

Patient's Name: _____

Today's Date: _____

Social Security Number: _____

Date of Birth: _____

Employer: _____

Age: _____

Occupation: _____

Work Phone: _____

Referred By: _____

Family Doctor: _____

What doctor are you seeing today? Lynch Pocos Powers Shine

How did you hear about our office? Doctor ER Friend Phone Book

Other: _____

What is your **primary** Orthopaedic problem today? Pain Tingling Numbness Instability Swelling

Stiffness Other: _____

Where is the location of your **primary** problem? Right Side Left Side Both Sides

What body part is involved with your primary orthopaedic problem? Neck Shoulder Elbow

Forearm Wrist Hand Finger Thigh Mid Back Low Back Pelvis Hip

Knee Lower Leg Ankle Foot Toe

Indicate any past testing you've had done for this problem. None X-rays MRI CAT Scan

Lab Tests EMG Ultrasound

When did the symptoms begin? Gradually Suddenly, without injury After an injury / accident

When did the injury of accident occur? Write a date: _____

How did the injury or accident occur? Write clearly and in complete sentences below.

Was the injury work related? No Yes Date reported to employer: _____

List all allergies that you have.

Type of Allergy	Reaction

What **pain medications** are you taking? None Advil Aleve Aspirin Celebre

Codeine Darvocet Motrin Naprosyn Percocet Tylenol Tylox Ultram

Vicodin

Stroke TB Other: _____

What is your BROTHERS' status?

Living Deceased Unknown

Please indicate your SISTERS' medical conditions.

Arthritis (Osteo) Cancer - Type: _____ Diabetes Heart Disease High Blood Pressure
 Stroke TB Other: _____

What is your SISTERS' status?

Living Deceased Unknown

Are you right-handed or left-handed?

Right Left

What is the highest level of education you have received?

Student High School Some College

Tech. School College Grad Grad School

What is your marital status?

N/A Single Married Divorced Separated Widowed

Do you smoke tobacco?

No Yes

If yes, how many packs per day?

Less than one One Two More than three

If yes, for how many years?

Do you drink alcohol?

No Yes

If yes, how frequently?

Rarely Socially (2-3 per week) Daily

Do you drink caffeinated beverages?

No Yes

If yes, list the type and number per day: _____

Sign and date

Patient's Signature

Date

Clinician's signature

Date

ed