CAROLINA ORTHOPAEDIC & NEUROSURGICAL ASSOCIATES

115 Deacon Tiller Ct
Duncan, SC 29344
(864) 721-0025

ake Form

Dr. James P. Bell

Dr. Tony DiNicola

__ DOB:_____

D

Work related? [ ] Yes [ ] No
Legal Actions pending? [ ] Yes [ ] No
Workers Compensation? [ ] Yes [ ] No
Are you working now? [ ] Yes [ ] No

Name of the doctor that referred you to this clinic:
_____
[ ] I referred myself.

How long have you had this pain? _____Days _____Weeks
_____Months _____Years

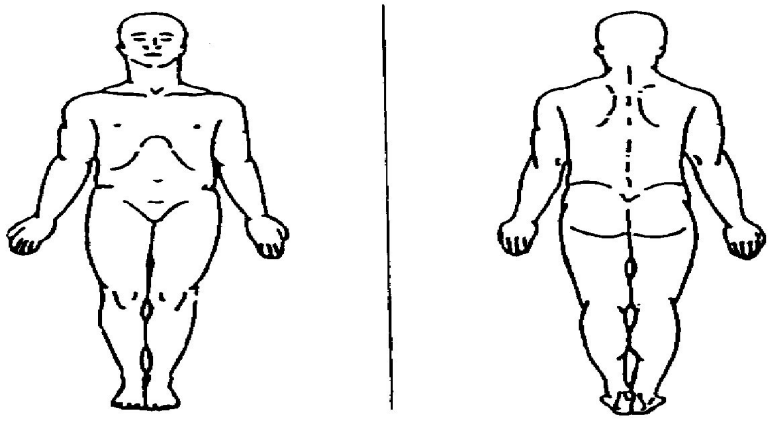
Was there any injury/event that caused your pain? [ ] No [ ] Yes
If yes briefly explain:_____

Any prior back injury or pain before the event above? [ ] No [ ] Yes
What type?_____

Have you had surgery on your back / neck? [ ] No [ ] Yes
What type?_____

WHERE IS THE PAIN?
Using any or all of the symbols below, please mark the diagrams to indicate your typical areas of pain.

Ache	>>>>>
Pins & Needles	ooooo
Numbness	---------
Stabbing	//////////



Please rate your pain over the last **TWO WEEKS:**

Rate your **WORST** pain:	**NO PAIN**	0	1	2	3	4	5	6	7	8	9	10	**THE WORST PAIN IMAGINABLE**
Rate your **LEAST** pain:	**NO PAIN**	0	1	2	3	4	5	6	7	8	9	10	**THE WORST PAIN IMAGINABLE**
Rate your **AVERAGE** pain:	**NO PAIN**	0	1	2	3	4	5	6	7	8	9	10	**THE WORST PAIN IMAGINABLE**

Is your pain: [ ] Constant or [ ] Intermittent

Please see reverse for page 2

Adjectives to describe your pain:

Sharp	Radiating	Cruel	Punishing
Burning	Achy	Dull	Shooting
Tingling	Numb	Pressure	Pins/Needles

What makes your pain better?_____

What makes your pain worse?_____

What treatments have you tried up to this point?

	Currently Receiving	Helped	Made things worse	No difference
Hot packs/ice/ultrasound	☐	☐	☐	☐
Massage	☐	☐	☐	☐
Physical therapy	☐	☐	☐	☐
TENS Unit at home	☐	☐	☐	☐
Body mechanics training	☐	☐	☐	☐
Strengthening exercises	☐	☐	☐	☐
Aerobics (e.g. treadmill)	☐	☐	☐	☐
Gravity inversion/traction	☐	☐	☐	☐
Bedrest	☐	☐	☐	☐
Chiropractic treatment	☐	☐	☐	☐
Osteopathic manipulation	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐
Local (trigger point) injection	☐	☐	☐	☐
Spinal injections	☐	☐	☐	☐
Soft back/neck brace	☐	☐	☐	☐
Rigid back/neck brace	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Pain Specialist	☐	☐	☐	☐
Other _____	c	c	c	c

Have you ever lost control of your bowel or bladder? [ ] No [ ] Yes

Do you have any weakness in your arm(s) or leg(s)? [ ] No [ ] Yes

In the past 1 month have you experienced any of the following more frequently than half of the time?

Trouble falling asleep?	[ ] No	[ ] Yes
Waking at night and not being able to fall back asleep?	[ ] No	[ ] Yes
Feeling not rested when you wake up in the morning?	[ ] No	[ ] Yes
Feeling excessively sleepy during the day?	[ ] No	[ ] Yes

Do you feel you might be depressed or overly anxious? [ ] No [ ] Yes

Circle the appropriate number to indicate the extent of the problem you are having with each of the following:

Anxiety:	None	0	1	2	3	4	5	6	7	8	9	10	Severe
Depression:	None	0	1	2	3	4	5	6	7	8	9	10	Severe
Irritability	None	0	1	2	3	4	5	6	7	8	9	10	Severe

Are you receiving care from a mental health professional? [ ] No [ ] Yes

If yes briefly explain:_____

Does your pain limit your function? [ ] No [ ] Yes

If yes briefly explain:_____