

LITCHFIELD HILLS ORTHOPEDIC ASSOCIATES

DATE: ____/____/____

Family Physician: _____

NAME: _____

ADDRESS: _____

EMAIL: _____

AGE: _____ DATE OF BIRTH: ____/____/____

SOCIAL HISTORY: RIGHT HANDED LEFT HANDED

WORKING RETIRED

OCCUPATION/TYPE OF WORK: _____

HOW MANY YEARS AT PRESENT OCCUPATION: _____

WORKING RETIRED

ANY STAIRS TO CLIMB AT HOME: YES NO

CIGARETTES: YES NO

HOW MANY PER DAY _____ HOW MANY YEARS _____

YEAR STOPPED SMOKING _____

ALCOHOL: HOW MUCH AND HOW OFTEN: _____

MEDICAL PROBLEMS: _____

LIST FRACTURES: _____

DO YOU HAVE ANY BONE DISEASES OR PROBLEMS: (Please explain)

OPERATIONS: (List all recent and past operations)

MEDICATIONS: _____



ALLERGIES:

FAMILY HISTORY: ALIVE DEAD AGE ILLNESSES

FATHER _____ _____ _____ _____

MOTHER _____ _____ _____ _____

BROTHERS _____ _____ _____ _____

_____ _____ _____ _____

SISTERS _____ _____ _____ _____

_____ _____ _____ _____

DAUGHTERS _____ _____ _____ _____

_____ _____ _____ _____

SONS _____ _____ _____ _____

_____ _____ _____ _____

GENERAL HEALTH: ___ EXCELLENT ___ GOOD ___ FAIR ___ POOR

PAST HISTORY OF:

___ RHEUMATOID FEVER ___ SCARLET FEVER ___ MUMPS ___ MEASLES ___ CHICKEN POX

___ MALARIA ___ TUBERCULOSIS

LAST IMMUNIZATION: ____/____/____

HEENT: Any problems with head, ears, eyes, nose, throat or teeth:

Please List: _____

RESP: Have you ever had:

___ PNEUMONIA ___ EMPHYSEMA ___ BRONCHITIS ___ PULMONARY EMBOLUS ___ ASTHMA

___ OTHER LUNG PROBLEMS (Please list)

COR: Any trouble with:

___ SHORTNESS OF BREATH ___ PALPITATIONS ___ RHYTHM ABNORMALITY ___ HEART ATTACK

___ HIGH BLOOD PRESSURE ___ MURMURS ___ HIGH CHOLESTEROL ___ ANGINA

___ CONGESTIVE HEART FAILURE ___ OTHER HEART PROBLEMS: PLEASE LIST: _____

Any trouble with:

ULCERS HIATAL HERNIA HERNIAS HEPATITIS APPENDICITIS

GALL BLADDER

DIVERTICULOSIS, DIVERTICULITIS, REGIONAL ENTERITIS, ULCERATIVE COLITIS, OR OTHER BOWEL PROBLEMS (Please list)

GU: Have you ever had:

CYSTITIS KIDNEY STONES BLADDER STONES URINARY TRACT INFECTIONS

VENERAL DISEASE URINARY INCONTINENCE PROSTATE CANCER

INCREASE IN PROSTATE SIZE RENAL FAILURE

HOW MANY TIMES DO YOU GET UP AT NIGHT TO VOID _____

NM: Have you ever had:

STROKE SEIZURE CONVULSION PARALYSIS OF ANY TYPE

DISC OR BACK PROBLEM

GYN: ARE YOU PREGNANT: YES NO

ARE YOUR PERIODS: NORMAL IRREGULAR AGE AT ONSET _____

ANY BREAST PROBLEMS: YES NO NUMBER OF BIOPSIES _____

MISC: DIABETIC THYROID PROBLEMS BLEEDING DISORDER ANEMIC

EMOTIONAL: ARE YOU VERY NERVOUS OR EASILY UNNERVED: YES NO

HAVE YOU EVER BEEN TREATED FOR A PSYCHOLOGICAL DISORDER: YES NO

HAVE YOU EVER BEEN INSTITUTIONALIZED: YES NO

SIGNATURE: _____ DATE: _____



**LITCHFIELD HILLS ORTHOPEDIC ASSOCIATES
PATIENT INTAKE QUESTIONNAIRE**

NAME _____ TODAY'S DATE _____

Please fill out the following. It will allow your doctor to better treat your medical problem.

