CENTRAL INDIANA ORTHOPEDICS

Dr. Badman Screening Form

Name: _____ Family Physician: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Hand Dominance (Right or Left): _____

Reason for Visit: _____

Email: _____ Occupation: _____

Physical Therapy: ☐ Yes ☐ No; If yes, how long? _____ Medication for Pain: _____

Have you had any of these treatments? ☐ Injection ☐ Brace ☐ Crutches ☐ Sling

Have you ever had surgery for this problem? Yes No; If yes, surgery date(s)/Physician(s)/Procedure(s):

_____

Is your skin sensitive to costume jewelry/nickel? ☐ Yes ☐ No

Are you currently under the care of a Pain Management physician? ☐ Yes ☐ No; If yes, Who? _____

Location of Pain: _____ Duration of Pain: _____ Work Related? _____

Did pain begin after a specific activity/injury? _____ ☐ Gradual ☐ Sudden Date/Length of injury: _____

Injury was due to: ☐ Sport/Exercise:(type) _____ ☐ Auto Accident ☐ Work Related ☐ Other: _____

Explain injury: _____

Have you noted any arm or leg weakness/numbness? _____

Pain Scale *(circle one)*: 0 (No Pain), 1 2 (Mild), 3 4 5 6 7 (Moderate), 8 9 10 (Severe)

Your pain is: ☐ Constant ☐ Intermittent Does your pain wake you from your sleep? ☐ Yes ☐ No

What best describes your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

What makes your symptoms worse?

☐ Standing ☐ Walking ☐ Running ☐ Getting Up Stairs ☐ Twisting ☐ Kneeling ☐ Squatting ☐ Lifting ☐ Reaching ☐ Gripping

What makes your symptoms better? _____

Since your problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

ANY RECENT IMAGING (with Dates and Location of Imaging)

Xray: _____

CT Scan: _____

MRI: _____

EMB/NCV: _____

CT Myelogram: _____

Bone Scan: _____

Other: _____

REVIEW OF SYSTEMS

- ☐ Fever
- ☐ Fatigue
- ☐ Loss of Appetite
- ☐ Current Illness
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Arthritis
- ☐ Poor Balance
- ☐ Joint Pain
- ☐ Stiffness
- ☐ Numbness
- ☐ Swelling
- ☐ Deformities
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gerd
- ☐ Ulcers
- ☐ Nausea
- ☐ Vomitting
- ☐ Bladder Infection
- ☐ Kidney Disease
- ☐ Retention
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Clotting Disorder/Blood Clots
- ☐ Strokes
- ☐ TIA's
- ☐ Epilepsy
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ MRSA History
- ☐ Latex Allergy

PAST MAJOR MEDICAL HISTORY

- ☐ Aids
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Clots/DVT
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gerd/Reflux
- ☐ HIV
- ☐ Gout
- ☐ Heart Attack when: _____
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Respiratory Issues
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Strokes/TIA's
- ☐ Thyroid Disorder
- ☐ Ulcers (Stomach)
- ☐ Other:

_____

_____

_____

PAST MAJOR SURGICAL HISTORY

- ☐ Back or Neck Surgery (Fusions, Etc.)
- ☐ Other _____
- ☐ CABG (Coronary Bypass) when: _____
- ☐ Gastric Bypass
- ☐ Pacemaker
- ☐ Stents
- ☐ None
- ☐ Arthroscopy
- ☐ Joint Replacement by who/what/when:

_____

- ☐ Other:

_____

ALLERGIES

_____

_____

_____

_____

PERTINENT FAMILY HISTORY

_____

_____

_____

_____

_____

SOCIAL HISTORY

Occupation:

_____

_____

- ☐ Currently Working
- ☐ Retired
- ☐ Disabled
- ☐ Unemployed

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Alcohol:

☐ Yes ☐ No

If yes, how much:

_____

Illegal Drug Use:

☐ Yes ☐ No

If yes, drug:

_____

Tobacco:

☐ Yes ☐ Chew ☐ Cigarettes

Packs/Cans Per Day:

_____

How Many Years:

_____

- ☐ No
- ☐ Quit (when) _____

PLEASE LIST ALL MEDICATIONS AND DOSAGES (Prescription and Over-the-Counter)

_____

_____

_____

_____

_____

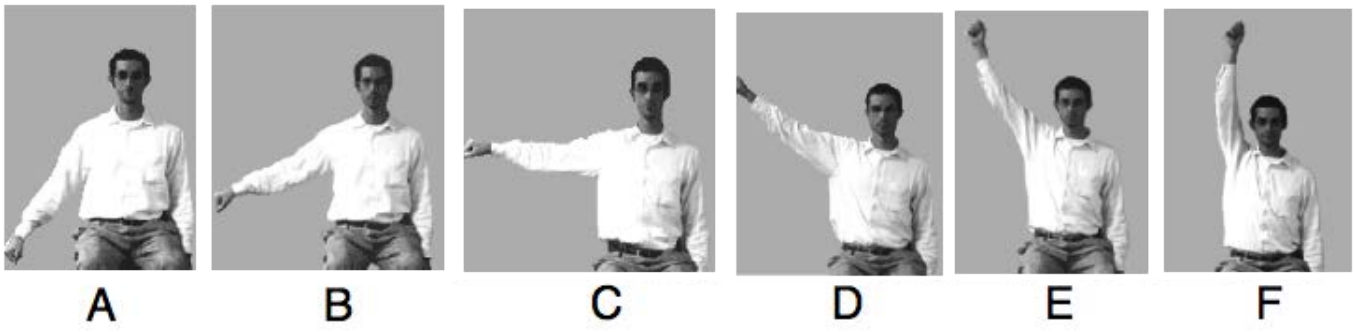
Are you currently receiving or plan to apply for: ☐ Workmen's Comp ☐ Unemployment ☐ *FMLA/STD

Patient Signature: _____ Date: _____

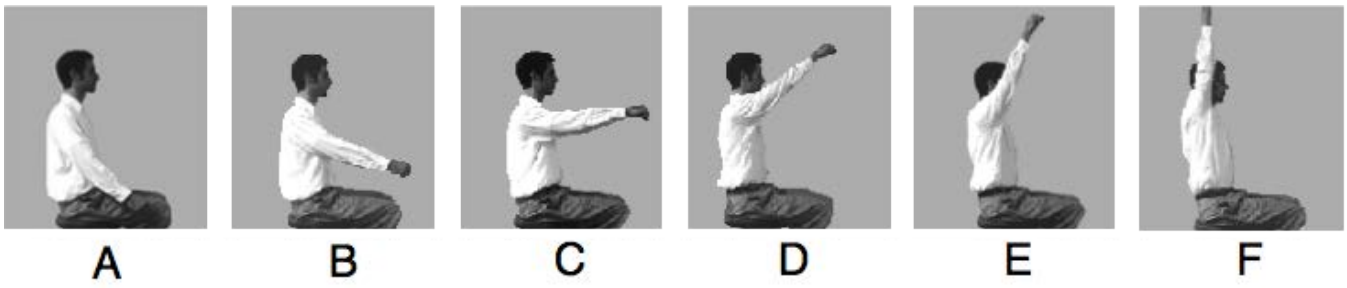
Range of Motion

Please circle the picture which most closely represents your current motion.

ABDUCTION



FORWARD FLEXION



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