ARVADA SPORT and SPINE GROUP

12189 W. 64th Ave. #102
Arvada, CO 80004
303-424-9549
www.arvadasportandspine.com

Legal Name: First: _____ Middle Initial: ___ Last: _____Preferred Name:_____

Address:_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: _____ Email: _____

Social Security Number: _____ Marital Status: _____ Spouse Name:_____

□Employed □Full time student □Part time student □Other Employer: _____Type of Work:_____

Emergency Contact Name: _____ Emergency Contact Phone: _____

How did you hear about Arvada Sport and Spine Group?_____

IF A MINOR: Parent's Legal Name: First:_____ Middle Initial:____ Last:_____

Parent's DOB:_____ Parent's Social Security Number:_____ Parent's Employer:_____

Parent's Home Phone:_____ Parent's Cell Phone:_____ Parent's Work Phone:_____

I the undersigned parent or legal guardian of _____, a minor, do hereby authorize and consent to treatment by Arvada Sport and Spine Group. _____(parent or guardian signature)

MEDICAL HISTORY

Primary Care Physician **(required)**:_____

Primary Care Physician Address or Phone #:_____

I give Arvada Sport and Spine Group my permission to communicate my progress to my primary care physician: □ Yes □ No

Briefly List Any and All Health Problems:_____

Has any doctor diagnosed you with Hypertension? ❑ Yes ❑ No If yes, describe:_____
Has any doctor diagnosed you with Diabetes? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II
Please list ALL surgeries and dates:_____

List any known allergies you have had to any medications or other. If no allergies are known, check here: ❑

_____

SOCIAL HISTORY

Caffeine Use: ❑Not at all ❑Occasionally ❑Often
Chew Tobacco: ❑Not at all ❑Occasionally ❑Often
Drink Alcohol: ❑Not at all ❑Occasionally ❑Often
Exercise: ❑Not at all ❑Occasionally ❑Often
Experience Stress: ❑Not at all ❑Occasionally ❑Often
Smoke: ❑Not at all ❑1 pack or less per day ❑more than 1 pack per day
Wear seatbelts: ❑Always ❑Never ❑Usually

FAMILY HISTORY

Does anyone in your family (parents, siblings, children) have a history of (please list relation in the blank beside the condition):

❑Arthritis_____ ❑Diabetes_____ ❑Cholesterol_____
❑Cancer_____ ❑Thyroid_____ ❑Psychiatric_____
❑Cardiovascular Problems: _____ ❑Stroke_____ ❑ Other: _____

Current medications, including frequency and dosage if known (use back of sheet if needed.) If there are no current medications, check here: ❑

Medication	Frequency	Dosage	Start Date

Recreational Activities:_____

Patient/Parent/Guardian Signature:_____ Date:_____

History of Present Illness

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Please describe **in detail** why you are here today:_____

_____

_____

When did pain/problem(s) begin time wise? _____

Was there a specific event that led to pain/problem(s)? _____

Are any of these complaint(s) the result of a fall or accident? Yes or No

Is this a new condition/problem? Yes or No

- If No then how long have you dealt with this problem?_____
- If No then have you sought help or treatment for this problem before? Yes or No
- If you've received treatment for this problem before who was it with and how did your condition respond to the treatment?

_____

_____

What is your pain **RIGHT NOW**? Circle the number: **0 1 2 3 4 5 6 7 8 9 10**
No pain Worst Pain Possible

What is your **TYPICAL or AVERAGE** pain? Circle the number: **0 1 2 3 4 5 6 7 8 9 10**
No pain Worst Pain Possible

Describe the character of pain/problem(s). Example: achy, dull, sharp, burning, tingling etc…

_____

Is the pain/discomfort constant or does it come and go? _____

What action or event causes the pain to feel better? _____

What action or event causes the pain to become worse? _____

Does pain radiate into other areas of the body? Yes or No

- If Yes where does pain radiate to? _____
- If Yes is radiating pain constant or does it come and go? _____

How does this pain or condition affect your daily activities? Example: Sleep, work, hobbies, household duties etc…