The reason I am here today is due to:

_____ an injury that I sustained while I was at work.
If yes, date it occurred _____ Was it in CT? _____ If not, what
state _____
I have filed a claim with my employer Y _____ N _____

_____ an injury that occurred while in an automobile.
If yes, date it occurred _____
Please present your motor vehicle insurance card with your health insurance
card to the receptionist.

_____ due to a fall or injury, but **not** while working or in an automobile.

_____ none of the above.

I authorize the offices of Litchfield Hills Orthopedic Associates to release this information and any other pertinent information related to this information to my insurance company in order to process my claims for payment.

Signed _____

Date _____



Litchfield Hills
Orthopedic Associates, LLC

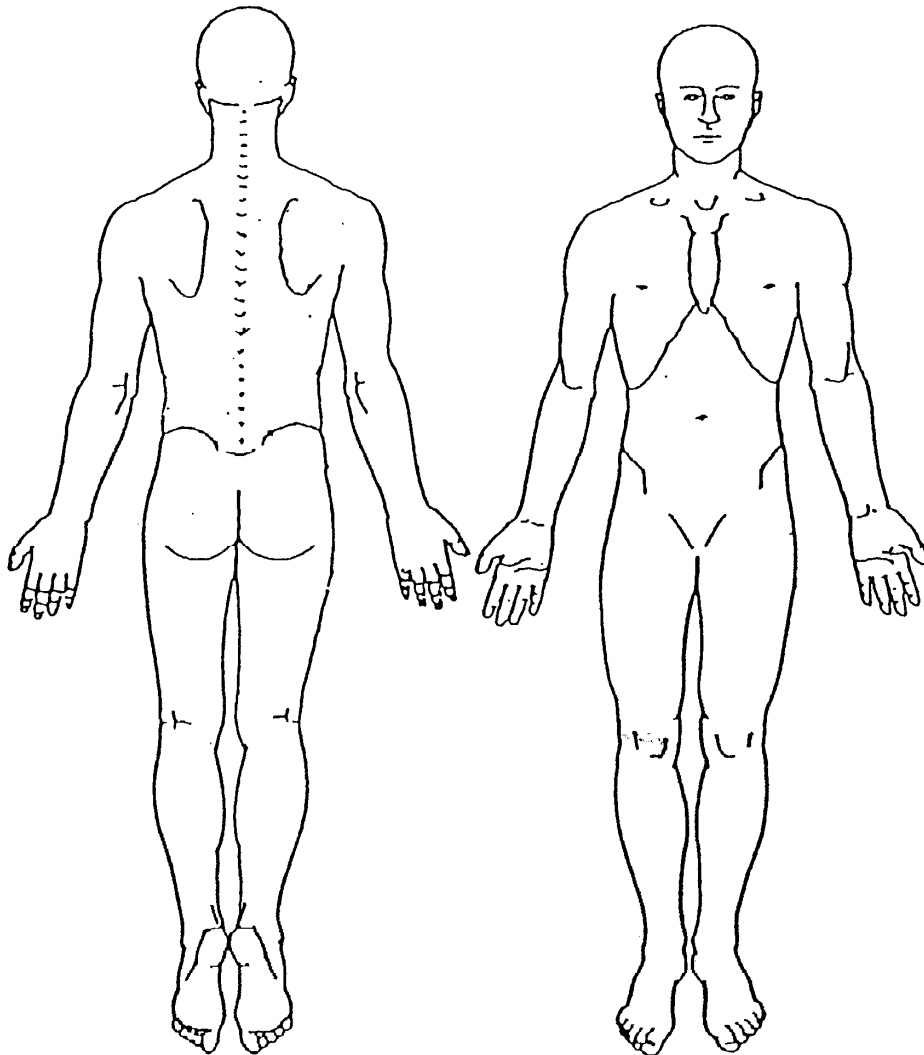
Lane Spero, MD

Patient Name _____ Date _____
Birthdate _____ Age _____ Height _____ ft _____ in Weight _____ lbs
My primary Doctor is _____ Tel # _____
I was referred by _____ Tel # _____

PAIN DRAWING

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
AAA	000	---	XXX	///
AAA	000	---	XXX	///
AAA	000	---	XXX	///

Mark area on this drawing where you feel the above sensations



THE FOLLOWING MAKE MY DISCOMFORT BETTER:

NECK: () Bed Rest () Massage () Stretching/"popping" neck () Heat () Ice
() Other _____ () Nothing Helps

BACK: () Bed Rest () Decreased Activities () Bending Forward () Bending Backward
() Other _____ () Nothing Helps

THE FOLLOWING MAKE MY DISCOMFORT WORSE:

NECK: () Activity () Bending Neck Forward () Bending Neck Backward () Bending Neck to left
() Bending Neck to Right () Other _____

BACK: () Activity () Bending Forward () Bending Backward () Sitting () Standing
() Walking () Sneezing/Coughing/Straining to go to the bathroom () Other _____

I ALSO HAVE THE FOLLOWING PROBLEMS:

- () Specific weakness of muscles in my arm or hands
- () Generalized weakness of arms or hands due to pain or discomfort
