Connecticut
Disc & Laser Therapy Centers
Shelton Medical Center | 9 Cots Street | Suite 2c | Shelton, CT 06484

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Patient Information Form

Please answer all the questions below in full. As you answer, please be as specific and as detailed as possible. Our office treats a variety of conditions including but not limited to severe/chronic pain, conditions such as carpal tunnel disease, nerve pain, neck pain, knee pain, shoulder pain, back pain and arthritis and stenosis of various body regions. Dr. Dalfino will review this information with you to determine if you are a good candidate for care.

Today's Date _____

Name _____ Age _____ Birthdate _____ Sex M F

Address _____ City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Place To Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes No

Email Address _____

SS# _____ Marital Status S M W D Spouse Name _____

Employer _____ Occupation _____ Length of Employ _____

What Is Your Reason For Prompting Your Request For A Consultation With The Doctor?

_____

How Do You View Your Problem (circle one)....
MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

How Serious Do You Think Your Condition Is? _____

In Reference To The Severity How Would You Rate it On A Scale Of 0-10 _____

How Did You Hear About Connecticut Disc & Laser Therapy Centers? _____

1. In spite of the fact that you are not a pain specialist, you are in fact the person who knows more about your condition more than anyone else. In your own words and in your own opinion what do you think the real problem is?

_____

2. How long have you been like this?

_____

3. What actions or activities do you have troubles with or have limitations in?

4. What kinds of treatments have you received?

Physical Therapy	Y / N	Approximate Date		Was There Any Relief?	Y / N
Injections	Y / N	Approximate Date		Was There Any Relief?	Y / N
Medication(s) Rx or OTC	Y / N	Approximate Date		Was There Any Relief?	Y / N
Surgeries	Y / N	Approximate Date		Was There Any Relief?	Y / N

Other

5. What actions can you take that temporarily decrease the pain?

6. What activities/movements are guaranteed to increase your pain and worsen your condition?

7. What does the pain feel like (sharp, dull, achy, toothache, shooting, stabbing, numb, tingling, etc...) and where?

8. Is it worse in the morning or the evening or later in the day?

9. What do you think will happen to you if you cannot find a solution to your pain/problem?

10. What percentage of time are you aware of your main problem? (circle one)
Occasionally (25% of the time)
Intermittently (50% of the time)
Frequently (75% of the time)
Constant (90-100% of the time)

List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above

1. How Long?
2. How Long?
3. How Long?

11. On a Scale of 0-10 (10 being unbearable, 0 being No Pain or Discomfort) Please rate the following...

The HIGHEST your pain gets WITHOUT medication
The LOWEST your pain gets WITHOUT medication
The HIGHEST your pain gets WITH medication
The LOWEST your pain gets WITH medication

I consent to allow Dr. Dalfino to speak with me and perform an evaluation (if necessary) in order to determine if I am a good candidate for treatment. It is also my understanding that the consultation is at no charge. The questions on this form have been answered completely and truthfully to the best of my knowledge.

Patient / Client Signature Date

Have you had ANY of the following?
(Fill in the bubble to the left.)

GENERAL

O Chills
O Convulsions
O Dizziness
O Fainting
O Fatigue
O Fever
O Headaches
O Loss of Sleep
O Loss of Weight
O Nervousness
O Wheezing
O Bronchitis

CARDIOVASCULAR

O High Blood Pressure
O Low Blood Pressure
O Pain over Heart
O Poor Circulation
O Rapid Heart Beat
O Previous Heart Problem
O Slow Heart Beat
O Stroke
O TIA
O Swollen Ankles
O Varicose Veins
O Aortic Aneurysm
O Bruise Easily

DISEASES/CONDITIONS

O Appendicitis
O Anemia
O Arthritis
O Alcoholism
O Abdominal Surgery
O Bleeding Disorder
O Blood Clots
O Breathing Difficulty
O Cancer
O High Cholesterol
O Colon Problems
O Diabetes
O Depression
O Epilepsy
O Eczema
O Eating Disorder
O Glaucoma
O HIV+
O Heart Disease
O Hernia
O Headaches
O Influenza
O Kidney Disease
O Liver Disease
O Low Back Pain
O Mental Illness
O Measles
O Mumps
O Pleurisy
O Pneumonia
O Polio
O Prostate Problems
O Hyperthyroid
O Hypothyroid
O Rectal Surgery

EARS/EYES/NOSE/THROAT

O Asthma
O Bad Breath
O Colds
O Dental Difficulties
O Difficulty Swallowing
O Double Vision
O Ear Pain
O Gingival Bleeding
O Hearing Loss
O Hoarse Voice
O Mouth Sores
O Neck Mass
O Neck Tenderness
O Neck Stiffness
O Nasal Congestion
O Nasal Discharge
O Nose Bleeding
O Sinus Problems
O Sore Throats
O Thyroid Problem

GASTRO-INTESTINAL

O Gas
O Colon Trouble
O Constipation
O Diarrhea
O Gallbladder Trouble
O Hemorrhoids
O Liver Trouble
O Nausea
O Stomach Ache
O Poor Appetite
O Poor Digestion
O Vomiting
O Vomiting Blood
O Rectal Bleeding
O Bloating

GENITO-URINARY

O Blood in Urine
O Frequent Urination
O Inability to Control Urine
O Kidney Infection
O Painful Urination

FOR MEN ONLY

O Prostate Trouble
O Lump in Testicles
O Penis Discharge

FOR WOMEN ONLY

O Menstrual Cramps
O Excessive Menstrual Flow
O Hot Flashes
O Irregular Cycle
O Painful Periods
O Birth Control Pills
O Abnormal Pap Smear

MUSCLE/JOINT/BONE

O Pain
O Stiffness / Swelling
O Limited Range of Motion
O Joint Pain
O Weakness
O Muscle Atrophy
O Night Cramps
O Back Pain
O Muscle Pain or Cramps
O Cold Extremities
O Difficulty Walking

NEUROLOGIC

O Seizures
O Dizziness
O Hand Trembling
O Weakness
O Difficulty with Speech
O Loss of Memory
O Loss of Coordination

RESPIRATORY

O Chest Pain
O Chronic Cough
O Difficulty Breathing
O Coughing / Spitting Blood

OFFICE USE ONLY: _____