SPINE & MUSCULOSKELETAL MEDICINE, P.C.

Dr James P. Devney, DO

Legal Name:_____Age:_____Date of Birth: _____Today's Date:_____

Height:_____ Weight:_____ ☐Right Handed ☐Left Handed Primary Care Physician:_____

Pharmacy Name and Location:_____ Pharmacy Phone Number:_____

History of Present Illness

Date current injury/symptom began: _____

If injury, is it: ☐Work comp ☐Motor vehicle accident ☐Injured at home ☐Sports injury

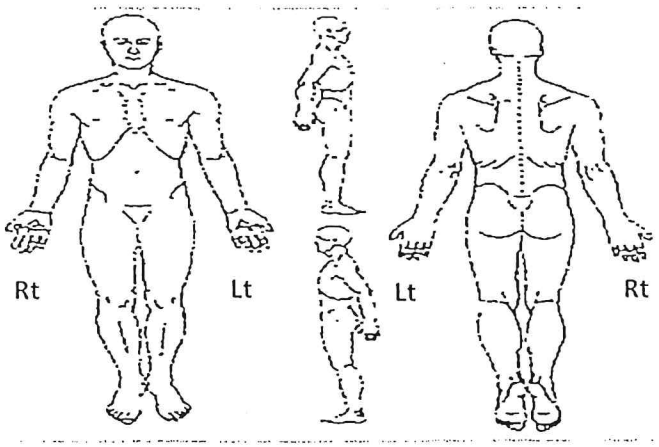
If car accident, were you: ☐Driver ☐Front seat passenger ☐ Back seat passenger Wearing seat belt? Y / N

Did you experience pain prior to this incident? ☐ No ☐ Yes If yes, when?_____ Was it work related? Y / N

Are you currently working? ☐ Yes ☐ No If no, when did you stop working?_____

Please provide a brief description of how the injury occurred: _____

Please use the diagram to show where your pain is located



Pain Location:

Neck	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Right shoulder	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Left shoulder	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Right arm	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Left arm	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Middle back	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Lower back	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Right buttock	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Left buttock	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Right leg	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Left leg	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____
Other:_____	☐Dull-achy ☐Sharp ☐Burning ☐Stabbing ☐Numb ☐Deep ache ☐Pins and needles	Comments: _____

Using the pain scale (0 = no pain to 10 = worst you can image) please indicate your pain:

Right now: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

At best: 0 1 2 3 4 5 6 7 8 9 10

How often do you have pain? ☐ Intermittently ☐ Constantly ☐ Daily ☐ Other:_____

Please describe your symptoms (example: I have constant burning pain in my back with intermittent sharp, shooting pain down my left leg into my foot.)

_____

How do the following activities affect your pain?

Bed Rest	☐Better ☐Worse	Sitting	☐Better ☐Worse
Athletics	☐Better ☐Worse	Prolonged positions	☐Better ☐Worse
Bending	☐Better ☐Worse	Standing	☐Better ☐Worse
Changing positions	☐Better ☐Worse	Walking	☐Better ☐Worse
Coughing/sneezing	☐Better ☐Worse	Working	☐Better ☐Worse
Heat	☐Better ☐Worse	Exercise/Stretching	☐Better ☐Worse
Ice	☐Better ☐Worse	Riding in car	☐Better ☐Worse
Lifting	☐Better ☐Worse	Twisting	☐Better ☐Worse
Lying down	☐Better ☐Worse	Other:	☐Better ☐Worse

Have you used a back or neck brace? ☐Yes ☐No If yes, when?_____ Type ☐ back ☐ neck

Treatment results: ☐No Relief ☐Temporary Relief ☐Lasting Mild Relief ☐Lasting Moderate Relief ☐Lasting Substantial Relief

Have you had any physical therapy? ☐Yes ☐ No If yes, location?_____ When?_____

Treatment type: ☐Exercise ☐Ultrasound ☐Whirlpool ☐Massage ☐Electrical Stimulation ☐Phonophoresis

