Revere Health
Orthopedics
& Sports Medicine

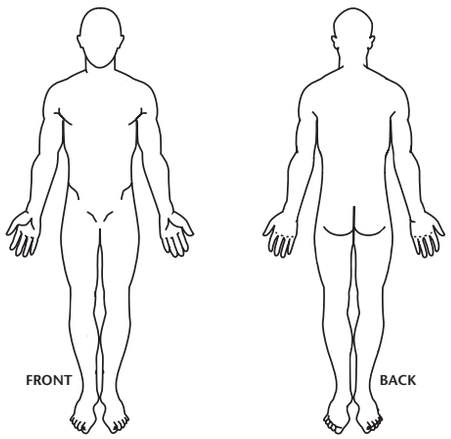
Benjamin S. Crouch, DO

Patient Name: _____ DOB ___/___/___ Age _____ Weight _____ Height _____

Date of injury or onset of symptoms: _____
How did you get injured, if known: _____
On a scale from 0 - 10, 0 = no pain, 10 = worst possible pain, what number describes how you feel right now? _____

Use the chart below to describe the type and location of your pain.

AAA	Aching
SSS	Stabbing
NNN	Numbness
BBB	Burning
EEE	Swelling
PPP	Pins
FFF	Stiffness
TTT	Throbbing
LLL	Locking
III	Instability
OOO	Other



What makes your pain WORSE? _____
(Lifting, Bending, Twisting, Sneezing/Coughing, Walking)

What makes your pain BETTER? _____
(Changing Position, Walking, Ice, Heat, Medication)

Using a scale from 0 - 10, how much does your pain interfere with each of the following?
0 = does not interfere, 10 = completely interferes

General Activity	_____	Sleep	_____
Mood	_____	Enjoying Life	_____
Walking Ability	_____	Concentration	_____
Work Routine	_____	Appetite	_____
Relationships	_____		

Pain Medication Treatment
Indicate which treatments you have tried AND their effectiveness.
0 = no relief, 10 = complete relief **0-10 Scale**

- ❑ Anti-inflamitory: Ibuprofen, Naprosyn, Lodine, Mobic, Celebrex _____
- ❑ Muscle Relaxer: Flexeril, Skelaxin, Soma, Robaxin, Norflex _____
- ❑ Narcotics: Tramadol, Hydrocodone, Oxycodone _____
- ❑ Extended Release: Methadone, Morphine, Fentanyl, OxyContin _____
- ❑ Nerve Meds: Neurontin, Lyrica, Cymbalta, Savella _____
- ❑ Anti-Depressants: Paxil, Prozac, Elavil, Effexor, Lexapro, Desyrel _____
- ❑ Anti-Anxiety: Xanax, Valium, Ativan, Klonopin _____
- ❑ Sleep Meds: Ambien, Restoril, Halcion, Lunesta, Rozerem _____

Patient Signature: _____ Date:_____

Physician Reviewed: _____ Date:_____

Past Trauma History - Check all that apply

- ❑ Accident ❑ MVA ❑ Assault
- ❑ Fall ❑ Sports ❑ Work-Related Injury

Have you been evaluated by any of these specialists?

- ❑ Neurologist ❑ Neurosurgeon
- ❑ Orthopedic Surgeon ❑ Psychiatrist
- ❑ Psychologist ❑ Pain Management

What was your diagnosis? _____

Previous Work-up FOR THIS PROBLEM
Check all that apply. Provide the most recent date AND check whether the study was normal (NL) or abnormal (AB).

❑ X-Ray	Date: _____	❑ NL	❑ AB
❑ CATscan	Date: _____	❑ NL	❑ AB
❑ MRI	Date: _____	❑ NL	❑ AB
❑ Bone Scan	Date: _____	❑ NL	❑ AB
❑ EMG	Date: _____	❑ NL	❑ AB

Previous Treatment FOR THIS PROBLEM
Check all that apply. Use a 0 - 10 scale to describe how much each intervention helped.
0 = no relief, 10 = complete relief

Surgery **0 - 10 Scale**

- ❑ Cervical (neck) Fusion _____
- ❑ Lumbar Laminectomy WITHOUT Fusion _____
- ❑ Lumbar Laminectomy WITH Fusion _____
- ❑ Carpal Tunnel Release _____
- ❑ Vertebroplasty/Kyphosplasty _____

Injections **0 - 10 Scale**

- ❑ Epidural _____
- ❑ Facet ❑ Left ❑ Right _____
- ❑ Sacroiliac/SI ❑ Left ❑ Right _____
- ❑ Trigger Point ❑ Left ❑ Right _____
- ❑ Shoulder ❑ Left ❑ Right _____
- ❑ Hip ❑ Left ❑ Right _____
- ❑ Knee ❑ Left ❑ Right _____
- ❑ Other: _____ _____

Physical Therapy **0 - 10 Scale**

How many weeks of PT have you done: _____
Were you able to tolerate therapy? _____
How much did it help? _____

Other **0 - 10 Scale**

- ❑ Osteopathic Manipulative Medicine _____
- ❑ Chiropractic Treatment _____
- ❑ Acupuncture _____
- ❑ TENS Unit _____
- ❑ Braces type: _____ _____