- () Numbness of: and/or () Tingling of: () arms () hands () legs () feet () toes
- () Specific weakness in legs
- () Generalized weakness of legs due to pain and discomfort
- () My legs fatigue or hurt when I walk too far () This is relieved by resting my legs
I can walk: () less than a block () 1 – 2 blocks () more than 3 blocks
- () Trouble with my bladder (urine) control
 - () Can't empty bladder () Loss of urine (accidents)
 - () I don't feel my perineal area when I wipe (the sensation is decreased)
- () Trouble with bowels
 - () Constipation () Loss of control (accidents)
 - () I don't feel my perineal area when I wipe (the sensation is decreased)
- () My pain is worse at night
- () My pain awakens me from a **sound** sleep

JOB HISTORY:

My job is _____

My Job requirements are:

- () Heavy – Lifting over 60 lbs/frequent bending and stooping
- () Medium – Lifting 30-50 lbs
- () Light – Lifting 10-20 lbs
- () Sedentary – Sit most of the time/ very little lifting
- () My job is highly stressful – it makes me tense



MARK "X" ON THE APPROPRIATE LINE:

1. How bad is your low back pain now?

No Pain 0 _____ 2 _____ 4 _____ 5 _____ 6 _____ 8 _____ 10 Worst Possible

2. How bad is your leg pain now?

No Pain 0 _____ 2 _____ 4 _____ 5 _____ 6 _____ 8 _____ 10 Worst Possible

3. How bad is your neck or upper back pain now?

No Pain 0 _____ 2 _____ 4 _____ 5 _____ 6 _____ 8 _____ 10 Worst Possible

4. How bad is your arm pain now?

No Pain 0 _____ 2 _____ 4 _____ 5 _____ 6 _____ 8 _____ 10 Worst Possible

5. How many times per week does this pain awaken you from a **sound** sleep?

Never 0 _____ 2 _____ 4 _____ 5 _____ 6 _____ 8 _____ 10 More than 10

EXPLAIN HOW YOUR PAIN BEGAN:

Injury On the job Date of Injury _____

Explain how it happened _____

I don't know how it began

My problem is chronic – Age it began _____ I remember an injury – Describe injury _____

Have you had back or neck pain before this episode? Yes _____ No _____ When _____ For how long _____

