MRN: _____

Name:_____

OrthoSouth

Dr. Winfred B. Abrams
Pre-Appointment Instructions

Documents

- If this is your first appointment with Dr. Abrams, print this form before and complete. One will be provided for you at your appointment if you are unable to complete it before your appointment.

- Bring **a disc** of your x-ray/CT scan/MRI if it was NOT ordered or performed by OrthoSouth.

- Bring **outside medical records** if you have been treated elsewhere for the pain you complain of today. Including previous surgery records if applicable).

- Bring an active list of **medications, medical conditions, and allergies.**

- Bring the name and phone number of your **pharmacy**. Or you can list this information on Page 3 of this document.

- Bring the name of your **health care providers** (ex/ Primary Care, Cardiologist, Neurologist, etc.). Or you can list this information on Page 3 of this document.

- Bring your Pacemaker card, Defibrillator card, Stent card, or other **implanted device information** if applicable.

- Bring a **Family Medical Leave Act (FMLA) form** or your **Short-Term Disability (STB)** form if you are requesting either with your job. Please include your job work description and what you are requesting.

Memphis: 6286 Briarcrest Ave., Suite 200, Memphis, TN 38120
Germantown: 2100 Exeter Rd., Suite 200, Germantown, TN 38138
Southaven: 7580 Clarington Cv., Suite 100, Southaven, MS 38671
Appointments: 901-259-1600
Main Phone: 901-641-3000 **Main Fax: 901-259-1698**
Direct Phone: 901-259-7603 **Direct Fax: 901-259-7649**

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Dr. Winfred B. Abrams

NEW PATIENT WORKSHEET

A. Present History of Illness (SELECT ONLY ONE BODY REGION FOR NEW VISITS – CAN BE BOTH SIDES)

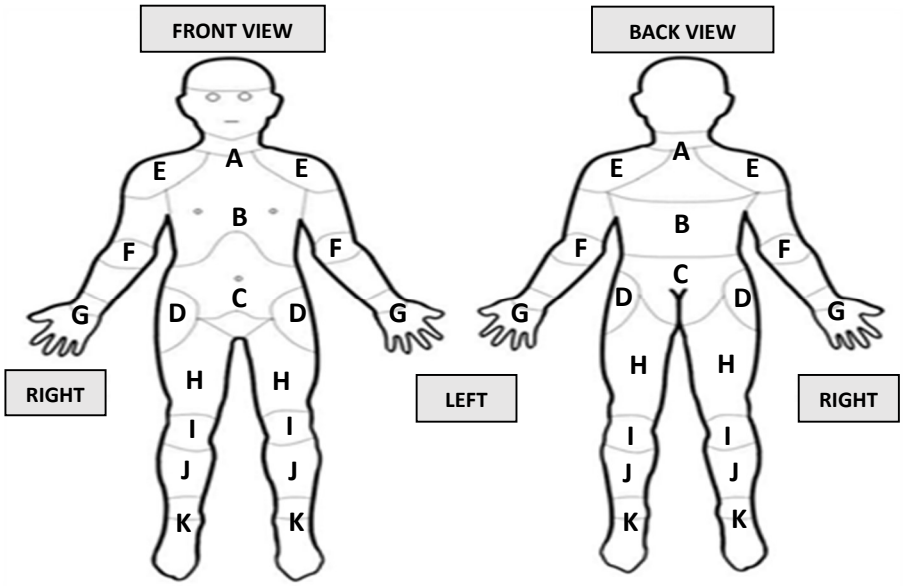
1. **My pain is located on ☐ BOTH SIDES ☐ RIGHT SIDE ☐ LEFT SIDE.**
2. **Please circle NO MORE than 2 DIFFERENT LETTERS indicating the painful area.**
   - **The same letter counts as one of the 2-limit. (Ex: 2 Ds count as one letter)**
3. **Check the box next to how you would describe the pain (top boxes on both sides of the body diagram.)**
4. **Fill in pain % boxes. Each box must equal 100% (Ex: 60% & 40%) (Bottom boxes).**

NERVE PAIN

- ☐ burning
- ☐ stabbing
- ☐ tingling/numb
- ☐ shooting/electric
- ☐ hot knife
- ☐ tearing

% of pain with bending: ____%

% of pain with extending: ____%



JOINT/MUSCLE PAIN

- ☐ dull
- ☐ achy
- ☐ throbbing
- ☐ annoying
- ☐ boring

% of pain in the neck/ back: ____%

% of pain in the arms/legs: _____%

I have had this pain for _____ (weeks / months/ years).

My average pain is _____ out of 10 and the highest pain I have experienced is _____ out of 10.

My symptoms are made worse by _____
and are made better by _____.

My pain was caused by an injury or accident [ ] yes or [ ] no. The date of injury was _____.

The injury was as work related [ ] yes or [ ] no; I work at _____.

My job description / Lifestyle (if retired) requires me to _____
and I unable perform the task(s) of_____.

I am referred by Dr./NP/PA _____ located at _____.

I am undergoing litigation ☐ yes or ☐ no

I am undergoing workman's compensation claims ☐ yes or ☐ no

I am unemployed ☐ yes or ☐ no. I am retired ☐ yes or ☐ no

I have had physical therapy or chiropractor therapy in the past 3-6 months [ ] yes or [ ] no.

If yes, where? _____. How long? _____(weeks/months).

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B. Medical Care Team and Pharmacy

Primary Care: _____ #: (_____)_____-_____

Cardiologist: _____ #: (_____)_____-_____

Other Specialist: _____ #: (_____)_____-_____

Other Specialist: _____ #: (_____)_____-_____

BLOOD THINNER? ☐NO ☐YES: NAME: PRESCRIBER: _____

Pharmacy Name: _____

Phone #: (_____)_____-_____

Zip Code: _____

C. Information I need to know.

Medications you have tried and failed for the condition you complain of **today**.

Please note improvement in pain as **minimal** (0-25%), **mild** (26-50%), **moderate** (51-75%), or **significant** (>75%).

Name	Dose	Frequency	Duration	Side Effects	Improvement in Pain

D. Previous Spinal Interventions

Injections or spinal surgeries.

Please note improvement in pain as **minimal** (0-25%), **mild** (26-50%), **moderate** (51-75%), or **significant** (>75%).

Procedure	Date	Physician Who Performed the Procedure	Location Performed	Improvement in Pain

E. My Current Health Conditions

☐ Hypertension
☐ Atrial Fibrillation /flutter
☐ Fibromyalgia
☐ Blood clots
☐ High Cholesterol
☐ History of Stroke
☐ Depression
☐ HIV or Hepatitis
☐ Renal Disease
☐ Lung Disease
☐ Anxiety
☐ Osteoarthritis
☐ Coronary Artery Disease
☐ Previous Chronic Pain
☐ Diabetes

F. My goals of today's visit: _____.