☐Work Hardening ☐Diathermy ☐Iontophoresis ☐Ice ☐Traction ☐Triggerpoint ☐Heat ☐Tens unit

Treatment results: ☐No Relief ☐Temporary Relief ☐Lasting Mild Relief ☐Lasting Moderate Relief ☐Lasting Substantial Relief

Have you had steroid injections of any type? ☐Yes ☐No

Date	Location (neck, back, joint)	X-ray Guided? (Yes/No)	Performed by (name/clinic)	Results of injection No relief / Temporary / Moderate / Substantial Relief

Have you had chiropractic care? ☐ Yes ☐ No If yes, when?_____

I had chiropractic in the form of: ☐Manipulation ☐Massage ☐E-stim ☐Acupuncture ☐X-rays

Where?_____ Performed by?_____

Treatment results: ☐No Relief ☐Temporary Relief ☐Lasting Mild Relief ☐Lasting Moderate Relief ☐Lasting Substantial Relief

Have you attended a pain clinic? ☐ Yes ☐ No If yes, when?_____

I had pain treatments in the form of:_____

Where?_____ Performed by_____

Treatment results: ☐No Relief ☐Temporary Relief ☐Lasting Mild Relief ☐Lasting Moderate Relief ☐Lasting Substantial Relief

Have you had any of the following tests in relation to your condition, and if so what body part, when, and where was it performed?

_____

☐ X-ray ☐ CT ☐MRI ☐Ultrasound ☐Myelogram ☐Bone Scan ☐Dexa Scan ☐EMG

☐Functional Capacity Evaluation (FCE) ☐Other: _____

lave you tried either prescription or over-the-counter medications? ☐Yes ☐No

OTC			Muscle Relaxants			Antiepileptics		
Tylenol	☐ Help	☐ No help	Flexeril (Cyclobenzaprine)	☐ Help	☐ No help	Lamotrigine	☐ Help	☐ No help
_____	☐ Help	☐ No help	Skelaxin	☐ Help	☐ No help	Lyrica	☐ Help	☐ No help
_____	☐ Help	☐ No help	Soma	☐ Help	☐ No help	Neurontin (Gabapentin)	☐ Help	☐ No help
			Zanaflex	☐ Help	☐ No help	Topamax	☐ Help	☐ No help
				☐ Help	☐ No help			

NSAIDS			Opioid Analgesics			Oral Steroid		
Advil	☐ Help	☐ No help	Avinza	☐ Help	☐ No help	Medrol Dosepak	☐ Help	☐ No help
Aleve	☐ Help	☐ No help	Darvocet	☐ Help	☐ No help	Prednisone	☐ Help	☐ No help
Ansaid	☐ Help	☐ No help	Fentanyl Patch	☐ Help	☐ No help		☐ Help	☐ No help
Cataflam	☐ Help	☐ No help	Kadian	☐ Help	☐ No help			
Celebrex	☐ Help	☐ No help	Lortab (Hydrocodone)	☐ Help	☐ No help			
Daypro	☐ Help	☐ No help	Oxycontin	☐ Help	☐ No help			
Feldene	☐ Help	☐ No help	Percocet (Oxycodone)	☐ Help	☐ No help			
Ibuprofen	☐ Help	☐ No help	Tylenol w/ Codeine	☐ Help	☐ No help			
Indocine	☐ Help	☐ No help	Tylox	☐ Help	☐ No help			
Lodine	☐ Help	☐ No help	Ultram (Tramadol)	☐ Help	☐ No help			
Mobic	☐ Help	☐ No help	Vicodin (Hydrocodone)	☐ Help	☐ No help			
Motrin	☐ Help	☐ No help		☐ Help	☐ No help			
Naprelan	☐ Help	☐ No help						
Naproxen	☐ Help	☐ No help						
Naprosyn	☐ Help	☐ No help						
Relafen	☐ Help	☐ No help						
Voltaren	☐ Help	☐ No help						
	☐ Help	☐ No help						