PREVIOUS TREATMENT: (For Back or Neck)

None

Physician's Name _____

He/She Prescribed:

	No Help	Some Help	Helps
<input type="checkbox"/> Medications (give names)	()	()	()
<input type="checkbox"/> Anti-inflammatories _____	()	()	()
<input type="checkbox"/> Muscle Relaxers _____	()	()	()
<input type="checkbox"/> Pain Meds _____	()	()	()
<input type="checkbox"/> Others _____	()	()	()
<input type="checkbox"/> Physical Therapy	()	()	()
<input type="checkbox"/> Traction	()	()	()
<input type="checkbox"/> Exercises	()	()	()
<input type="checkbox"/> Injections: Describe _____	()	()	()
<input type="checkbox"/> Manipulation (osteopath) _____	()	()	()
<input type="checkbox"/> Chiropractor's Name _____	()	()	()
<input type="checkbox"/> Heat <input type="checkbox"/> Ice	()	()	()
<input type="checkbox"/> Surgery: Age _____ Describe _____	()	()	()

I have had the following tests:

Regular X-rays CT Scan MRI Myelogram Discogram

EMG _____ Nerve Conduction Studies _____

I have seen other doctors for my condition. List types of doctors and what they prescribed _____



GENERAL MEDICAL HISTORY

INJURY HISTORY

() Vehicle/machinery accidents etc: (describe) _____

() NO Major Injuries

HOSPITALIZATIONS (explain) _____

FEMALES – MENSTRUAL HISTORY

() My periods are normal for me () I have been pregnant _____ times _____ stillbirths
I am () menopausal () post-menopausal () I have had _____ vaginal deliveries _____ C-sections
() I have had problems with deliveries and pregnancies - Describe: _____

CHILDHOOD DISEASES

() Rheumatic fever () Other (major only) _____
() Nothing unusual

FAMILY MEDICAL HISTORY

MOTHER: () alive & well – age _____ () alive but suffers with _____ age _____
() deceased – cause _____ age at death _____
FATHER: () alive & well – age _____ () alive but suffers with _____ age _____
() deceased – cause _____ age at death _____

I have ____ living brothers/sisters ____ deceased brothers/sisters – cause _____

Members of my family (brothers, sisters, grandparents, aunts, and uncles) suffer with the following:

- () Stroke () High blood pressure () Cancer – type _____
- () Diabetes () Heart trouble () Lung-disease () Back problems
- () Arthritis () Other _____ () I don't know

SOCIAL HISTORY

I am () single () married () separated () divorced () widow-widower
Number of children at home _____ away from home _____

I work as a _____

I am retired from _____

() I live with my children or other relatives. Explain _____

I drink () beer () wine () hard drinks () daily () socially () I DON'T USE ALCOHOL
() I honestly consider myself to drink too much () others think I drink too much

() I smoke () cigarettes () pipe () cigars _____ packs/day for _____ years
() I DON'T USE TOBACCO

My recreational activities include () jogging () bicycling () sports – list _____



REVIEW OF SYSTEMS

- Do you have physical problems other than neck or back? _____
- eyes ears nose throat Explain _____
 - skin moles, spots, or sores that are unusual Explain _____
 - unusual lumps or bumps under skin such as enlarged lymph nodes Explain _____
 - Trouble breathing shortness of breath cough pain with breathing other _____
 - Chest pains/discomfort - sharp aching arm discomfort along with chest discomfort
 with activity after meals when under stress other _____
 - trouble with stomach or bowels - nausea/vomiting stomach pain diarrhea
 constipation bleeding in bowel movements black tarry stools other _____
 - trouble with legs fatigue with walking/relieved by rest other _____
 - trouble with nerves
 - anxious/fearful
 - I feel down/depressed

FEMALES:

- I have problems with menstrual periods vaginal bleeding after menopause vaginal discharge
- other problems you need to discuss with a doctor

MALES:

- problems with sexual function discharge other problems you need to discuss with a doctor
-

