



# New Patient Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Who referred you to our office? Name/Address/Phone Number/Specialty \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Care Physician name and contact information (if different than referring doctor) \_\_\_\_\_

Is the problem you are being seen for today:

Work related injury?  Yes  No

Automobile accident?  Yes  No

Personal injury/lawsuit:  Being considered

Ongoing/active

Side of the pain or problem:  Right  Left  Both Sides

Which hand do you write with?  Right  Left  Both Hands

Please describe your current orthopaedic problem/injury (how it started, symptoms, etc.): \_\_\_\_\_

On what date did the problem start? \_\_\_\_\_ How did it start?  Suddenly  Gradually

Mark the number/spot that best represents your average pain level over the last week:

(No pain) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (Worst Pain Imaginable)

Mark the number/spot that best represents your overall disability/dysfunction level:

(Normal Function) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (Wheelchair/Bedbound)

Pain Quality:  sharp  dull  stabbing  stinging  aching  
 throbbing  burning  tingling  electrical

Associated Symptoms:  swelling  redness  warmth  stiffness  locking/catching  numbness  
 deformity  lump/mass  cut/laceration  open sore/ulcer  instability/giving way

Timing of Pain:  morning  night  constant  variable  wakes you up from sleep  
 gets worse as the day goes on  gets worse with exercise  gets worse with activity/movement  
 start-up pain (worse with first few steps after sitting/resting)  gets better with activity/movement

Does the pain radiate?  Yes  No If yes, from where to where? \_\_\_\_\_

What makes the symptoms better? \_\_\_\_\_

What makes the symptoms worse? \_\_\_\_\_

Have you ever had a similar pain/problem in the past?  Yes  No When? \_\_\_\_\_

Treatments tried so far:  Rest  Ice  Heat  Cane/crutches/walker  Orthotics/shoe inserts/pads

Boot (#wks) \_\_\_\_\_  Brace (#wks, what type?) \_\_\_\_\_  Cast/splint (#wks) \_\_\_\_\_

Physical/Occupational Therapy (#wks) \_\_\_\_\_  Other treatments \_\_\_\_\_

Medication for this problem (name/dose/duration) \_\_\_\_\_

Injections (how many? % improvement, duration?) \_\_\_\_\_

Prior surgery for this problem or body part (who/where/when/what) \_\_\_\_\_

Prior tests/imaging:  X-Ray  MRI  CT  Bone Scan  Ultrasound  Nerve Testing  Blood Tests

**Continues on the Back: Please Complete All Pages**

Name: \_\_\_\_\_

**Past Medical History:** Please list any other medical conditions you have

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Heart Failure  | <input type="checkbox"/> Heart Attack     | <input type="checkbox"/> Pacemaker       | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Vascular Disease     | <input type="checkbox"/> Asthma   | <input type="checkbox"/> Emphysema/COPD   | <input type="checkbox"/> Sleep Apnea     | <input type="checkbox"/> Pulmonary Embolism  |
| <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Dialysis            |
| <input type="checkbox"/> Cirrhosis            | <input type="checkbox"/> Hepatitis ( <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C ) | <input type="checkbox"/> Stomach Ulcer    | <input type="checkbox"/> Neuropathy      | <input type="checkbox"/> Reflux/GERD         |
| <input type="checkbox"/> Colitis/Crohn's      | <input type="checkbox"/> Seizure Disorder   | <input type="checkbox"/> Stroke/TIA       | <input type="checkbox"/> Osteoarthritis  | <input type="checkbox"/> Charcot-Marie-Tooth |
| <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Polio  | <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Fibromyalgia    | <input type="checkbox"/> Rheumatoid (RA)     |
| <input type="checkbox"/> Lupus/SLE            | <input type="checkbox"/> Psoriasis  | <input type="checkbox"/> Gout             | <input type="checkbox"/> Depression      | <input type="checkbox"/> Lyme Disease        |
| <input type="checkbox"/> HIV/AIDS             | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Anemia           |  | <input type="checkbox"/> Anxiety             |
| <input type="checkbox"/> Cancer [Type: _____] | <input type="checkbox"/> Other: _____   |   |  |  |

**Past Surgical History:** List all surgeries you have ever had (example: appendix, tonsils, gallbladder, hysterectomy, etc.)