Antidepressants		
Amitriptyline	☐ Help	☐ No help
Cymbalta	☐ Help	☐ No help
Elavil	☐ Help	☐ No help
Paxil	☐ Help	☐ No help
Prozac	☐ Help	☐ No help
Xanax	☐ Help	☐ No help
Zoloft	☐ Help	☐ No help
	☐ Help	☐ No help

Topical		
_____	☐ Help	☐ No help
_____	☐ Help	☐ No help
_____	☐ Help	☐ No help

Anxiolytics		
Vistaril	☐ Help	☐ No help
_____	☐ Help	☐ No help
_____	☐ Help	☐ No help

Are you currently taking prescription or over-the-counter medication? ☐Yes ☐No If yes, please fill out below

Medication	Dose	Quantity	Medication	Dose	Quantity
	mg	times a day		mg	times a day
	mg	times a day		mg	times a day
	mg	times a day		mg	times a day
	mg	times a day		mg	times a day
	mg	times a day		mg	times a day
	mg	times a day		mg	times a day
	mg	times a day		mg	times a day
	mg	times a day		mg	times a day
	mg	times a day		mg	times a day

☐ No Known Medical Allergies

Allergy	Reaction	Allergy	Reaction
☐ Penicillin		☐ Demerol	
☐ Aspirin		☐	
☐ Morphine		☐	
☐ Codeine		☐	
☐ Sulfa		☐	

Social History

Highest level of education: ☐GED ☐Graduated High School ☐Some College ☐Graduated College ☐Trade School
Grade level completed: _____

Military Service: ☐Yes ☐No Branch?_____ How long?_____

Present employment status: ☐ Full time ☐ Part time ☐ Retired ☐ Disability
Current Employer: _____Occupation:_____ How long?_____
Date Stopped working?_____ Previous employer_____ How long?_____
Do you have physical work restrictions? ☐ Yes ☐ No If yes, what are they?_____
Do you have an application pending or do you intend to apply for workers compensation or disability? ☐Yes ☐ No
Do you have a pending lawsuit for your pain or injury? ☐ Yes ☐No Name of attorney: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed
Number of Children:_____

Do you use nicotine products?
☐ No, Never
☐ Yes How much? ☐Pack ☐Can ☐Cigar ☐Nicotine Gum/Patch _____per day for _____years
☐ Former Use, Stopped on: _____How much did you use? ☐Pack ☐Can ☐Cigar _____per day for _____years

Do you use alcohol? ☐None ☐Yes, _____# of drinks/day/week/month
Do you use recreational drugs? ☐ Yes ☐ No If yes, please list:_____
Do you have a history of Alcoholism, drug abuse, or addiction? ☐ Yes ☐ No

Caffeine use: ☐None ☐Minimal ☐Moderate ☐Heavy

Exercise: ☐None ☐Daily ☐Weekly _____# per week Type?_____

Diet: ☐No specific ☐Diabetic ☐Low Fat ☐Low Salt ☐Vegetarian ☐Weight Reduction ☐Other:

Family History

☐ Unknown
☐ I have no family history of heart disease, cancer or other serious illness
☐ Heart disease Who and what kind?_____
☐ Cancer Who and what kind?_____
☐ Other: _____

Previous/Ongoing Medical Problems

☐None
☐Asthma
☐Bronchitis
☐Blood Clot
☐Cancer_____
☐Chronic Immunity Problems
☐Constipation
☐Depression
☐Diabetes
☐Diarrhea
☐Emphysema
☐Environmental Allergies
☐Gastroesophageal Reflux
☐Gout
☐Hay Fever
☐Heart:_____
☐Hypertension / High Blood Pressure
☐High Cholesterol
☐Kidney Disease
☐Migraines
☐Osteoporosis
☐Parkinson's Disease
☐Pulmonary Disease
☐Prostate Problems
☐Ulcers
☐Other:_____

Are you currently pregnant, believe that you may become pregnant or nursing? ☐Yes ☐No ☐N/A

