Davis Spine & Orthopaedics

Spine and Orthopaedic Surgeon
Board Certified and Fellowship Trained
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Patient History and Data

Patient's name: ____ Age: ___________ DOB: ______________

Date: __________________ Are you Right or Left handed? Right / Left Height: _______ Weight: _______

Occupation: ________________________________ Referred by: ____

Description of job duties: ____

____

Are you currently working? Yes / No In not, when did you stop working? __________________________

History of present problem:

Reason for visit: ____

Date of injury: _____________________ Date problem first started: _____________________

This occurred at: Work / Home / Motor Vehicle Accident / Other (please specify): ________________________

Describe how you were injured: ____

Location of your pain: ____

Usual severity of your pain for your ongoing issue (please circle):

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

Type of pain (please circle all that apply): Dull, Burning, Aching, Throbbing, Sharp, Other _________________

Pain is made **WORSE** by (circle all that apply): Moving, Lifting, Twisting, Walking, Running, Other ________

____

What provides **RELIEF** of your pain? ____

Is the pain better, worse, or the same at night? _____________ How many hours of sleep do you get? __________

Treatment:

Have you had treatment for this injury? ____

List any medications taken for this injury: ____

Have you had physical therapy for this injury? __________ If yes, how long? _____________________________

List all medications you currently take: ____

List any allergies you have had and the type of allergic reaction: ____