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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