The ORTHOPEDIC CENTER OF ST. LOUIS

Benjamin P. Crane, MD

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South - 10296 Big Bend Rd Suite 205 Saint Louis, MO 63122
Chesterfield - 14825 N. Outer Forty Rd Suite 200 Chesterfield, MO 63017

Thank you for taking the time to complete this questionnaire.
Your careful answers will help us to understand your presenting problem and design a customized treatment program for you.

Today's Date: _____

Name:_____

DOB: ____/_____/_____ Age: _____

REFERRED BY:

- ☐ Physician
- ☐ Chiropractor
- ☐ Case Manager/Adjustor
- ☐ Attorney
- ☐ Friend
- ☐ Other

NAME:

_____
_____
_____
_____
_____
_____

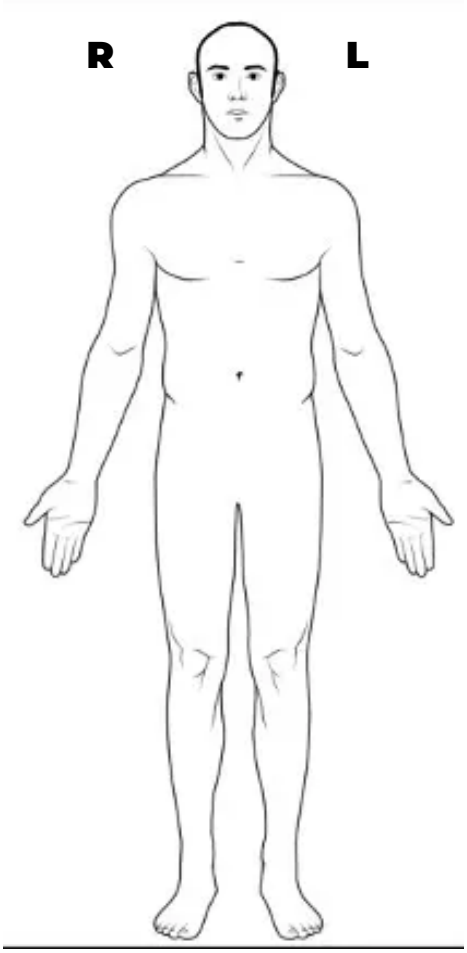
Chief complaint/Main Problem:_____

When did your current problem start? _____/_____/_____ (month/day/year)

Have you ever had similar problems before? ☐ yes ☐ no

If yes, please explain: _____

PLEASE MARK DRAWING WITH AN "X" ACCORDING TO YOUR PAIN



Front

Neck Pain:
Circle Severity Level

0 1 2 3 4 5 6 7 8 9 10
Minor Moderate Severe

- ☐ Neck pain worse that shoulder/arm pain
- ☐ Neck pain same as shoulder/arm pain
- ☐ Neck pain less than shoulder arm pain

