ocpn | easton

ORTHOPEDIC CARE PHYSICIAN NETWORK
& REHABILITATION SERVICES

Date of Intake:_______

Patient Name: ______________________________ **Date of Birth:** ____________
Current Pharmacy Name: ______________ **Address:** ____________ **Fax #:** ____________
Primary Care Physician Name: ______________________________
Primary Care Physician Address: ______________________________
Primary Care Physician Phone Number: ______________________________
What is the reason for today's visit? ______________________________
How were you referred to us? ______________________________
Is your visit today a result of a work injury?_____**YES** _____**NO** **Date of injury:** ____________
Details of injury: ______________________________
Are you currently represented by an attorney?___**YES**_____**NO** **Name of Attorney?**____________
How long have you had this problem? ______________ **Are you Left ☐ or Right ☐ Handed?**
Have you had any prior treatments for this?_____**Yes**______**No**
What type?______________________________
Please check any of the following treatments you have had for this problem:

	YES	NO		YES	NO
Pain Clinic			Improved Pain?		
Physical Therapy			Improved Pain?		
Surgery			Improved Pain?		
Injections (epidural, facet, etc.)			Improved Pain?		
Tens Unit			Improved Pain?		
Brace/ Collar			Improved Pain?		
Acupuncture			Improved Pain?		
Chiropractor			Improved Pain?		
Ice			Improved Pain?		
Hot Packs			Improved Pain?		
Traction			Improved Pain?		
Ultra Sound			Improved Pain?		

Activity Levels: Please choose the letters from **List 2** that answer questions from **List 1:**

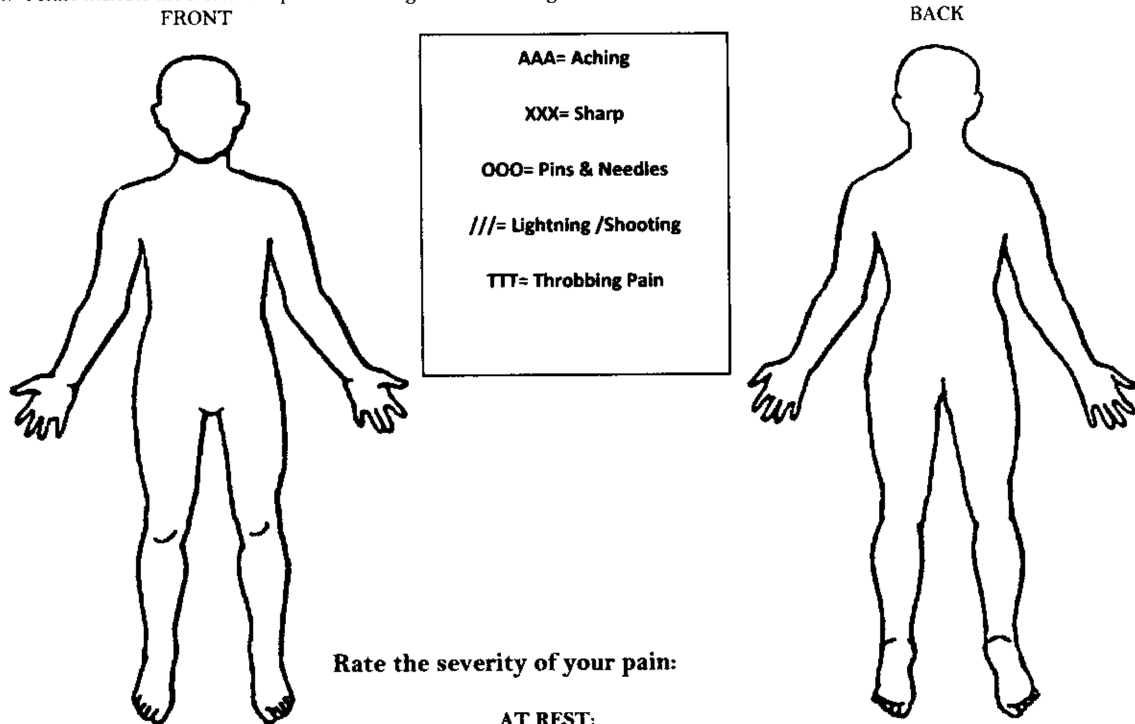
1.) How long can you stand? ___
2.) How long can you sit? ___
3.) How long can you walk? ___

A. Unable to tolerate.
B. About 15 minutes daily
C. About 30 minutes only
D. About an hour.
E. Indefinitely

Which of the following activities change the nature of your pain:

	Aggravates Pain	Relieves Pain	Neither
Sitting			
Standing			
Rising from sitting			
Leaning forward			
Walking			
Lying on your side			
Lying on your back			
Lying on your stomach			
Driving			
Coughing/Sneezing			
Bending Forward			

PAIN: Please indicate the location of pain on the diagram below using the indication.



