ORTHOPEDIC PARTNERS

Patient Name _____ DOB: _____

Your Hand Dominance: ◯ Right ◯ Left

Referred By
- ◯ Primary Car Physician
- ◯ Other Specialty physician
- ◯ Emergency Dept.
- ◯ Self ◯ Other Source:

Referring Physicians name / location:

REASON for this visit:

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 ◯ MRI ◯ Cat scan ◯ EMG/nerve test ◯ Bone scan ◯ Other:	◯ Medications ◯ Injection ◯ Physical Therapy ◯ Surgery ◯ Manipulation/ Chiropractic

PAIN PATTERN—Describe your current symptoms

Character/quality of pain:

Constant:	Stable	Worsening
	Comes & goes	Improving
	Burning	Dull ache
	Electric	Sharp/Stabbing

Other: _____

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

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 to stand
◯ Standing	◯ Looking overhead	◯ Stooped/forward bending
◯ Walking	◯ Down stairs	◯ Twisting/roatating
◯ Laying flat	◯ Up stairs	◯ Coughing/sneezing
◯ Worse @ night	◯ Worse @ morning	◯ Worse @ end of day

Lessons symptoms:

◯ Inactivity	◯ Motion/activity	◯ Sitting/driving
◯ Arching back	◯ Stretching	◯ Arising to stand
◯ Standing	◯ Heat	◯ Stooped/forward bending
◯ Walking	◯ Cold	◯ Twisting/roatating
◯ Laying flat		◯ Medications

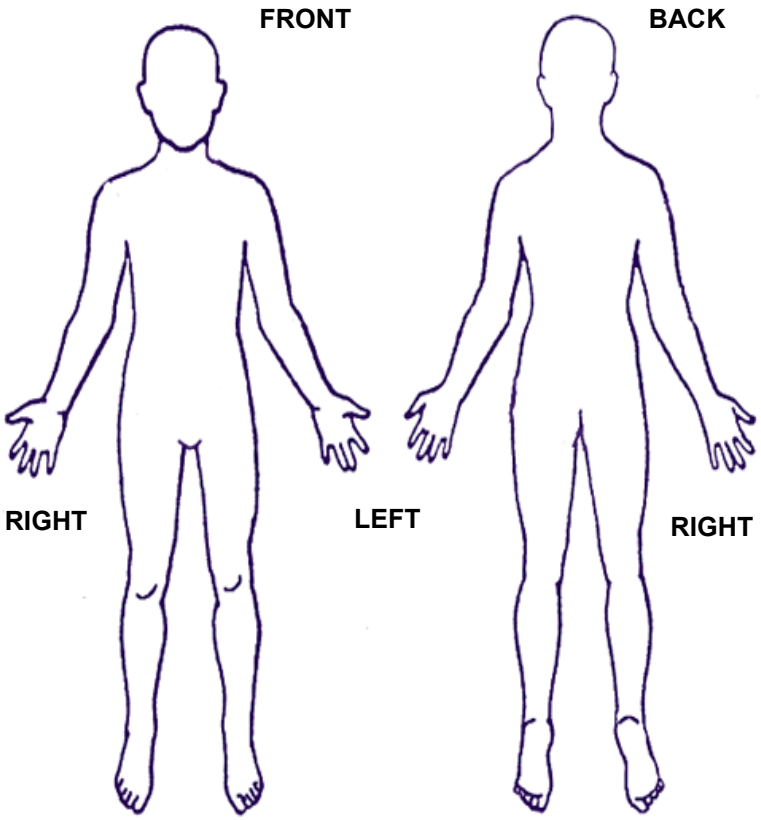
Functions unable to do because of this problem:

◯ Work	◯ Driving/sitting	◯ Lift/carry
◯ Walking	◯ Stair climbing	◯ Sports/exercise/fun
◯ House chores	◯ Yard work	◯ Childcare
◯ Sleep	◯ Upper body dressing	◯ Grooming
◯ Toileting	◯ Lower body dressing	◯ Sexual activity

Control problems or urine or stool ◯ yes ◯ no

Mark Location / Path of pain along your body:

Burning	XXXX
Numbness	00000
Pins/needles	=====



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 _____

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