Azalea Orthopedic and Sports Medicine
Physical Medicine and Rehabilitation
Jerry Schwarzbach, M.D.

Completing this form helps your physician better care for you. Thank you.

Name: ______________________________ Date: _____/_____/_____
Age: __________________ Right ❐ Left ❐ handed Male ❐ Female ❐
Weight: ________________ Height: ________________
Primary Care Physician: ______________________________ Referring Physician: ______________________________

1. What is your main problem (chief complaint)? ______________________________
____

2. When did it start? _____/_____/_____ If exact date is unknown, approximately when? _____/_____/_____

3. Is your problem related to work? ❐ Yes ❐ No If yes, please describe: ______________________________
____

4. Is your problem related to a motor vehicle accident? ❐ Yes ❐ No
If yes, please answer the following:
Were you ❐ driving or a ❐ front ❐ rear passenger?
Were you wearing a seat belt? ❐ Yes ❐ No
Did you hit your head? ❐ Yes ❐ No
Did you lose consciousness? ❐ Yes ❐ No
If yes, for how long? ___________________

5. How did your problem start? ❐ gradually ❐ suddenly
Describe: ______________________________
____

6. Describe your problem (check all that apply):

❐ constant	❐ dull	❐ aching	❐ cramping
❐ intermittent	❐ numb	❐ tingling	❐ burning
❐ sharp	❐ stabbing	❐ electrical	❐ other ______________________

7.

Your problem/pain is	Better	Worse	No Different
Morning	❐	❐	❐
Middle of the night	❐	❐	❐
Lying on back	❐	❐	❐
Sitting	❐	❐	❐
Standing	❐	❐	❐
Walking	❐	❐	❐
Bending forward	❐	❐	❐
Leaning backward	❐	❐	❐
Lifting	❐	❐	❐
Reaching overhead	❐	❐	❐

8. What else makes it better? ____

9. What else makes it worse? ____

10. Do you have numbness? ❒ Yes ❒ No
If yes, please answer the following:
Where? ____________________
At night? ❒ Yes ❒ No
While driving? ❒ Yes ❒ No

