Radiotherapy Centers of Kentuckiana
The US Oncology Network

David P. Musich, MD
Lawrence Hochman, DO
Matthew Forsthoefel, MD

General Painful Joints Intake Form

Patient Name: _____ Date of Birth: _____

General Data:

Have you consulted a practitioner in the past for pain symptoms and/or disorder?
If yes, name of the practitioner? _____

Height _____ Weight _____

Mark any that apply:

	Bone Fracture / Trauma		Infection of bone/joint		Chronic Polyarthritis
	Diabetes Type I or II		Perfusion Disorder		Osteoporosis
	Peripheral Nerve disorder		Thyroid Disorder		Other: _____

Have you been diagnosed with Rheumatoid or Psoriatic arthritis in the past? No Yes
If yes, when? _____ What treatment was prescribed? _____

Do you drink alcohol? □ No □ Yes, how much per week_____
Do you use tobacco? □ No □ Yes, how much per week _____

Where do you feel pain:

	Knee(s)		Feet / Ankle / Toes
	Shoulder(s)		Elbow(s)
	Hip(s)		Other _____

How long have you experienced pain:

	1-4 Weeks		3-6 Months		___# of Years
	1-3 Months		6-12 Months		Other: _____

How is the pain characterized? (exact description) _____

When does the pain occur? (exact description) _____

In Which Direction is the pain irradiating? (exact description) _____

Which degree of pain exists? Please check each box

	None (0)	Mild (1)	Moderate (2)	Severe (3)
Pain at **Strain**				
Pain at Night				
Permanent Pain				
Pain at **Rest**				
Pain at **First Movement**				

How do you score you pain overall? 1-10, 10 being most severe pain
_____

Radiotherapy Centers OF KENTUCKIANA

The US Oncology Network

Which Symptoms exist? Check all that apply

	Redness of Joints		Swelling of Joints
	Limited Motion		Loss of Function
	Restricted Profession		Restricted Sports

Have the pain symptoms increased within the past time period? No Yes
If yes, within the past
[ ] Weeks
[ ] Months
[ ] Years

Previous/Current Treatments:

Type of Treatment:	**Period (From/To):**	**Success: Yes or No**
Oral Medications: Steroids Non-Steroidal Medications Opioids / Pain Relief Others		
Physical Therapy:		
Local Injections: Number, Type of Injection		
Local Ointments: Name of medication		
Surgery Date, Type of Surgery		
Electrotherapy		
Other Treatments:		