

**Dr. Todd M. Aordkian**

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Dear Patient:

Welcome back. Please take a few moments to update your records. This first page which concerns your demographic and insurance information needs to be filled out only if it has changed since the last time you were here.

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Home Phone No.: \_\_\_\_\_

Marital Status: **S M D W** Sex: **M F** Work No.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Primary Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

**Guarantor/Insurance Information**

**Primary** Insurance Name: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Soc Sec No.: \_\_\_\_\_

Insured's Birthday: \_\_\_\_\_ Relationship: \_\_\_\_\_

**ABOUT YOUR CONDITION:**

What is your major complaint? \_\_\_\_\_

How did it start? \_\_\_\_\_

When did it begin? \_\_\_\_\_ How is it changing? better worse staying the same

On the scales below, rate your pain intensity by circling the appropriate number. 0 = no pain, 10= unbearable pain.

1. My pain when it is at its worst is: 0 1 2 3 4 5 6 7 8 9 10

2. My pain right now is: 0 1 2 3 4 5 6 7 8 9 10

3. My average pain is: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Occasionally (26-50% of the day)
- Frequently (51-75% of the day)
- Intermittently (0-25% of the day)

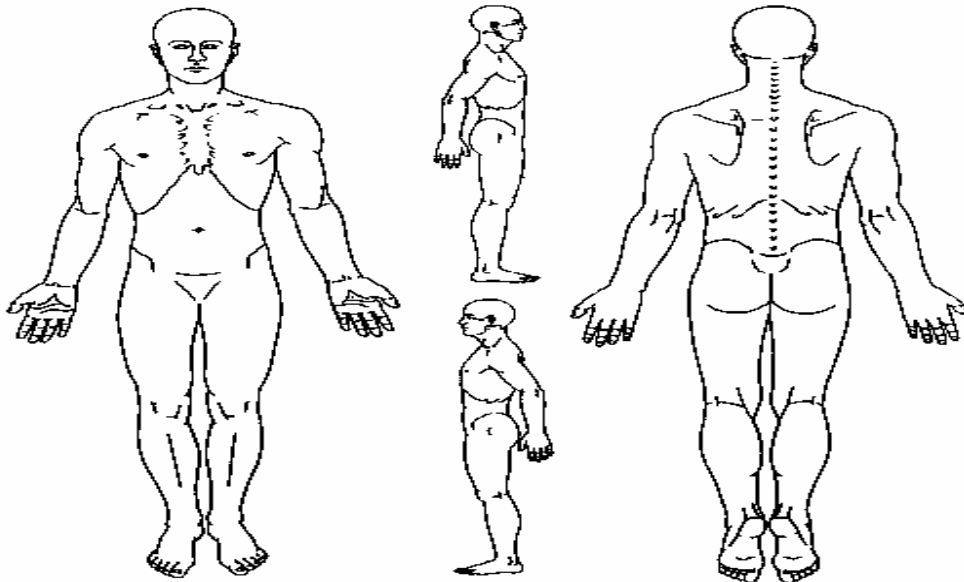
To what degree do your symptoms interfere with your daily activities?

- Not at all
- Mild (forgotten with activity)
- Moderate (prevents full activity)
- Severe (no activity possible)

Specifically they interfere with my:  work  personal care social life recreation

I have difficulty with:  lifting  walking  standing  sitting  driving  sleeping

**PAIN DIAGRAM: Please mark the location of your pain on the figure below.**



In general, how would you describe your overall health?

- Excellent
- Very Good
- Good
- Fair
- Poor

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_