Gavin Orthopaedics, LLC

MOSS CREEK ORTHOPAEDIC URGENT CARE
Scrapes • Sprains • Shots • Stitches

# Established Patient Back/Neck Visit

Date:_____

Age:_____

Patient Name: _____

Date of Birth _____

Referring Physician: _____ Primary Physician _____

Problem with: ☐ Back ☐ Neck Estimated date first noticed problems: _____/_____/_____

Was this due to injury? ☐ Yes ☐ No Was injury work related? ☐ Yes ☐ No

Currently working? ☐ Yes ☐ No How did injury occur :_____

Prior Back/Neck surgery? ☐ Yes ☐ No If yes, list date, procedure and doctor _____

How would you rate your worst pain? ☐ 1 (No pain), ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9 and ☐ 10 (severe pain)

Problem is presently: ☐ Worsening ☐ Unchanged ☐ Improving

The pain is? ☐ Constant ☐ Intermittent

Location? ☐ Neck ☐ Shoulder ☐ Below Knee ☐ Below Elbow to Hand
☐ Groin ☐ Buttock ☐ Upper Back ☐ Lower Back ☐ Thigh

Quality? ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing
☐ Tingling ☐ Electric Shocks

Other Complaints? ☐ Locking ☐ Giving way ☐ Back Pain ☐ Night Pain
☐ Stiffness ☐ Swelling ☐ Weakness ☐ Pain arising from chair

**Activities which were interfered with include:**

☐ Sports ☐ Walking ☐ Shopping ☐ Stair Climbing ☐ Sleeping
☐ Running ☐ Gardening ☐ Working ☐ Other_____

**When do Symptoms occur?:** ☐ Night ☐ Morning ☐ At Work ☐ During Exercise ☐ After Exercise
☐ Other_____

**Treatments that have been tried include:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Anti Inflammatory_____ | ☐ Helped? | ☐ Not Helped | ☐ Physical Therapy | ☐ Helped? | ☐ Not Helped |
| ☐ Pain Medications _____ | ☐ Helped? | ☐ Not Helped | ☐ Crutches/Cane | ☐ Helped? | ☐ Not Helped |
| ☐ Exercises | ☐ Helped? | ☐ Not Helped | ☐ Injection | ☐ Helped? | ☐ Not Helped |
| ☐ Reduced Activity | ☐ Helped? | ☐ Not Helped | ☐ MRI | | |
| ☐ Bracing | ☐ Helped? | ☐ Not Helped | ☐ Other_____ | | |

**Review of Systems: Any Changes since the last visit with the following: Circle & Explain**

| | | |
|---|---|---|
| ☐ Weight Loss | ☐ Mouth/Throat | ☐ Kidneys/Bladder |
| ☐ Fevers | ☐ Heart | ☐ Skin |
| ☐ Eyes | ☐ Lungs | ☐ Nerves/Aniety/Depression |
| ☐ Ears | ☐ Stomach | ☐ Bleeding/Clotting |
| ☐ Nose | ☐ Bowels | ☐ Recurrent Infections |

Explain: _____

New Medication?: _____

Recent Surgery?: _____

Any Questions for the Dr. Gavin that you would like answered?:_____

_____

Patient Signature: _____

Physician Signature: _____