Rate the severity of your pain:

AT REST:

0 No Pain	1	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable

WITH ACTIVITY:

0 No Pain	1	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable

Please list any other physicians you have seen for your pain:

Doctors Name	Approximate Date of last visit	Doctors Specialty

Tests: Please indicate which diagnostic procedures (tests) you have had for this pain problem:

Test	Body Part	Approximate Date	Facility preformed
MRI Scan			
CT Myelogram			
X-Ray			
EMG/NCS			
Disco gram			
Bone Scan			

Review of Systems:

CONSTITUTIONAL:		
Are you in good health?	YES	NO
Have you had recent weight loss?	YES	NO
SKIN:		
Do you have rashes or ulcers?	YES	NO
EYES:		
Do you wear glasses or contact lenses?	YES	NO
Have trouble with red swollen eyes?	YES	NO
EARS/NOSE/THROAT		
Do you have difficulty swallowing?	YES	NO
Do you wear hearing aids?	YES	NO
CARDIOVASCULAR:		
Do you have swelling in your ankles?	YES	NO
Do you have palpitations?	YES	NO
RESPIRATORY:		
Do you wheeze?	YES	NO
GYNECOLOGICAL:		
Are you pregnant?	YES	NO
Date of last menstrual period:	______	
Are you breastfeeding?	YES	NO
GENITOURINARY:		
Do you have any problems with urination?	YES	NO
GASTROINTESTINAL:		
Do you have abdominal pain?	YES	NO
Have you had any change in bowel habits?	YES	NO
PSYCHIATRIC:		
Do you feel anxious or depressed?	YES	NO
ENDOCRINE:		
Experiencing increased thirst or sweating?	YES	NO
HEMATOLOGY:		
Do you bruise easily?	YES	NO
Do you have painful or enlarged glands?	YES	NO
NEUROLOGIC:		
Do you have frequent headaches?	YES	NO

Medical History: Please review the list below. If you have now, or have had in the past, a problem in any of these areas, please check "YES" and explain in the space provided. If not check "NO".

	YES	NO		YES	NO
Heart disease			Mitral valve prolapse		
Angina/chest pain			Asthma/Allergies		
High blood pressure			Lung disease		
Heart murmur			Hepatitis/Liver disease		
Diabetes			Kidney disease		
Gastrointestinal disease			Thyroid disease		
Stomach ulcers			Anemia/Abnormal bleeding		
Seizures/Epilepsy/Stroke			Depression/Anxiety		
HIV/AIDS			Other psychiatric condition		

Surgeries: Please list any surgeries you have had: (Include the date of the surgery).

Surgery Type	Date

Medications: Please list all the medications you are currently taking: including prescription drugs, inhaler, aspirin products, non-steroidal anti-inflammatory drugs, eye drops, herbal supplements, nutritional supplements, vitamins, over-the-counter medications and non-prescription drugs.

Medication	Dose	Time/ Frequency	Reason for Medication

Allergies: Please list allergies, sensitivities, medication reactions: include medications; vaccinations; foods; insects/venom, such as bee sting; substances, such as latex; environmental allergies; seasonal allergies; reactions, including iodine or radiology contrast material.

I have no known allergies, sensitivities or medication reactions: ____________________

Allergy/Sensitivity/Medication	Type of reaction:

Family History: Has anyone in your immediate family ever had the following:

	YES	NO	WHO?		YES	NO	WHO?
Gastrointestinal				Rheumatologic disorders			
Cancer				Kidney disease			
Diabetes				Neurological disease			
Heart Disease				Skin disease			
Lung disease				Blood disorders			

Social History:

What country are you from/ethnicity?______________________________

Are you currently working? ☐ YES ☐ NO Occupation: ______________________

Do you smoke? ☐ YES ☐ NO If yes, how many packs? _____ # of years?_____

If no, did you smoke formerly? ☐ YES ☐ NO Packs per day? ___________# of years?_____

Do you use alcohol? ☐ YES ☐ NO Amount weekly: __________Monthly:_______

What is your marital status? ______________________________

PATIENT CERTIFICATION:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes on my medical status.

____ / /

Signature **Date**

Patients or Responsible Party

CLINICIAN REVIEW:

I have reviewed the above information with the patient.

____ / /

Clinician's Signature: **Print Name:** **Date:**

THIS SECTION IS COMPLETED BY:

MEDICAL ASSISTANT

Height: **Weight:** **BP:** **Pulse:**