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
	❑ x-ray	❑ medications
	❑ Cat scan	
	❑ Bone scan	❑ physical therapy
	❑ Myelogram/dye test	
	❑ MRI	❑ manipulation/chiropractic
		❑ injection
	❑ Emg/nerve test	
	❑ Discogram	❑ surgery
	Other	

PAIN PATTERN Describe your current symptoms

Character/quality of pain:

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

Other: _____

	^^^^^		xxxxx		/////		00000		=====
ache	^^^^^	burning	xxxxx	stabbing	/////	numbness	00000	pins/needles	=====
	^^^^^		xxxxx		/////		00000		=====

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

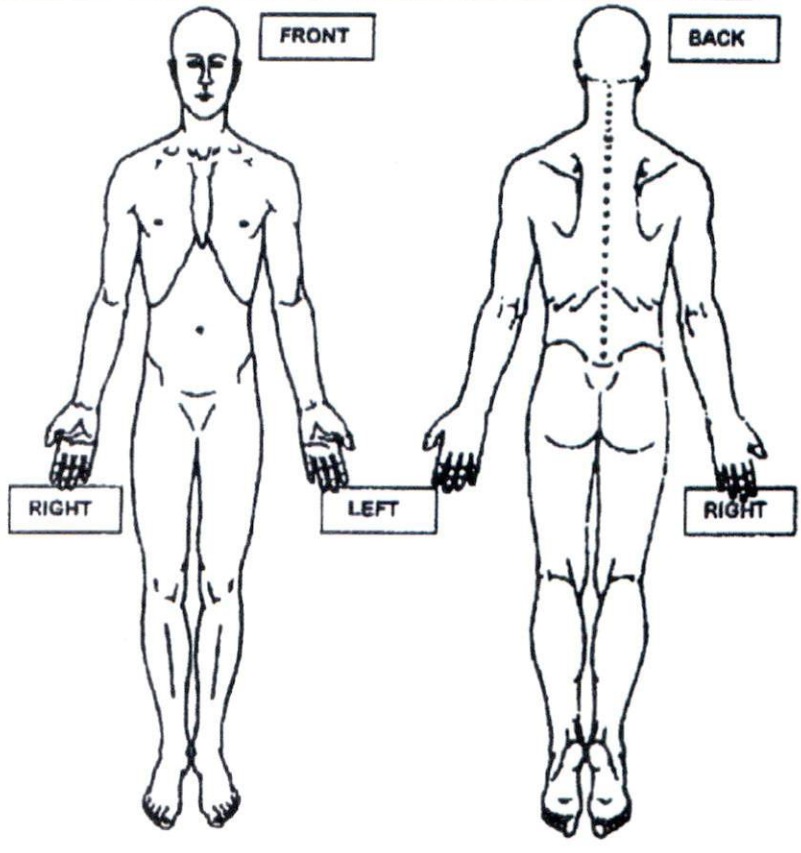
Lessens symptoms:

❑ 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

Mark Location / Path of pain along your body:



ORTHOPEDIC
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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 _____