SPORTS, PAIN & REGENERATIVE INSTITUTE

103 River Rd STE 101
Edgewater, NJ 07020
Phone: 201-308-8995
www.SPRInstitute.com

TODAY'S DATE: _____

PATIENT FIRST NAME_____

LAST NAME _____

BP_____ Puke_____
HT_____WT_____

DATE OF BIRTH _____ AGE: _____ SEX: MALE FEMALE

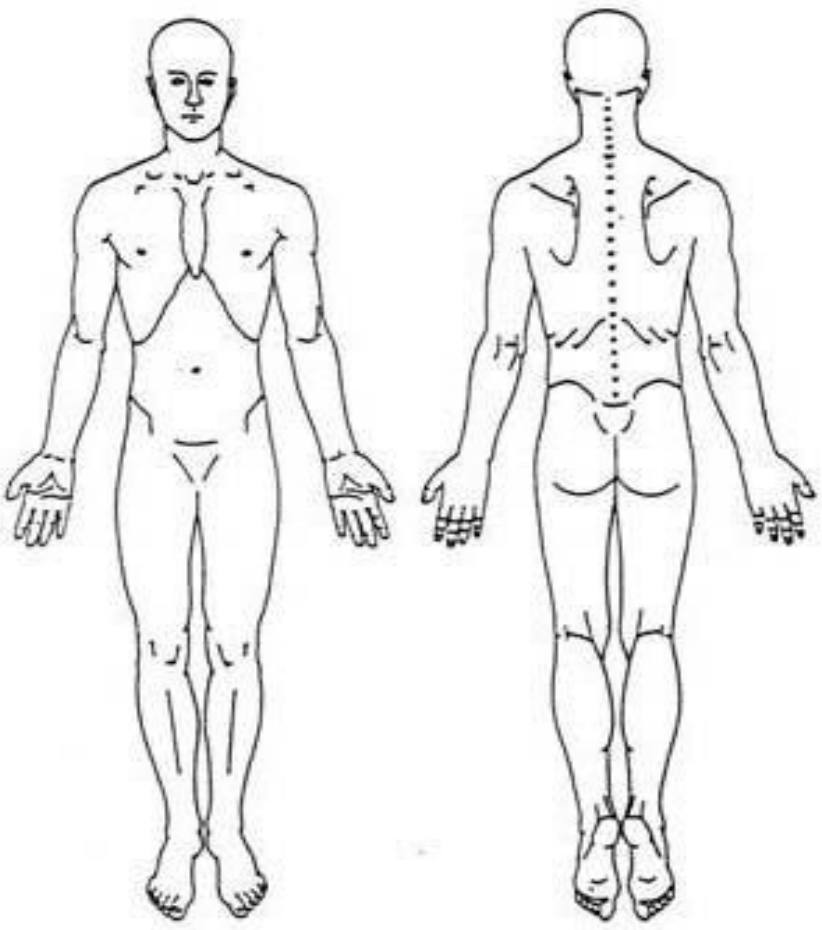
REFERRED BY: _____ REFERRING DOCTOR'S PHONE #:_____

WHY ARE YOU HERE? _____

DURATION OF SYMPTOMS: _____ HOW DID IT BEGIN? _____

Please complete the pain drawing below by marking where you feel pain right now on the figures below.

(If you do not feel pain, please skip to page 2)



RATE YOUR PAIN ON A SCALE OF 0 TO 10
(0 = no pain 10 = extreme pain)

1. Right Now: 0 1 2 3 4 5 6 7 8 9 10

2. At Best: 0 1 2 3 4 5 6 7 8 9 10

3. At Worst: 0 1 2 3 4 5 6 7 8 9 10

4. What does the pain feel like (cirlce all that applies)?

Sore	Aching	Burning
Shooting	Throbbing	Dull
Tender	Stabbing	Tingling
Sharp	Pulling	Cramping
Radiating	Unsure	

5. What makes it better (cirlce all that applies)?

Heat	Cold	Bending Forward
Sitting	Standing	Bending Back
Walking	Twisting	Lying Down
Coughing	Sneezing	Weather Change
Sexual Intercourse		Nothing

