Name:
DOB:
Acct #:
Age:
Date:

New Problem Intake

Patient Information

First and Last Name: ______________________ **Preferred Name:** ______________

Age: ________ **Date of Birth:** ______________ **Height:** __________ **Weight:** ______________

How were you referred to our office? ☐ **Emergency Room** ☐ **Physician** ______________ ☐ **Other** __________

Who is your primary care physician? ______________________ **Patient Occupation:** ______________

New Problem Information

What is the primary orthopaedic concern you are here for today? (circle)

Shoulder	Knee	Back	Foot
Elbow	Neck	Hand	Ankle
Hip	Arm	Wrist	Other

Which side(s)? Right Left Both

How did your injury occur?

- ☐ No Injury - just started hurting
- ☐ Sports (which sport) ______________
- ☐ Motor Vehicle Accident
- ☐ Work
- ☐ Other ______________________

Do you have a work comp claim? ☐ Yes ☐ No

Date of Injury: ______________

Describe your injury: ______________________

____

____

List any previous surgeries you've had for this problem.

______________________ Date __________

______________________ Date __________

Problems: (check all that apply)

- ☐ Pain
- ☐ Weakness
- ☐ Instability/giving way/ dislocation
- ☐ Stiffness
- ☐ Swelling
- ☐ Other ______________________

How long have you had these symptoms?

_____ Days _____ Months _____ Years

Rank the severity of your pain.
(0= none, 10 severe pain)

At rest: 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

List any previous treatments for this problem.

____

____

____

List any imaging studies you've had for this problem.

- ☐ X-ray Date: ________ Location ______________
- ☐ MRI Date: ________ Location ______________
- ☐ CT Scan Date: ________ Location ______________
- ☐ Other Date: ________ Location ______________

Patient/Guardian Signature ______________________ **Date** ______________

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