_____

_____

Functional Assessment/Activities of Daily Living – **Check the box**

Headaches
- ☐ Having no headaches
- ☐ Having 1 headache per month
- ☐ Having 2 headaches per month
- ☐ Having 1 headache per week
- ☐ Having 2 headaches per week
- ☐ Having 3 headaches per week
- ☐ Having 4-5 headaches per week
- ☐ Having 6-7 headaches per week
- ☐ Having constant headaches

Picking up objects
- ☐ Able to lift heavy objects without extra pain
- ☐ Able to pick up 45 lbs. without increased pain
- ☐ Able to pick up 40 lbs. without increased pain
- ☐ Able to pick up 35 lbs. without increased pain
- ☐ Able to pick up 30 lbs. without increased pain
- ☐ Able to pick up 25 lbs. without increased pain
- ☐ Able to pick up 20 lbs. without increased pain
- ☐ Able to pick up 15 lbs. without increased pain
- ☐ Able to pick up 10 lbs. without increased pain
- ☐ Unable to lift anything due to pain

Lying
- ☐ Able to lay as long as would like without pain
- ☐ Able to lay 120 minutes without pain
- ☐ Able to lay 90 minutes without pain
- ☐ Able to lay 60 minutes without pain
- ☐ Able to lay 50 minutes without pain
- ☐ Able to lay 40 minutes without pain
- ☐ Able to lay 30 minutes without pain
- ☐ Able to lay 20 minutes without pain
- ☐ Able to lay 10 minutes without pain
- ☐ Unable to lay at all without pain

Personal Care
- ☐ Able to do without causing extra pain
- ☐ Able to do, but causes extra pain
- ☐ Able to do independently with pain, but must do slowly and carefully
- ☐ Able to manage most personal care with some help
- ☐ Able to do with daily assistance

Recreation
- ☐ Able to engage in all recreational activities with no pain
- ☐ Able to engage in all recreational activities but with pain
- ☐ Able to engage in the major, but not all recreational activities
- ☐ Able to engage in a few usual recreational activities
- ☐ Able to do very little recreational activities
- ☐ Unable to do any recreational activities

Sit to Stand
- ☐ Able to get out of high chair without pain
- ☐ Able to get out of medium height chair without pain
- ☐ Able to get out of low chair without pain
- ☐ Able to get out of lazy boy recliner without pain
- ☐ Able to get out of any chair without increased pain
- ☐ Unable to get out of any chair without assistance and pain

Sitting
- ☐ Able to sit with no trouble
- ☐ Able to sit 8 hours before having pain
- ☐ Able to sit 7 hours before having pain
- ☐ Able to sit 6 hours before having pain
- ☐ Able to sit 5 hours before having pain
- ☐ Able to sit 4 hours before having pain
- ☐ Able to sit 3 hours before having pain
- ☐ Able to sit 2 hours before having pain
- ☐ Able to sit 1 hour before having pain
- ☐ Unable to sit due to symptoms

Sleeping
- ☐ Able to sleep with no trouble
- ☐ Slightly disturbed (loss of less than 1 hour of sleep)
- ☐ Mildly disturbed (loss of 1-2 hours)
- ☐ Moderately disturbed (loss of 2-3 hours)
- ☐ Severely disturbed (loss of 3-5 hours)
- ☐ Completely disturbed (loss of 5-7 hours)

Standing
- ☐ Able to stand as long as desired without pain
- ☐ Able to stand 60 minutes without pain
- ☐ Able to stand 45 minutes without pain
- ☐ Able to stand 30 minutes without pain
- ☐ Able to stand 25 minutes without pain
- ☐ Able to stand 20 minutes without pain
- ☐ Able to stand 15 minutes without pain
- ☐ Able to stand 10 minutes without pain
- ☐ Able to stand 5 minutes without pain
- ☐ Unable to stand at all due to pain

Walking
- ☐ Able to walk with no trouble
- ☐ Able to walk 1 or more miles
- ☐ Able to walk ½ mile
- ☐ Able to walk 1 block
- ☐ Able to walk 100 feet
- ☐ Able to walk 50 feet
- ☐ Able to walk 10 feet
- ☐ Unable to walk due to symptoms

Print Patient Name:_____

Patient/Parent/Guardian Signature:_____ **Date:**_____