Have you had any problems with anesthesia? (describe) \_\_\_\_\_

**Family History:** Please list any medical conditions that run in your family

- |  |  |                                       |  |                                 |
|--|--|---------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Blood Clots  | <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Charcot-Marie-Tooth | <input type="checkbox"/> Other: _____ |  |                                 |

**Social & Personal History:**

**Occupation:** \_\_\_\_\_  Student  Homemaker  Retired  Unemployed  Disabled

**Do you get to exercise?**  Never  Rarely  Weekly  Daily What type of exercise: \_\_\_\_\_

**Number of stairs at home:** \_\_\_\_\_ **Who Do You Live With?** \_\_\_\_\_

**Hobbies/Interests:** \_\_\_\_\_

**Do you smoke (cigarettes, cigars, e-cigarettes, vaping)?**  Yes  No  Quit (when?) \_\_\_\_\_

The most you have ever smoked on a regular basis? \_\_\_\_\_ How many years have you/did you smoke in your life? \_\_\_\_\_

**Do you drink alcohol?**  Yes  No  Quit (when?) \_\_\_\_\_ Drink of choice? # per week? \_\_\_\_\_

**Recreational drugs?**  Currently use  Used in the past  Never used What type? \_\_\_\_\_

**Review of Systems:** Please list any other symptoms that you **currently** have

**Hematologic**

- Bleeding Tendency
- Easy Bruising

**Constitutional**

- Fevers  Chills
- Night Sweats
- Unplanned Weight Gain
- Unplanned Weight Loss

**Genitourinary**

- Incontinence
- Problems Urinating
- Burning with Urination

**Cardiovascular**

- Chest Pain
- Palpitations
- Heart Murmur
- Swelling in the Legs

**Gastrointestinal**

- Nausea  Vomiting
- Constipation
- Chronic Diarrhea
- Blood in Stool

**Psychiatric**

- Anxious  Depressed/Sad

**Neurologic**

- Numbness  Tingling
- Weakness
- Dizziness
- Balance Problems
- Frequent Headaches

**Skin**

- Rash  Itching
- Non-healing Sores
- Head/Ears/Nose/Throat**
- Hearing Loss
- Tooth Pain  Gum Bleeding

**Pulmonary**

- Chronic Cough
- Wheezing
- Shortness of Breath

**Musculoskeletal**

- Stiffness  Joint Pain
- Joint Swelling
- Neck  Back Problems

**Eyes**

- Double Vision
- Blurry Vision
- Blindness/Vision Loss

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Name: \_\_\_\_\_

Allergies:  **No Allergies**     Penicillin     Latex     Iodine     Shellfish     Adhesives

Please list anything else you are allergic to, including what reactions you have had (*examples: hives, trouble breathing, etc.*)

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Medications:  **No Medications**

Please list all medications/vitamins/supplements below, or attach a list

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Preferred Pharmacy: \_\_\_\_\_

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**Spine Pain Questionnaire (For Spine Patients):**

Please draw in wherever you are feeling any of the following symptoms, using the following symbols:

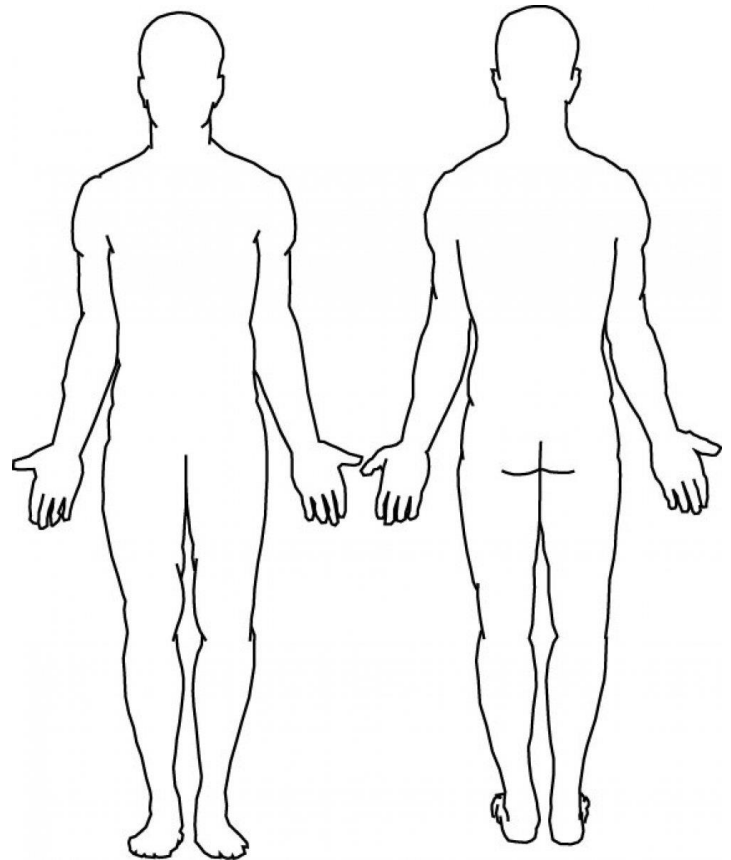
Pain (+)

Numbness (-)

Tingling (O)

Burning (X)

What percentage of your pain is in these areas:	
Back	%
Buttock/leg	%
Neck	%
Shoulder/arm	%



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I have reviewed the above information, and attest that it is true and correct to the best of my knowledge.

Patient's Signature: \_\_\_\_\_

Physician/NP's Signature: \_\_\_\_\_