6. What makes it worse (cirlce all that applies)?

Heat	Cold	Bending Forward
Sitting	Standing	Bending Back
Walking	Twisting	Lying Down
Coughing	Sneezing	Weather Change
Sexual Intercourse		Nothing

7. Since the pain began, is it (check one): getting better getting worse staying the same
8. Have you ever had pain in this area prior to this episode? NO YES If yes, when? _____
9. Have you had any recent falls? NO YES
10. How far can you walk? _____ Do you require an assistive device (e.g. cane, brace)? NO YES
11. Do you need help with household activities? NO YES

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS (check all that applies)**?**

Easy Bleeding/Bruising	Weight Change	Breathing Problems	Fever/Chills	Heart Problems
Stomach Problems	Joint pain/ Swelling	Morning Stiffness	Weakness	Skin Problems
Bowel/Bladder Changes	Night Pain	Depression/Anxiety	Numbness	Tingling
Shortness of Breath	Vision Change	Sleep Problems	Headaches	Chest Pain
Rash	Other _____			

HAVE YOU HAD ANY OF THE FOLLOWING TESTS OR TREATMENTS FOR YOUR CURRENT PROBLEM?

	NO	YES	Date(s)		NO	YES	Date(s)
X-RAYS	**[ ]**	**[ ]**	_____	**EMG (Nerve Test)**	[ ]	[ ]	_____
CT SCAN	**[ ]**	**[ ]**	_____	**BONE SCAN**	[ ]	[ ]	_____
MRI SCAN	**[ ]**	**[ ]**	_____	**INJECTION**	[ ]	[ ]	_____
SURGERY	**[ ]**	**[ ]**	_____	**PHYSICAL THERAPY**	[ ]	[ ]	_____
MEDICATIONS			_____				

If yes, list names of medications for current problem
_____/_____

MEDICAL HISTORY

PAST MEDICAL PROBLEMS: _____
_____

PAST SURGERIES & DATEs:_____
_____

NAME ALL CURRENT MEDICATIONS:_____
_____

LIST ANY MEDICATION ALLERGIES:_____

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Family Member	Alive	Arthritis	Cancer	Heart Disease	Diabetes	Other
	Y N					
	Y N					
	Y N					

SOCIAL HISTORY (Circle all that applies)

Single Domestic Partner Married Divorced Widow/Widower

Smoker _____packs per day Nonsmoker (if previous smoker quit date: _____)

ALCOHOL CONSUMPTION: YES or NO If so, how many drinks in 1 week _____

RESIDENCE: House Apartment Other (Stairs: YES NO) (Elevator: YES NO)

EMPLOYMENT STATUS: Full Time Part Time Retired Student Unemployed Disability Workers' Compensation

If applicable, Occupation_____

Signature: _____ Date:_____

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Last Name: _____ First Name: _____ MI: _____

Home Phone: _____ Work: _____ Cell: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: M / F

Marital Status: _____ Social Security #:_____

Email Address:_____

Medical Doctor:_____

Referring Doctor:_____

Pharmacy Name:_____

Pharmacy Town & Phone (if applicable):_____

Patient's Employer: _____

Employer's Address:_____

In case of emergency, notify:_____ Phone Number: _____Relationship:_____

Primary Insurance Company

Name:_____

Address: _____

City/State/Zip: _____

Phone Number:_____ ID#:_____Group#:_____

Secondary Insurance Company

Name:_____

Address: _____

City/State/Zip: _____

Phone Number:_____ ID#:_____Group#:_____

Race: (check one) [ ] African American [ ] American Indian or Alaska Native [ ] Asian [ ] Caucasian [ ] Native Hawaiian [ ] Other Pacific Islander [ ] More than one [ ] Prefer not to say

Ethnicity: (check one) [ ] Hispanic or Latino [ ] Neither Hispanic nor Latino

Preferred Notification Method: (check one) [ ] Mail [ ] Phone [ ] Email

Check off to authorize our staff to leave a message: (test results, appointment reminders) [ ] On your voice mail [ ] With a family member [ ] Speak to me directly

Signature:_____ Date:_____