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| Patient name | Date of birth - Age |
|---|---|
| | |

| Whom should we thank for referring you to us? | Who is your primary care physician? |
|---|---|
| | |

**Chief complaint** (reason for today's visit)

Date of injury / onset of symptoms _____

Where were you at the time? _____

How did the injury happen? _____

Location of pain / symptoms (please be specific) _____

Rate your pain from 1 (mild) to 10 (unbearable) _____

Quality (aching, throbbing, burning, etc.) _____

Timing of the pain (Is the pain constant? Does it come and go?) _____

Is your pain getting better, worse, or staying the same? _____

What makes your pain/symptoms better? _____

What makes your pain/symptoms worse? _____

Any burning, tingling, numbness, snaps, swelling, weakness, stiffness, catching, etc?_____

Have you received any treatment for this condition?
Please check all that apply

- □ No previous treatment
- □ Another orthopedist
- □ Pain specialist
- □ I have had surgery
- □ I've had an injection
- □ Physical therapy
- □ I've used a brace
- □ I am taking meds

Please check all that apply:

- □ Injury on the job
- □ Worker's compensation
- □ Involved in legal proceedings
- □ Receiving disability income

**Do you have any allergies?** □ No □ Yes (please list your allergies and reactions below)

| Drug | Type of allergy | Drug | Type of allergy |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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**Are you taking any medications?** □ Check here if none

| Name of medication | Dosage | Frequency | Name of medication | Dosage | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Past medical history (please list below)** □ Check here if none

| Medical problem | Treating physician | Medical problem | Treating physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Past surgeries and hospitalizations** □ Check here if none

| What | When | Where | What | When | Where |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Social history**

| | |
|---|---|
| Your occupation | |
| Living arrangements | □ Alone □ Live with parents □ Assisted living<br>□ Live with spouse □ Single parent |
| Substance use | □ Tobacco: _____ packs per day, for ___ years, □ current / □ quit in ____<br>□ Alcohol: _____ drinks per week □ current / □ quit in ____<br>□ Illicit drugs: _____ □ current / □ quit in ____ |

**Family history** (please tell us about any medical problems in your family) □ Check here if none

| | |
|---|---|
| Mother | |
| Father | |
| Siblings | |
| Children | |
| Grandparents | |