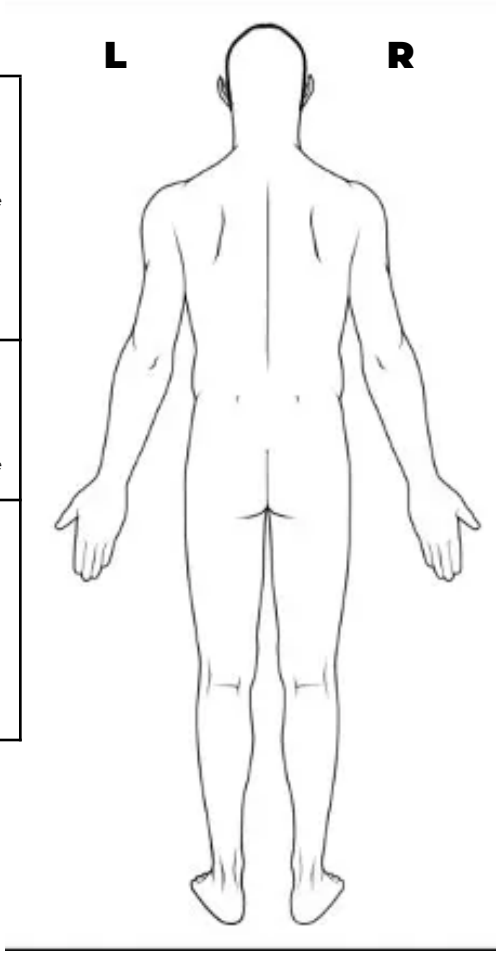
Upper back:
Circle Severity Pain Level

0 1 2 3 4 5 6 7 8 9 10
Minor Moderate Severe

Low Back Pain:
Circle Severity Pain Level

0 1 2 3 4 5 6 7 8 9 10
Minor Moderate Severe

- ☐ Back pain worse than hip/leg pain
- ☐ Back pain same as hip/leg pain
- ☐ Back pain less than hip/leg pain



Back

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CURRENT STATE OF PAIN:
Please check (√) the appropriate box for each line

ARE YOU GETTING	☐ Better	☐ Worse	☐ Unchanged
ARE YOU USUALLY IN	☐ Mild Discomfort	☐ Moderate Discomfort	☐ Severe Discomfort
PAIN IS WORSE IN THE	☐ Morning (6am-Noon)	☐ Afternoon (1pm-3pm)	☐ Night (6pm-6am)
DOES PAIN COME ON	☐ Suddenly	☐ Gradually	
PAIN IS	☐ Constant	☐ Good & Bad Days	

Are you working? ☐ Yes ☐ No If not, when did you stop? _____

Is the problem the result of an on-the-job injury?	☐ Yes	☐ No
Do you have an attorney helping you?	☐ Yes	☐ No
Is this problem the result of a motor vehicle crash (MVC)?	☐ Yes	☐ No
Is this problem the result of a fall?	☐ Yes	☐ No

Which INCREASES your pain/discomfort?

☐ Standing	☐ Lying on back	☐ Coughing/Sneezing
☐ Sitting	☐ Lying on stomach	☐ Urination
☐ Walking	☐ Lying on side	☐ Bowel Movement
☐ Bending forward	☐ Getting out of bed	☐ Driving
☐ Bending backward	☐ Raising from sitting	☐ Heat/Cold

Which DECREASES your pain/discomfort?

☐ Standing	☐ Lying on back	☐ Coughing/Sneezing
☐ Sitting	☐ Lying on stomach	☐ Urination
☐ Walking	☐ Lying on side	☐ Bowel Movement
☐ Bending forward	☐ Getting out of bed	☐ Driving
☐ Bending backward	☐ Raising from sitting	☐ Heat/Cold

What is the approximate amount of time you can perform the following activities?
Sit _____minutes Stand_____minutes Walk_____minutes

For your current problem, have you had (Please List Dates Below if Available):

☐ X-Ray	☐ MRI	☐ CT Scan	☐ Myelogram	☐ EMG	☐ Bone Scan	☐ Discogram
Date: __/__/___	__/__/___	__/__/___	__/__/___	__/__/___	__/__/___	__/__/___

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TREATMENT:
Please check (√) all of the treatments you have tried for your pain, including dates and outcomes.

Treatment	Date	No Relief	Moderate Relief	Excellent Relief
☐ Physical/Occupational Therapy	__/__/___	☐	☐	☐
☐ Heat/Ice	__/__/___	☐	☐	☐
☐ Traction	__/__/___	☐	☐	☐
☐ Injections (epidural, facet, etc.)	__/__/___	☐	☐	☐
☐ TEN – Electrical Stimulator	__/__/___	☐	☐	☐
☐ Ultrasound	__/__/___	☐	☐	☐
☐ Brace or collar	__/__/___	☐	☐	☐
☐ Massage	__/__/___	☐	☐	☐
☐ Psychotherapy - Biofeedback	__/__/___	☐	☐	☐
☐ Chiropractic	__/__/___	☐	☐	☐
☐ Dorsal Column Stimulator	__/__/___	☐	☐	☐
☐ Morphine pump	__/__/___	☐	☐	☐
☐ Other	__/__/___	☐	☐	☐

Height: _____ Weight: _____

MEDICATIONS:
Please List all medications you are currently taking below:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy: _____ Location: _____ Phone#: _____

ALLERGIES:
Please list all allergies below:

_____ _____

_____ _____

_____ _____

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REVIEW OF SYSTEMS
Please check (√) the appropriate box for each line

