Patient sticker	**Sports Medicine Intake** North Shore Physicians Group Mass General / North Shore	***Navid Mahooti, MD, MPH*** ***Sports Medicine*** ***Non-Surgical Regenerative Orthopedics*** *Lifestyle Medicine*

How did you find out about Dr. Mahooti?:

- Referred by my primary care doctor (name): _____
- Referred by someone else (who?: other doctor, friend…): _____
- Internet search / Other (please explain): _____

1. In regards to your current symptoms, how relevant (important) are nutrition and the food you eat?
   Circle one: Relevant Not Relevant I don't know

2. Is this a workers compensation case? Yes No
3. Occupation: student / other:_____
4. How many **hours** per day do you sit (at a desk, TV, work...?) 0-2 3-5 6-8 > 8
5. Do you use tobacco? If so, how much? How long?
6. Which hand is your dominant hand (circle one)? Right Left
7. What is your main concern today? _____
8. When did this problem start (specific date or approximate month/year): _____
9. How did the pain/problem start? **(Circle one)** Injury Suddenly, no injury Gradually Other
10. Please ***briefly*** describe what happened:

11. Have you visited another health care provider for **this or a related** problem? Yes No
12. What prior treatments have you received (circle all that apply, **and then list all treatments below**):

None… Medication… Injections…physical therapy…chiropractic…surgery… massage ….other

~Date / Year	**Provider's Name**	**Treatment → Did it help?**
1)		
2)		
3)		

13. Please circle the number on the pain scale (0 = no pain, 10 = excruciating, severe pain)

My pain ***right now*** is rated:	0	1	2	3	4	5	6	7	8	9	10
My pain ***at its worst*** is rated:	0	1	2	3	4	5	6	7	8	9	10
My pain ***at its best*** is rated:	0	1	2	3	4	5	6	7	8	9	10

14. Does the pain "radiate" (move) anywhere? No Yes, please explain:

15. **Aggravating**: What types of things (activities, movements etc) make the pain **worse**, if any?

16. **Alleviating**: What types of things (activities, movements, medicines) make the pain **better**, if any?

OVER ===>

17. Past Medical History (**circle all that apply**):
Heart disease/problems diabetes cancer bleeding disorder/on blood thinners Others (list):

18. Past Surgical History (please list), especially orthopedic operations:

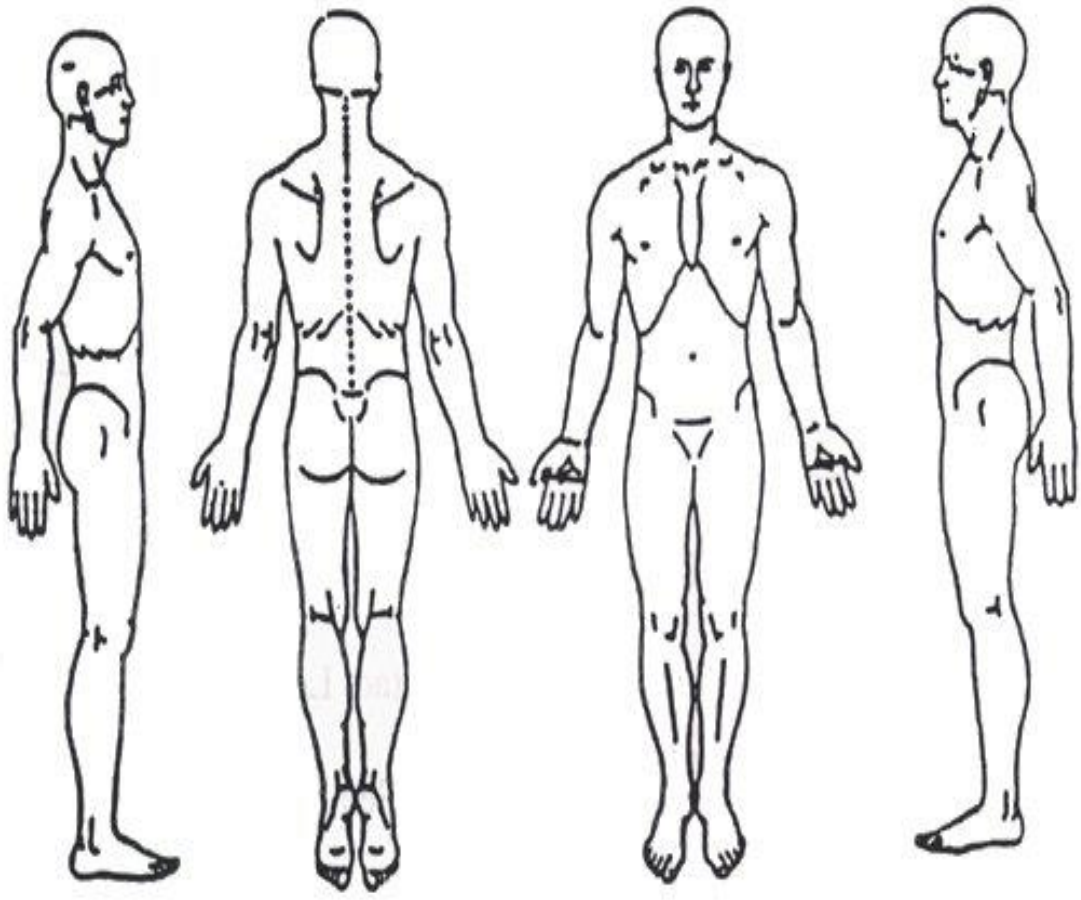
19. Do any of your **family members** have a similar problem? No Yes, explain:

20. Review of Systems: Do you experience any of the following symptoms? **Please circle Y / N**

Y / N Fevers/chills	**Y / N** Shortness of breath / lung problems	**Y / N** Easy bruising / bleeding / on blood thinners
Y / N Skin changes / rashes	**Y / N** Abdominal pain	**Y / N** Depression / Anxiety
Y / N Neurological symptoms (numbness, tingling)	**Y / N** Urinary problems	**Y / N** Allergies to latex, cortisone novacaine, adhesives
Y / N Chest pain / heart problems	**Y / N** OTHER muscle/joint pain	

- Is your primary care doctor aware of this/these symptom(s) Yes No
- Is the symptom in any way related to today's main problem? Yes No

21. On the images below, mark with an "X" the area where your pain is the greatest; if your pain radiates, please use arrows to show the radiation patterns:



22. **WOMEN ONLY:**
    a. When was your last menstrual period?
    b. Over the last 12 months, approximately how many menstrual periods have you had?

23. Is there **something else** that you'd like Dr. Mahooti to know? If yes, please explain: