ORTHOPAEDIC ASSOCIATES – NEW PROBLEM HISTORY

Date__________________________

Name____ Date of Birth___________________

Family Doctor_____________________________ Referring Physician__________________

***CONSENT TO TREATMENT* – By signing this agreement, I consent to have Orthopaedic Associates and its physicians and/or therapists provide treatment and care (including physical/occupational therapy) as prescribed. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including the risks or alternatives to the treatment plan that has been prescribed by my physicians and/or therapist.**

Patient or Guardian Signature____

HISTORY OF PRESENT ILLNESS

Was there a specific injury that started the current problem (please describe):

____

____ Date of Injury:______________

Problem Area (be specific): _________________________Left or Right (if applicable)________

Check which apply to your symptoms:

- ☐ work related injury
- ☐ recurrence of previous injury
- ☐ motor vehicle accident
- ☐ injury related to lifting
- ☐ injury related to falling
- ☐ cause unknown
- ☐ athletic/recreational injury
- ☐ Other__________________

Did the injury occur at: ☐ Work ☐ Home ☐ Other (please specify)_________________________

If work related, have you filed a Worker's Compensation claim? ☐ Yes ☐ No

Can you describe your pain in any of the following ways:

Constant_____ Burning_____ Sharp_____

Comes & Goes_____ Ache_____ Dull_____

How long have you had your pain?_________________

How is your pain now compared to when it started? Better_____ Worse_____ Same______

Rate your current pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (most severe)

Do you have any of the following (please check): Numbness ☐ Weakness ☐ Tingling ☐

Do any of the following activities affect your pain, or make it worse?

Walking ☐ Sitting ☐ Housecleaning ☐ Running ☐ Stairs ☐

Driving ☐ Sleeping ☐ Getting Dressed ☐ Sports ☐

OVER→

Have you tried any of these treatments?

Heat ☐ Ice ☐ Aspirin ☐ Tylenol ☐ Braces ☐
Advil or Aleve ☐ Muscle Relaxants ☐ Exercise ☐ Physical Therapy ☐
Chiropractor ☐ Cane/Walker ☐ Cortisone Shots ☐ Pain Meds ☐

Have you had surgery for this problem? ☐ Yes ☐ No
Have you missed work for this problem ☐ Yes ☐ No Dates you missed work_______________

What tests have been done for this problem:
☐ X-rays ☐ CAT Scan ☐ MRI Scan
☐ Bone Scan ☐ Blood tests ☐ EMG (nerve test)

PAST MEDICAL HISTORY

Have you had any problems or treatment of: (If **YES**, please describe)

HEAD: ☐ Yes ☐ No ____
EYES: ☐ Yes ☐ No ____
EARS, NOSE & THROAT: ☐ Yes ☐ No ____________________________________
LUNGS: ☐ Yes ☐ No Describe____
HEART OR BLOOD PRESSURE: ☐ Yes ☐ No Describe__________________________
STOMACH OR BOWELS: ☐ Yes ☐ No Describe________________________________
KIDNEY OR BLADDER: ☐ Yes ☐ No Describe________________________________
REPRODUCTIVE ORGANS: ☐ Yes ☐ No Describe______________________________
MUSCULOSKELETAL: ☐ Yes ☐ No Describe__________________________________
NERVE OR MENTAL ILLNESS: ☐ Yes ☐ No Describe____________________________
CANCER: ☐ Yes ☐ No Describe____
DIABETES: ☐ Yes ☐ No Describe____
PACEMAKER: ☐ Yes ☐ No Describe_______________________________________
METAL IMPLANT: ☐ Yes ☐ No Describe___________________________________

Are you presently taking any medications ? ☐ Yes ☐ No
If yes, please list the medications: ____
____
____

List any allergies (or none): ____

List any previous surgeries (or none):____________________________________

FEMALES: Pregnant or chance of being pregnant ☐ Yes ☐ No

SOCIAL

Has any member of your immediate family had this same problem? ☐ Yes ☐ No

Marital Status: Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐

Occupation:____________________ If retired, where was your prior job____________________
Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ No ☐ Daily ☐ Occasionally

OVER→