ocpn | easton

ORTHOPEDIC CARE PHYSICIAN NETWORK
& REHABILITATION SERVICES

Name: ______________________________ Date of Birth: ____________

PCP: ______________________ Referring Physician: ____________

Pharmacy Name: ____________ Address: ______________________

When did your pain begin (date)? ____________ Is your pain from a work-related injury? ☐ Y ☐ N

What part of your body did the pain begin? ______________________

How did the pain start? ______________________

Has you pain changed since? ______________________

Are you receiving compensation or disability payments? ☐ Yes ☐ No

Are you in litigation because of your pain/injury? ☐ Yes ☐ No

PRIOR TREATMENTS *(check all that apply)*

	Helpful	Not Helpful
Surgery	☐	☐
Injections	☐	☐
Physical Therapy	☐	☐
Biofeedback/Relaxation Therapy	☐	☐
Professional Psychological Support	☐	☐

Other: ______________________

List all prior medications tried: ______________________

Have you ever seen a therapist/psychologist/psychiatrist? ☐ Yes ☐ No

Who? ____________ Why? ____________

PAIN INTENSITY *(please circle)*

	No Pain				*Moderate Pain*					*Worst Pain*	
Pain on average -	0	1	2	3	4	5	6	7	8	9	10
Pain at its worst -	0	1	2	3	4	5	6	7	8	9	10
Pain at its best -	0	1	2	3	4	5	6	7	8	9	10

INCREASES/DECREASES PAIN *(please check what makes your pain feel)*:

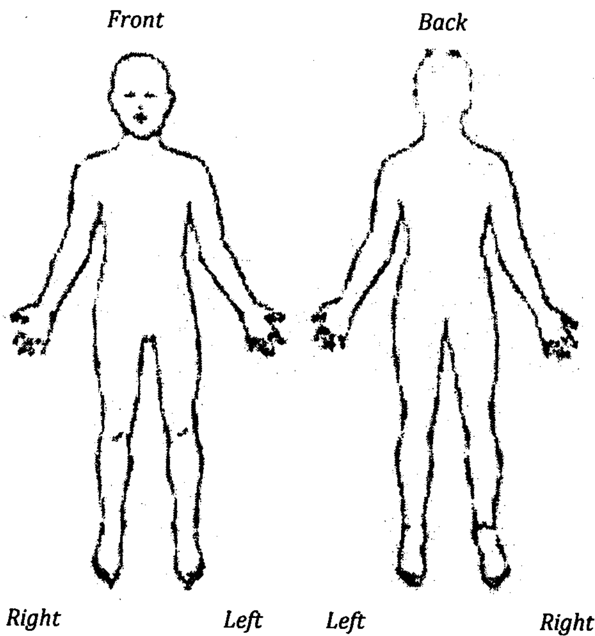
WORSE
- ☐ Walking
- ☐ Lifting
- ☐ Bending
- ☐ Lying
- ☐ Standing
- ☐ Sitting
- ☐ Coughing/Sneezing

BETTER
- ☐ Heat
- ☐ Ice
- ☐ Rest
- ☐ Lying
- ☐ Standing
- ☐ Sitting
- ☐ Medication

Additional Info: ______________________

LOCATION OF PAIN

Please shade in the locaton(s) or your pain:



QUALITY OF PAIN

Describe your pain (check all that apply):

- ☐ Pricking
- ☐ Throbbing
- ☐ Dull
- ☐ Aching
- ☐ Sharp/Stabbing
- ☐ Pulling
- ☐ Burning
- ☐ Shooting
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling

Other: ____________________

MEDICAL HISTORY *(please check and explain)*:

- ☐ Heart Problems: ____________
- ☐ Hypertension: ____________
- ☐ Lung Problems/Asthma: ____________
- ☐ Diabetes: ____________
- ☐ Kidney/Bladder Problems: ____________
- ☐ Anxiety/Depression: ____________
- ☐ Cancer: ____________
- ☐ Blood Disorders: ____________
- ☐ Intestinal Problems/Ulcers: ____________
- ☐ Blackouts/Falls: ____________
- ☐ Neurologic Disorders: ____________

Other: ____

PAST SURGICAL HISTORY

Surgeries	*Date*	*Surgeries*	*Date*

Do you have any medical devices implanted in your body? ☐ Yes ☐ No Explain: ____________________

SOCIAL HISTORY

Previous/Current Occupation: ____

Are you currently working? ☐ Yes ☐ No If no, why? ________________________________

Living Arrangement: ______________ Tobacco Use? ☐ Yes ☐ No # per day: _______ # years: _______

How much Beer/Wine/Liquor drinks per week? ________________________________

Recreational drug use? ☐ Yes ☐ No Explain: ____________________ History of addiction? ☐ Yes ☐ No

FAMILY HISTORY *(please check)*:

	Yes	No	Who?		Yes	No	Who?
Heart Disease				Neurologic Disease			
Lung Disease				Diabetes			
Cancer				Rheumatologic			
Gastointestinal				Blood Disease			
Kidney Disease				Skin Disease			

REVIEW OF SYSTEMS *(please circle all symptoms that you currently have)*:

General:	Fever, Chills, Fatigue, Nausea
Ears/Nose/Throat:	Ringing in ears, Loss of Hearing, Sore Throat, Difficulty Swallowing
Cardiovascular:	Chest pain, Palpitations, Irregular Heartbeat
Pulmonary:	Cough, Wheeze, Shortness of Breath
Gastrointestinal:	Heartburn, Diarrhea, Constipation, Stomach Pain, Bloody Stool, Incontinence
Genitourinary:	Increased Frequency, Discharge, Incontinence, Bloody Urine
Neurologic:	Headache, Dizziness, Lightheaded, Spasms, Loss of Consciousness
Psychiatric:	Anxiety, Depression, Suicidal Thoughts
Endrocrine:	Heat/Cold Intolerance, Unexplained Weight Loss/Gain
Hematologic:	Easy Bruising, Easy Bleeding,
Skin:	Rash, Lesions

ALLERGIES *(with specific reaction)*: ____

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CURRENT MEDICATIONS

Name	*Dose*	*Frequency*	*Name*	*Dose*	*Frequency*

DIAGNOSTIC TESTS

	Date	*Facility*
XRAY	__________	__________
MRI	__________	__________
CT Scan	__________	__________
EMG	__________	__________
Other	__________	__________

Patient's Signature: ______________________________ **Date:** ______________

Reviewed By: ______________________________ **Date:** ______________

OFFICE USE ONLY:

BP: ________ HR: __________
CV: ______________________
Pulm: ____________________
Abd: soft, NT/ND ____________
Ext: no C/C/E ______________
Neuro: ☐ CNII-XII __________
Motor: ___________________
Strength: __/5 RUE, __/5 LUE, __/5 RLE, __/5 LLE
Sens: _____________________

☐ Hoffmans ☐ Clonus

	C 5/6/7	C 5/6	C 6/7/8	L 2/3/4	S 1/2
Left					
Right					

Gait: Non-Antalgic ____________ ☐ Heel ☐ Toe

MSK: C ROM ____________________ Spurlings ____________
C Tender ____________________ Trigger ____________
L ROM ____________________ Axial loading R ☐ L ☐
L Tender ____________________ Trigger ____________
SI Joint ☐ R ☐ L SLR ☐ R ☐ L
Patricks ☐ R ☐ L GTB ☐ R ☐ L