DEDICATED ORTHOPEDIC CENTER – Urgent Care

ESTABLISHED PATIENT

Date:____________________

PATIENT'S FULL NAME: ____________________________________ PATIENT DATE OF BIRTH: ________________

ADDRESS: ____ CITY: ____________________ ST: ______ ZIP: __________

BEST PHONE: ______________________ FAMILY PHYSICIAN ____________________ PHARMACY ________________

HEIGHT: ___________ WEIGHT: ___________ HAND DOMINANCE: RIGHT / LEFT

CHIEF COMPLAINT:

BODY SIDE: (circle one) Right Left

BODY REGION: (only one per visit)

Shoulder	Arm	Elbow	Forearm	Wrist	Hand	Fingers
Hip	Thigh	Knee	Leg	Ankle	Foot	Toes
Neck	Back					

MAIN SYMPTOMS:

Pain	Popping	Instability	Stiffness
Weakness	Swelling	Tingling	Night Pain
Catching	Numbness	Decreased Motion	

HISTORY OF COMPLAINT:

How did symptoms start? ____________________________________ When (date)________________

Symptom Severity Scale (1-10): ________ (1 is minimal pain. 10 is Worst pain you can imagine)

Symptom quality (Circle all that apply): none / sharp / dull and achy / throbbing / stabbing / burning / constant / on & off

Symptoms worsen with: ____

Symptoms improve with: ____

Have you been seen by other provider for this problem? No Yes Who:____________________

Were you referred to our clinic? No Yes Prior physical therapy? No Yes

Have you injured this body part before? No Yes When:(date) ________________

Prior injection? No Yes When: __________ Prior surgery? No Yes

Since prior visit, symptoms are: Improving ________% Unchanged Worse ________%

MEDICAL HISTORY

- Diabetes: Yes / No
- Heart disease: Yes / No
- Kidney disease: Yes / No
- Lung disease: Yes / No
- Blood clots: Yes / No
- Stroke: Yes / No
- Bone Infection: Yes / No

SOCIAL HISTORY

Tobacco Use: Yes / No

Alcohol Use: Yes / No

Recreation Drug Use: Yes / No

Surgery since last visit: Yes / No

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CURRENT MEDICATIONS

No Changes or list below

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DRUG AND METAL ALLERGIES:______________________________

CC, HPI, X-ray, Upper/lower/right/left extremity Template, Impression, Plan, Procedure