Previous Spine Surgeries

☐ I have never had surgery on my spine

Date of Surgery:_____ Surgeon Name:_____

Hospital:_____City,State:_____

Reason:_____Surgery Performed:_____

Results: ☐Pain Free ☐ Very Good ☐ Good ☐ Some Help ☐ No Change ☐ Worse

Date of Surgery:_____ Surgeon Name:_____

Hospital:_____City,State:_____

Reason:_____Surgery Performed:_____

Results: ☐Pain Free ☐ Very Good ☐ Good ☐ Some Help ☐ No Change ☐ Worse

Previous Surgeries

☐None
☐Appendectomy
☐Biopsy of _____ ☐Right ☐Left ☐Benign ☐Malignant
☐Cardiac Surgery: _____
☐Carpal Tunnel ☐Right ☐Left ☐Bilateral
☐Cataract ☐Right ☐Left ☐Bilateral
☐Gallbladder
☐Hip Replacement ☐Right ☐Left ☐Bilateral
☐Hysterectomy ☐Uterus only ☐Uterus and Ovaries
☐Knee Arthroscopy ☐Right ☐Left ☐Bilateral
☐Knee replacement ☐Right ☐Left ☐Bilateral
☐Mastectomy ☐Right ☐Left ☐Bilateral
☐Prostatectomy
☐Radiation Therapy:_____
☐Thyroidectomy
☐Tonsillectomy
☐Other:_____

Medical Screening(s)

Colonoscopy Screening:
Date:_____ Type: ☐ Fecal Occult Blood (FOBT) / ☐ Colonoscopy Result: ☐ Normal / ☐ Abnormal

Comments:

Breast Cancer Screening:
Date:_____ ☐ Mammogram Result: ☐ Normal / ☐ Abnormal

Comments:

Cervical Cancer Screening:
Date:_____ ☐ Pap Test Result: ☐ Normal / ☐ Abnormal

Comments:

Influenza Vaccination Status:
Date:_____ ☐ Received / ☐ Declined Declined Reason: ☐ Patient / ☐ Medical

Comments:

Pneumonia Vaccination Status:
Date:_____ ☐ Received / ☐ Declined Declined Reason: ☐ Patient / ☐ Medical

Comments:

Review of Systems -Check any of the following symptoms you are experiencing
☐ No further complaints
General: ☐fever ☐sweats ☐chills ☐decreased energy/activity level ☐major weight gain ☐major weight loss ☐change in appetite
HEENT: ☐runny nose ☐nose bleeds ☐sinus congestion/pain ☐ringing in the ears ☐hearing loss ☐vision changes Do you wear a hearing aid? ☐Yes ☐No Do you wear? ☐contacts ☐glasses
Cardiac: ☐chest pain ☐heart palpitations ☐tachyarrhythmia ☐difficulty breathing ☐lightheaded ☐dizziness
Endocrine: ☐excessive thirst ☐excessive urination ☐heat intolerance ☐diabetes ☐ thyroid problems ☐cold intolerance
GI: ☐abdominal pain ☐abdominal bloating ☐vomiting ☐heart burn ☐reflux ☐constipation ☐diarrhea ☐bowel incontinence ☐bloody stools
GU: ☐urinary incontinence ☐urinary frequency/urgency ☐erectile dysfunction ☐pain w/urination ☐prostate problems ☐vaginal problems ☐ postmenopausal ☐irregular menstrual cycles ☐post hysterectomy
Hema/Lymph: ☐anemia ☐easy bruising ☐swollen nodes
Musc/Skel: ☐joint inflammation ☐joint restriction ☐joint pain ☐back pain ☐muscle pain ☐muscle swelling ☐neck pain
Neuro: ☐poor balance ☐poor coordination ☐limp ☐seizure disorder ☐paralysis ☐numbness ☐weakness in any extremity: ☐arm ☐leg
Psych: ☐stress ☐depression ☐sleep disturbance ☐mood changes
Respiratory: ☐snoring ☐sleep apnea ☐recent upper respiratory infection ☐wheezing ☐cough ☐blood stain sputum
Skin: ☐rash ☐birth marks ☐discoloration of the skin ☐non-healing skin lesions

The above information is true to the best of my knowledge:_____

Patient or patient representative signature