ORTHOPEDIC PARTNERS

NAME_____ DATE_____ DOB _____

My pain is (please circle)

Minimal Mild Moderate Severe Incapacitating

My overall condition is (please circle)

Improving Unchanging Getting Worse

I have been experiencing these symptoms for (please check & write in the appropriate number)

☐ _____Weeks ☐ _____Months ☐ _____Years

I have been treated for this condition with: (please circle all that apply)

Physical Therapy Chiropractic Epidural Injections Other Injections
Acupuncture Medications (if so please list) *Other_____

_____

_____

_____

My pain is made worse with: (circle all that apply)

Standing Laying Walking Sneezing Bending Mornings
Sitting Coughing Lifting Driving My Pain is Constant
*Other_____

My pain is made better with: (circle all that apply)

Standing Sitting Laying Down Activity Rest
Shifting Positions Leaning Forward Nothing Relieves My Pain
*Other_____

I live: ☐ Alone ☐ With Someone Else

I am: ☐ Employed ☐ Unemployed ☐ Retired

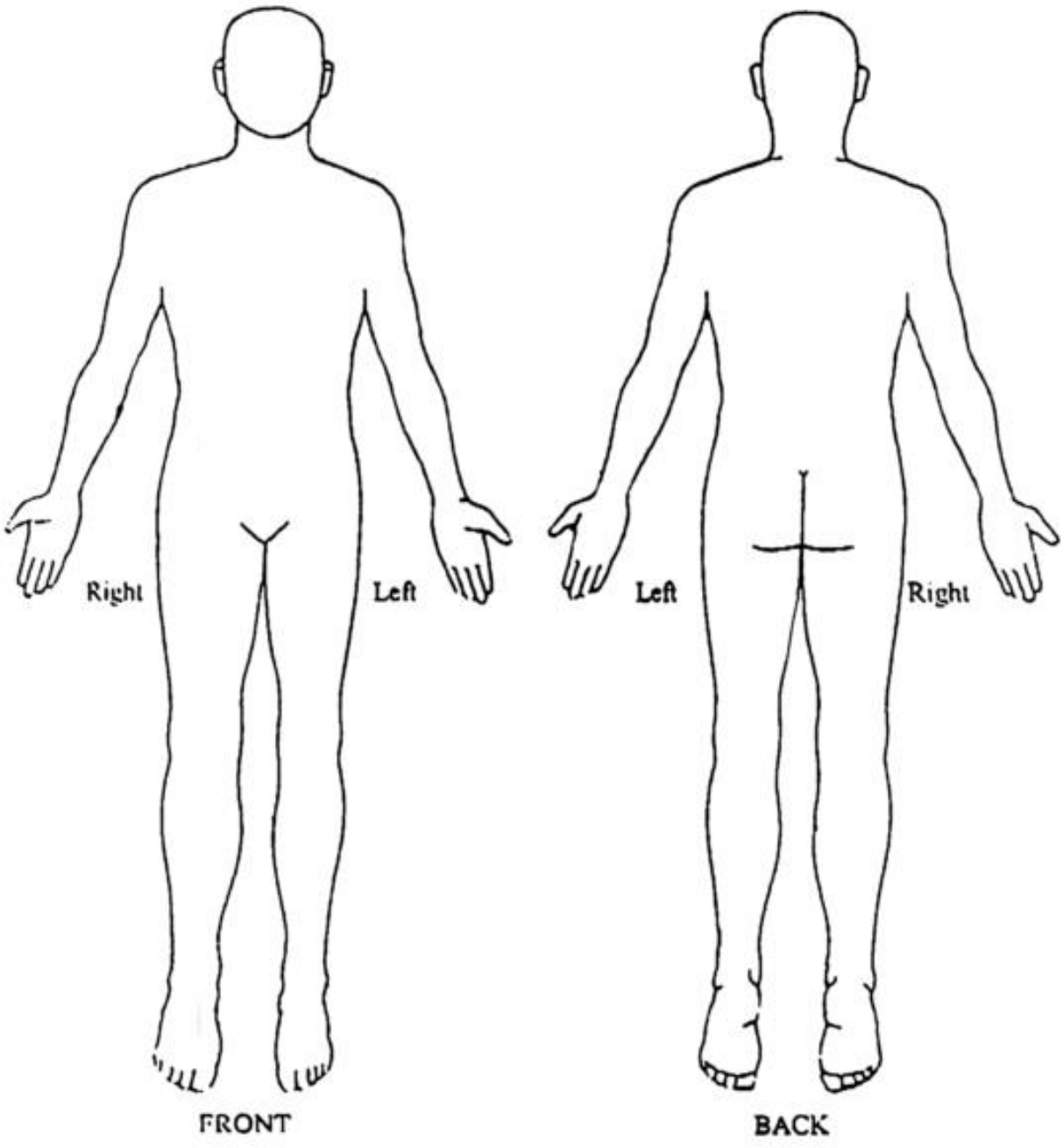
My Job Title Is:_____

My Employer Is:_____

I am presently working: Full Time Part Time Disabled from work since_____

Mark the areas on your body where you feel the described sensations. Use appropriate symbols and include all affected areas:

Ache ^^^^^ Numbness ooooo Pins & Needles ------ Burning xxxxx 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 <u>how</u> and <u>where</u> it occurred as required by your insurance:

_____

_____

_____

Signature _____ Witnessed _____

(860) 889-7345

82 New Park Avenue
North Franklin, CT 06254

11 Industrial Park Road
Niantic, CT 06357

(860) 963-2133

35 Kennedy Drive
Putnam, CT 06260

5 Founders Steet
Willimantic, CT 06226