11. Mark your pain severity.

Today

____

0 — No pain ... 10 — Worst pain

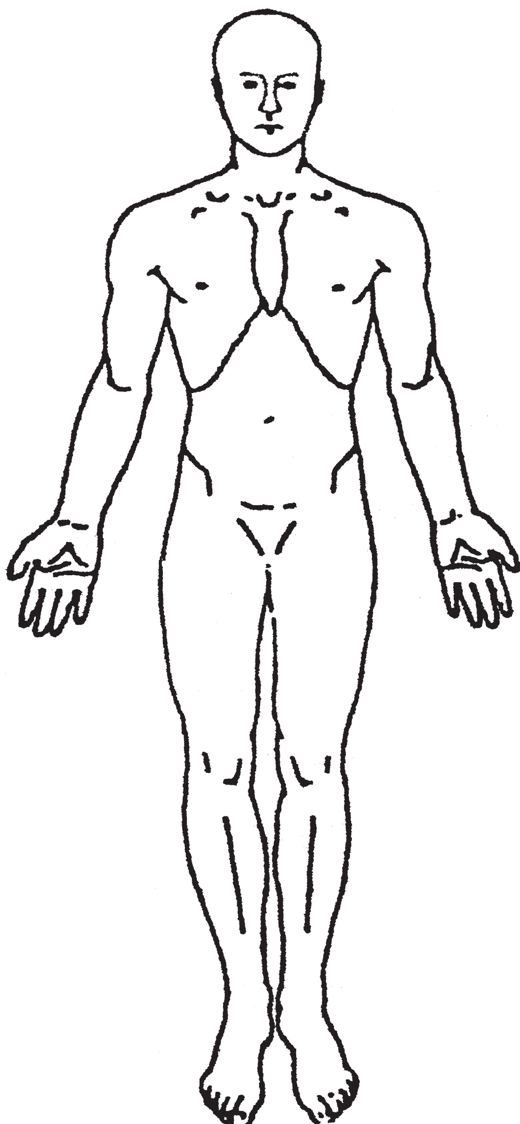
Last 2 weeks

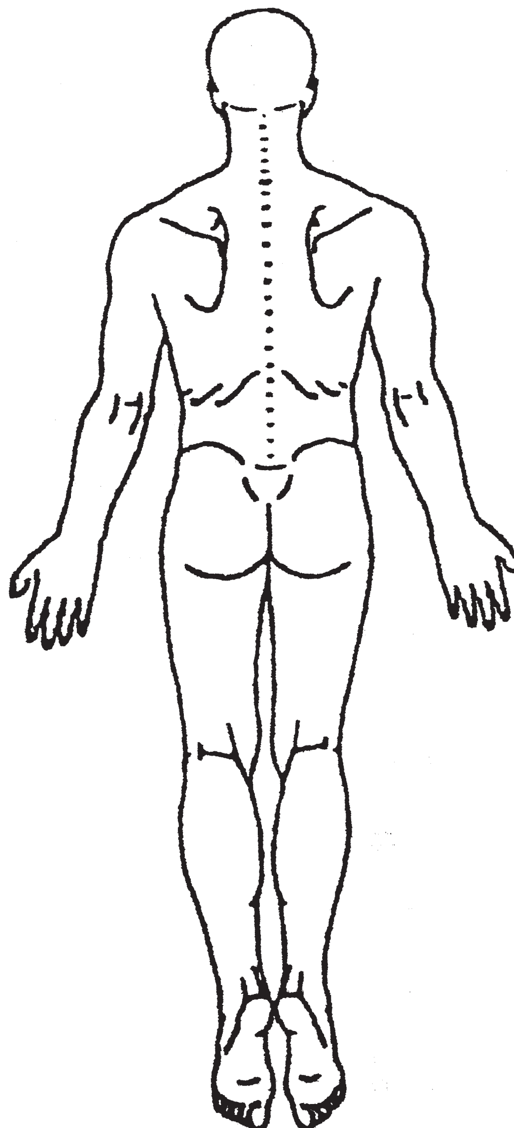
____

0 — No pain ... 10 — Worst pain

Mark the areas on your body where you feel the described sensation using the following symbols

Ache vvv vvv	Numbness = = = = = =	Pins & Needles OOO OOO	Burning XXX XXX	Stabbing /// ///





12. Are you sleeping well? ❒ Yes ❒ No Do you wake up tired in the morning? ❒ Yes ❒ No

13. What doctors have you seen for your main problem? ______________________________

14. What treatments have you had?

Treatment		Better	Worse	No Change	When/Where?
Physical Therapy	______	❒	❒	❒	______
Ultrasound	______	❒	❒	❒	______
Hot packs	______	❒	❒	❒	______
Cold packs	______	❒	❒	❒	______
Electrical Stimulation	______	❒	❒	❒	______
TENS	______	❒	❒	❒	______
Dynamic Spine Stabilization	______	❒	❒	❒	______
Stretching	______	❒	❒	❒	______
Massage	______	❒	❒	❒	______
Traction	______	❒	❒	❒	______
Bracing	______	❒	❒	❒	______
Work hardening	______	❒	❒	❒	______
Chiropractic treatment	______	❒	❒	❒	______
Trigger point injection	______	❒	❒	❒	______
Epidural steroid injection	______	❒	❒	❒	______
Facet injection	______	❒	❒	❒	______
SI joint injection	______	❒	❒	❒	______
Surgery	______	❒	❒	❒	______

15. What tests have been performed?

Test		When/Where/Results?
X-rays	______	______
MRI	______	______
CT or CAT scan	______	______
Myelogram	______	______
Diskogram	______	______
Bone scan	______	______
EMG	______	______

16. Past Medical Problems (check all that apply):

❒ None
❒ Diabetes
❒ High blood pressure
❒ Stomach Ulcer
❒ Arthritis
❒ Heart Attacks
❒ Stroke
❒ Rheumatoid Arthritis
❒ Depression
❒ Heart Failure
❒ Anxiety
❒ Prostate
❒ Bladder
❒ Arrhythmia
❒ Gout
❒ Asthma
❒ Cancer
❒ Kidney
❒ Blood Clots
❒ Other: ______________________________
❒ Emphysema
❒ Thyroid Disease
❒ Bleeding Problem
❒ Pneumonia

17. Past Surgical History (Please list what types and when): ______________________________

____

18. Medication Allergies (Please list): ______________________________

____

19. Medication and dosages (Please list): ______________________________

____

____

20. Social History:
❒ Married ❒ Single ❒ Divorced ❒ Widowed
Children (Please list ages and sex): ______________________________
____
Last grade completed? ______________________________
Have you ever smoked? ❒ Yes ❒ No; If yes, how much? ______ pack(s) per day for _______ years.
Are you still smoking? ❒ Yes ❒ No
How much alcohol do you drink? ______________________________

21. Occupational History:
Current employment: ______________________________
Describe your work: ______________________________
How long have you worked at your present employment? ______________________________
Are you currently employed? ❒ Yes ❒ No
If yes, are you ❒ working regular duties? → how many hours? ______________________________
❒ working modified duties? → how many hours?______________________________
❒ off work with pay → ❒ worker compensation ❒ vacation ❒ student
❒ other______________________________

22. Pharmacy name: ______________________________ Location: ______________________________

23. Has anyone in your family had the following problems?
❒ Cancer ❒ Stroke ❒ Heart Attacks ❒ Bleeding Problems ❒ Mental Illness
❒ Neuromuscular Disease ❒ Other: ______________________________

24. Have you had the following problems recently (Please check all that apply)?
❒ None
❒ Indigestion/Stomach Pain ❒ Irregular Heart Beat ❒ Rash
❒ Fever ❒ Headaches ❒ Speech difficulty
❒ Chest Pain ❒ Urinary Incontinence ❒ Bowel incontinence
❒ Shortness of Breath ❒ Chills ❒ Change in bowel habits
❒ Bloody Stools ❒ Jaundice ❒ Joint swelling
❒ Depression ❒ Blurred Vision ❒ Ringing in ears
❒ Anxiety ❒ Night Sweats ❒ Unexplained weight loss