ORTHOPEDIC PARTNERS

Patient Name ______________________________

Age ________

Your Hand Dominance: ○ Right ○ Left

Referred By
- ○ Primary Car Physician
- ○ Other Specialty physician
- ○ Emergency Dept.
- ○ Self ○ Other Source:

Referring Physicians name / location:

REASON for this visit:

Symptoms Present for: ______days ______months ______weeks ______ years

Date of injury: ______________

Describe onset of your symptoms:

Prior history of problems with this region of your body:

Previous medical providers and interventions for this current problem:

Dr. & type of specialty	Diagnostic testing & results	treatments prescribed or attempted
	○ X-ray ○ MRI ○ Cat scan ○ EMG/nerve test ○ Bone scan ○ Discogram ○ Myelogram/dye test ○ Other:	○ Medications ○ Injection ○ Physical Therapy ○ Surgery ○ Manipulation/ Chiropractic

PAIN PATTERN—Describe your current symptoms

Character/quality of pain:

Constant: Stable, Worsening, Comes & goes, Improving, Burning, Dull ache, Electric, Sharp/Stabbing

Other: __________

Circle *Intensity* 0 = no pain 10 = max. imaginable pain

Today 0—1—2—3—4—5—6—7—8—9—10

"Good" days 0—1—2—3—4—5—6—7—8—9—10

"Bad" days 0—1—2—3—4—5—6—7—8—9—10

Minimal..mild..moderate..severe..incapacitating

Any numbness / pins & Needles: None, Frequent, Rare, Constant

Aggravates symptoms:
- ○ Inactivity
- ○ Motion/activity
- ○ Sitting/driving
- ○ Arching back
- ○ Reaching overhead
- ○ Arising to stand
- ○ Standing
- ○ Looking overhead
- ○ Stooped/forward bending
- ○ Walking
- ○ Down stairs
- ○ Twisting/roatating
- ○ Laying flat
- ○ Up stairs
- ○ Coughing/sneezing
- ○ Worse @ night
- ○ Worse @ morning
- ○ Worse @ end of day

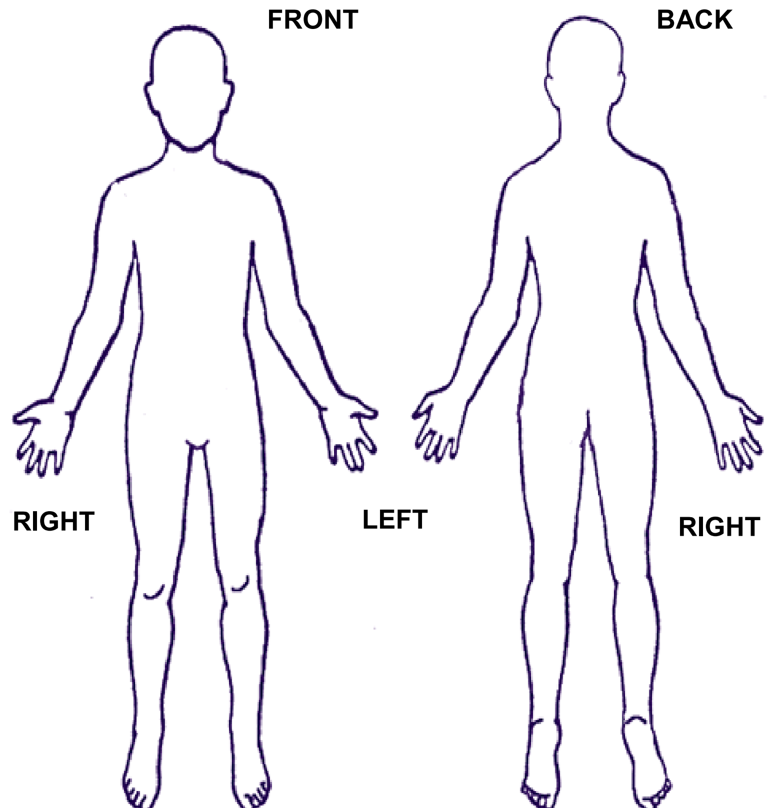
Lessons symptoms:
- ○ Inactivity
- ○ Motion/activity
- ○ Sitting/driving
- ○ Arching back
- ○ Stretching
- ○ Arising to stand
- ○ Standing
- ○ Heat
- ○ Stooped/forward bending
- ○ Walking
- ○ Cold
- ○ Twisting/roatating
- ○ Laying flat
- ○ Medications

Functions unable to do because of this problem:
- ○ Work
- ○ Driving/sitting
- ○ Lift/carry
- ○ Walking
- ○ Stair climbing
- ○ Sports/exercise/fun
- ○ House chores
- ○ Yard work
- ○ Childcare
- ○ Sleep
- ○ Upper body dressing
- ○ Grooming
- ○ Toileting
- ○ Lower body dressing
- ○ Sexual activity

Control problems or urine or stool ○ yes ○ no

Mark Location / Path of pain along your body:

Ache	^^^^^^	Numbness	00000
Burning	XXXX	Pins/needles	=====
Stabbing	/////////		



ORTHOPEDIC PARTNERS

Date: ___________________________ Date of Injury: ____________________

Patient: _________________________ Place of Injury: ___________________

Provider: ________________________ Work Related? _____ Yes / ______ No

Account #: _______________________ Auto Accident: _____ Yes / ______ No

Insurance: _______________________ ID: _____________________________

Subscriber: ______________________

If your care is the result of an auto accident, please check one of the below:

_____ I have Med Pay on my Auto Policy
(this means the auto insurance pays as your primary insurance)

______I have no Auto Med Pay Insurance
(this means personal health insurance pays as your primary insurance. Please supply a statement from your auto carrier that there was no med pay effective at time of the accident)

Are you pursuing legal action against another party? _____ Yes / ______ No

What did you injure? (example: left arm) _____________________________

Attention Pequot Plus members: if your injury is the result of an auto accident and you were the driver, Pequot Plus requires that you submit a copy of the police report to their office.

Give a complete and accurate account of the injury, including how and where it occurred as required by your insurance:

____

____

____

Signature ____ Witnessed ___________________________