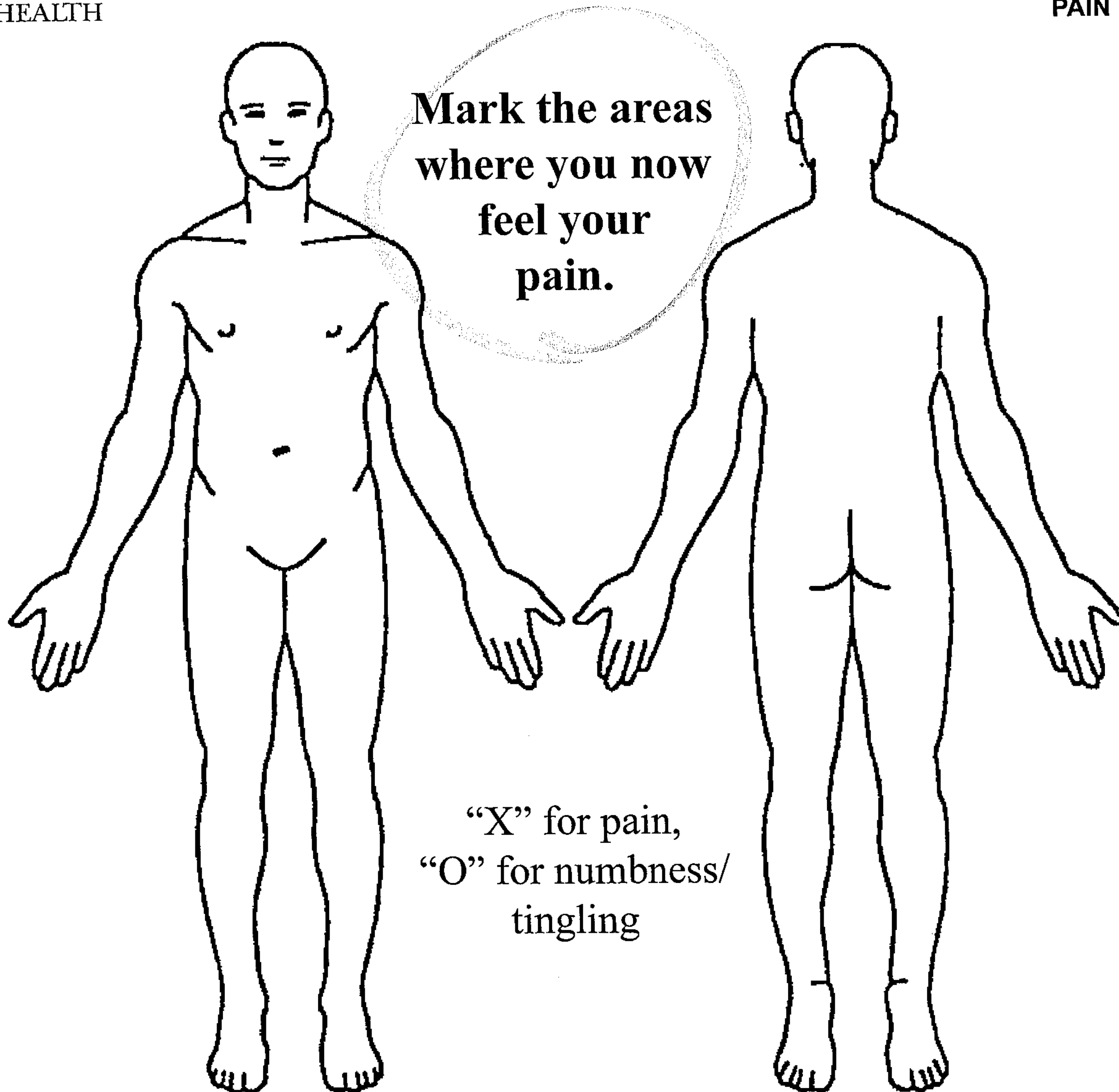
LOCATION OF SERVICE: ____________________

DATE OF SERVICE: ____________________

Doctor's Signature: ____________________

Confluence HEALTH

PAIN DIAGRAM



Out of 100%, how much of your pain/symptoms would you rate the affected body parts:

Neck: + _______%
(If applicable)

Upper Extremity: + _______%
(If applicable)

Back: + _______%
(If applicable)

Lower Extremity: + _______%
(If applicable)

***Total amounts must be equal to* 100%**

PLACE LABEL HERE, IF AVAILABLE
IF NOT, FILL IN FOLLOWING INFORMATION:

PATIENT NAME: ______________________

MRN: ______________________

PATIENT DATE OF BIRTH: ______________________

LOCATION OF SERVICE: ______________________

DATE OF SERVICE: ______________________