Constitutional	☐ None	☐ Night-Sweats	☐ Fever/Chills	☐ Weight Loss/Gain:___lbs./ last yr	
Eyes	☐ None	☐ Visual Changes	☐ Glasses/Contacts		
Ear, Nose, Throat	☐ None	☐ Hearing Problem	☐ Sore Throat	☐ Cold	☐ Sinus Allergies
Cardiovascular	☐ None	☐ Chest Pain	☐ Palpitations	☐ Leg Swelling	☐ Calf Cramps w/ Walking
Sexual Function	☐ None	☐ Impotence	☐ Painful Intercourse	☐ Not Sexually Active	
Respiratory	☐ None	☐ Short of Breath	☐ Wheezing	☐ Frequent Cough	☐ Coughing Blood
Gastrointestinal	☐ None	☐ Ulcer	☐ Bowel/Bladder Control Issues	☐ Diarrhea	☐ Vomiting
Genitourinary	☐ None	☐ Incontinence	☐ Burning Urination	☐ Blood in Urine	☐ Kidney Stones
Musculoskeletal	☐ None	☐ Backache	☐ Joint Stiffness	☐ Joint Swelling	☐ Joint Pain
Integumentary	☐ None	☐ Rash	☐ Hair Problem	☐ Nail Problem	
Neurological	☐ None	☐ Headaches	☐ Fainting	☐ Memory Loss	☐ Tingling/ Numbness
Psychiatric	☐ None	☐ Depression	☐ Anxiety	☐ Personality Change	☐ Past Psych Care
Endocrine	☐ None	☐ Excessive Urination	☐ Excessive Thirst	☐ Intolerance to Heat/Cold	
Hematologic/ Lymphatic	☐ None	☐ Anemia	☐ Abnormal Bleeding		
Allergic/ Immunologic	☐ None	☐ Allergy Shots	☐ Immunization Issues		

PAST MEDICAL HISTORY:
Please check (√) any illnesses you currently have, or have had in the past.

☐ Hypertension	☐ Renal Failure/Dialysis	☐ Emphysema
☐ A-fibrillation	☐ Diabetes	☐ GERD/Reflux
☐ Seizures	☐ Heart Attack/Arrhythmia	☐ Elevate liver tests
☐ Depression	☐ CHF	☐ Osteoporosis
☐ Asthma	☐ Blood Clots	☐ Drug/Alcohol Dependency
☐ Irritable Bowel	☐ HIV	☐ Stroke
☐ Thyroid Disease	☐ Osteoarthritis	☐ Gastric Ulcer
☐ Rheumatoid Arthritis	☐ High Cholesterol	☐ Hepatitis

☐ OTHER:

_____

_____

_____

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PAST SURGICAL HISTORY:
Please check (√) any surgery you have had.

- ☐ Tonsils/Adenoids
- ☐ Appendectomy
- ☐ Gallbladder Removal
- ☐ Hernia Repair
- ☐ Cataract extraction
- ☐ Hysterectomy
- ☐ Bladder Suspension
- ☐ Vasectomy
- ☐ Prostate
- ☐ Coronary Bypass
- ☐ Pacemaker/Defibrillator
- ☐ Biopsies of: _____
- ☐ Fracture repair: _____
- ☐ Joint Replacement: _____
- ☐ Neck Surgery
- ☐ Back Surgery

Other : _____
_____

FAMILY HEALTH HISTORY:

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

SOCIAL HISTORY:
Please check (√) the appropriate box for each line:

Marital Status: :	☐ Single	☐ Married	☐ Widowed	☐ Divorced
Do you smoke cigarettes/vape?	☐ Yes	☐ No		
Former smoker?	Pack/Day:_____		# of years:_____	
Do you dip/chew tobacco?	☐ Yes	☐ No		
Do you drink alcohol?	☐ Yes	☐ No	Drinks/Week:_____	
Occupation: _____	Highest Level of Education: :_____			
Is your job:	☐ Sedentary	☐ Light	☐ Medium	☐ Heavy
Are you?	☐ Right Handed	☐ Left Handed		
Race: _____	Ethnicity: _____		Preferred Language: _____	