

Patient Name \_\_\_\_\_

Orthopedic Partners

Age: \_\_\_\_\_

Your Hand Dominance:  Right  Left

Referred By  Primary Care Physician  
 Other Specialty physician  
 Emergency Dept.  
 Self  Other source:

Referring Physician's name / location:

REASON for this visit:

Work related injury  
 Motor vehicle collision

Job Title:  
Employer:

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
	<input type="checkbox"/> x-ray	<input type="checkbox"/> medications
	<input type="checkbox"/> Cat scan	<input type="checkbox"/> physical therapy
	<input type="checkbox"/> Bone scan	<input type="checkbox"/> manipulation/chiropractic
	<input type="checkbox"/> Myelogram/dye test	<input type="checkbox"/> injection
	<input type="checkbox"/> MRI	<input type="checkbox"/> surgery
	<input type="checkbox"/> Emg/nerve test	
	<input type="checkbox"/> Discogram	
	Other	

PAIN PATTERN Describe your current symptoms

Mark Location / Path of pain along your body:

Character/quality of pain:

constant:  stable  worsening  
 comes & goes  improving  
 burning  dull ache  
 electric  sharp, stabbing

ache	~~~~~	XXXXX	/////	00000	=====
burning	~~~~~	XXXXX	/////	numbness 00000	pins/needles =====
stabbing	~~~~~	XXXXX	/////	00000	=====

Other: \_\_\_\_\_

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

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:

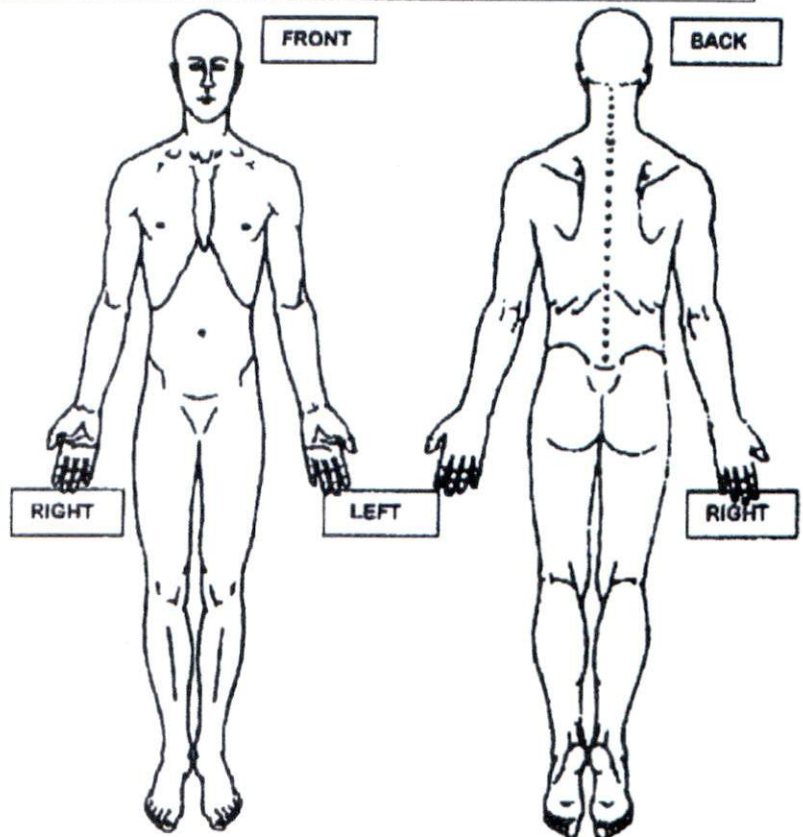
inactivity  motion/activity  sitting/driving  
 arching back  reaching overhead  arising sit to stand  
 standing  looking overhead  stooping/forward bending  
 walking  down stairs  twisting/rotating  
 laying flat  up stairs  coughing/sneezing  
 worse @ night  worse @ morning  worse @ end of day

Lessens symptoms:

inactivity  motion/activity  sitting/driving  
 arching back  stretching  arising sit to stand  
 standing  heat  stooping/forward bending  
 walking  cold  twisting/rotating  
 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  
 upper body dressing  grooming  
 lower body dressing  sleep  sexual activity  
 toileting  Control problems or urine or stool  yes  no





**ORTHOPEDIC  
PARTNERS**  
Formerly Norwich Orthopedic Group  
EST. 1957

Daniel Glenney, M.D.

Date: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Patricia Stuart, M.D.

Patient: \_\_\_\_\_

Place of Injury: \_\_\_\_\_

Kenneth Paonessa, M.D.

Provider: \_\_\_\_\_

Work Related? \_\_\_ Yes / \_\_\_ No

Michael Halperin, M.D.

Account #: \_\_\_\_\_

Auto Accident: \_\_\_ Yes / \_\_\_ No

Gabriel Abella, M.D.

Mohammad Pasha, M.D.

Insurance: \_\_\_\_\_

ID: \_\_\_\_\_

Tarik Kardestuncer, M.D.

Ammar Anbari, M.D.

Subscriber: \_\_\_\_\_

Nicole Arcand, M.D.

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

Scott Stanat, M.D.

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

Richard Thoms, M.D.

Steven Wei, M.D.

\_\_\_\_\_ 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)

Jonathan Piposar, M.D.

Emily Vafek, M.D.

Nimit Patel, M.D.

Are you pursuing legal action against another party? \_\_\_ Yes / \_\_\_ No

Tammie Simao, CMPE,  
CEO

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 \_\_\_\_\_