

_____/_____/_____
Last Name First Name Appointment Date What Dr. are you seeing today?

CC: Chief complaint: What is the reason for this visit? _____

Did you bring films/disc? X-Ray Y N MRI Y N CD/DVD Y N

Location: What is the location of your injury? *Check all that apply*

- Spine/Back Neck R Shoulder L Shoulder R Arm L Arm R Elbow L Elbow L Wrist R Wrist
 R Hand L Hand R Hip L Hip Toes Finger Pelvis Chest Ribs Clavicle
 R Leg L Leg R Knee L Knee R Ankle L Ankle R Foot L Foot Other: _____

State of NY – Workers Compensation: If this injury was WORK RELATED, Please answer all of the questions below.

Check the ONE box which best describes how your problem started and answer the questions asked.

- NO INJURY or onset was: Gradual Sudden
 INJURY AT WORK From a: lift twist fall bend pull reach Date: _____ Time: _____ Where? _____
 WORK RELATED (BUT NO INJURY) Date: _____ How did your job cause the problem? _____
Have you missed time from work? Y N If yes, how much? _____ days/weeks/months/years
When is the last date you worked at your regular job? Date: _____
If you are NOT currently working, is your goal to return to work? Y N
Current Work Status? Regular Light Duty Not working due to this injury Disabled Retired Student
Are you currently receiving or plan to apply for: Disability: Y N Worker's Comp: Y N Unemployment: Y N
Was your injury reported to your employer? Y N If so, who did you report it to? _____
Were you hospitalized for this injury? Y N On date of injury what was your job title/description? _____
On date of the injury what were your work activities? _____

Please write specific details of your problem (if accident/injury, list details):

Are you being treated by another physician for this condition/injury? Y N If yes: Dr. _____

What tests/scans have you had for this problem? X-Ray MRI CT Scan Bone Scan Nerve Test (EMG/NCV)
If yes, where? _____

Dominant Hand L R Ambidextrous (both)

If this injury was due to a MOTOR VEHICLE ACCIDENT, please answer the questions below

- Were you wearing a seat belt at the time of the accident? Y N Did your airbag deploy? Y N
Your Car: Hit another car Was hit in the: Right Left Rear Front
Type of Accident: Head on collision Broad side collision Rear end collision
 Front impact T collision You were a Pedestrian
Date of Accident: _____
Did you go to the hospital for this problem? Y N If yes, which hospital? _____

What type of pain do you have? Burning Diffuse Dull/Aching Localized Radiating Sharp
 Shooting Stabbing Throbbing Tightness Tingling

What is your level of pain when active? Please Circle 0 1 2 3 4 5 6 7 8 9 10 most severe

What is your level of pain at rest? Please Circle 0 1 2 3 4 5 6 7 8 9 10 most severe

What is your severity of pain? Please Circle 0 1 2 3 4 5 6 7 8 9 10 most severe

_____/_____/_____
Last Name **First Name** **Date**

Duration: How long have you had your pain? 1 2 3 4 5 6 7 8 9 10 11 12 Hours / Days / Weeks / Months / Years

Have you had a problem like this before? Y N **Date original problem/condition started?** _____

Is your pain with activity? Constant or Intermittent (comes and goes) Frequent Occasional

Does your pain affect your ability to asleep? Y N

When do you have the worst pain? Morning Afternoon Night with Activity

Does your pain get better with? *Please Circle* Warmth or Cold **Does it get worse with?** Warmth / Cold / Dampness

What makes your symptoms/pain worse? Stretching Sitting Standing Twisting Walking Bending Squatting
 Kneeling Warmth Cold Lifting Exercise Stairs Lying in bed Coughing Other: _____

Context: Which make your symptoms/pain better? Rest Rx Meds Elevation Ice Heat Massage
What are you treating your pain with? _____

Have you had any of these treatments? Injections Brace/s Physical Therapy

Associated signs and symptoms: Do you have any of the following? *check all that apply* None (denies any symptoms)

