

ADVANCED ORTHOPEDICS NEW ENGLAND

NAME: _____

DOB: ____/____/____

If first appointment or new injury, please start here and complete the rest of the form:

How did injury occur? HOME WORK AUTO ACCIDENT OTHER: _____

For Follow-Up appointments, start here: Body Part: _____ **RIGHT** **LEFT** **BILATERAL**

Pain quality: none aching burning cramping shooting stabbing sharp

Pain Scale: On average: 0 1 2 3 4 5 6 7 8 9 10

At its worse: 0 1 2 3 4 5 6 7 8 9 10

Pain Severity: none mild moderate severe

Pain frequency: none constant intermittent

Progression: same improving worsening

Symptoms: none inability to bear weight loss of motion loss of sensation

numbness tingling swelling radiating pain muscle weakness

Other Symptoms: _____

Aggravated by: nothing movement palpation weight bearing lifting

Prior Treatments: nothing elevation heat immobilization home exercises

rest ice bracing cortisone injections non-weight bearing

Other prior treatments: _____

Physical therapy: YES NO **Start Date:** _____ **For how many weeks:** _____

Improvement on prior treatments: no relief mild relief moderate relief significant relief

Have you taken any pain medications for your condition? (Prescription and/or over the counter)

Medication name: _____ Was it helpful? Yes No Moderate

REVIEW OF SYSTEMS (Please Circle all that apply)

Abdominal pain/discomfort	Abnormal Menstrual periods	Back Pain	Chest Pain
Chills	Constipation	Depression	Diarrhea
Double Vision	Easy Bruising	Environment Allergies	Fatigue
Fever	Glasses	Headaches	Incontinence
Joint Pain (Arthralgia)	Leg swelling/pain	Neck Pain	Neck Stiffness
Nervousness/Anxiety	Numbness	Rash	Shortness of Breath

None of the Above

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