- Blurred Vision Depression Irritability/Mood Swings Localized Tingling Nausea Ringing in Ears
 Stiffness Headaches Weakness Aches Burning Cold Limb(s) Difficulty Walking Sleep Disturbance
 Dizziness Ecchymosis Chronic Fatigue Fever Heartburn Joint Stiffness Muscle Spasm
 Muscle Weakness Numbness Pale Bluish Skin Pins & Needles Rhinorrhea Shortness of Breath Sweating
 Swelling Locking/Catching Loss of control of bladder or bowel Bruises

REVIEW OF SYSTEMS **Have you had any problems related to the following systems?** *Circle all that apply*

If "No" mark NONE / If "Yes" write Details or Comments below

Constitutional Systems	Chills	Fever	Headache	None
Eyes	Blurred	Double Vision	Vision Change	None
Ear/Nose/Throat	Earache	Sore Throat	Sinus Congestion	None
Cardiovascular	Chest Pain	Shortness of Breath	Palpations	None
Respiratory	Chronic Cough	Wheezes	Asthma	None
Gastrointestinal	Abdominal Pain	Nausea	Bowel Habit Changes	None
Genitourinary	Frequent Urination	Urine Retention	Kidney Problems	None
Musculoskeletal	Neck Pain	Back Pain	Joint Pain	None
Skin	Rash	Skin Discolor	Persistent Itch	None
Neurologic	Stroke	Weakness	Vertigo	None
Psychiatric	Anxiety	Depression	Sleep Disorders	None
Endocrine	Thirst Increase	Sweats	Thyroid Disease	None
Hematologic/Lymphatic	Swollen Glands	Blood Clotting Problem	Anemia	None
Allergic/Immunologic	Hay Fever			None

_____/_____
Last Name First Name Date

Vitals: What is your height and weight? Height: _____ Ft _____ Inches Weight: _____ lbs _____ oz

Do you take anti coagulants? (blood thinners) Plavix/Clopidogrel Coumadin/Warfarin Fragmin Lovenox Platal
check all that apply

PAST MEDICAL HISTORY (PHX)

Have you had any prior Orthopedic Surgery? Yes No If yes: Procedure & Date _____

Please list any other Surgery you have had by operation (type) and date: _____

CURRENT PERSONAL ILLNESSES: Check all that apply

None (denies any personal illnesses)
 Diabetes Heart Disease High Blood Pressure Elevated Cholesterol Lung Disease Thyroid Disease Ulcers
 Peripheral Vascular Disease Cancer Pacemaker Kidney Disease Liver Disease Seizures Psychiatric Disorders
 Serious Infection HIV Hepatitis Other _____, _____

FAMILY HISTORY (FHX)

Is there a family history of medical or orthopedic conditions? Yes No

If yes; please list _____, _____, _____

Which family member: (Mother, Father, Sister) _____, _____, _____

Have you or any family member had a blood clot (Deep Vein Thrombosis)? Yes No

SOCIAL HISTORY (SHX) Check all that apply

Marital Status: Single Married Divorced/Separated Widowed

Smoking Status: Never Smoked Former Smoker Current every day Smoker Current someday Smoker

If you smoke, how many packs a day? _____

Alcohol usage: Non-Drinker Social Drinker Alcoholic Have you been treated for alcohol addiction? Yes No

Drug usage: Yes No If yes; (check off type used) Marijuana Cocaine Amphetamines Other _____

Have you been treated for drug addiction? Yes No

Do you now or have you ever used illicit or intravenous drugs? Yes No

MEDICATIONS: please list current medications and doses

_____/_____/_____

_____/_____/_____

ALLERGIES: Do you have any allergies? Yes No

Drug Allergy Yes No If yes; Drug Name _____ Type of Reaction & Date _____

Food Allergy Yes No If yes; Food _____ Type of Reaction & Date _____

Environmental Allergy (example; latex, dust, pet dander, grass) Yes No

If yes, what are you allergic to? _____ Type of Reaction & Date _____