DEDICATED ORTHOPEDIC CENTER – Urgent Care

NEW 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? Fall Car Accident Work Injury unknown Other:_____

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 When: _____

Symptoms alter: Sleep work sports daily activities other: _____

PAST MEDICAL HISTORY:

_____Arthritis	_____High Blood Pressure	_____Bone Infection	_____Asthma
_____Seizures	_____Ulcers	_____Stroke	_____TIAs
_____Gout	_____Thyroid Disease	_____COPD/lung issues	_____Heart Disease
_____Hepatitis	_____Tuberculosis	_____Blood Clots	_____Kidney Disease

_____Diabetes (diet controlled Oral medications Insulin) _____Frequent urinary tract infections

_____Cancer: _____ _____Other: _____

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

PAST SURGICAL HISTORY:

TYPE: _____ YEAR: _____ COMPLICATIONS: _____
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SOCIAL HISTORY:

◯ Student ◯ Retired ◯ Work-Occupation: _____

Personal status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Do you use a: ◯ Cane ◯ Walker ◯ Wheelchair?

Do you live with someone who is capable of assisting you during your recovery? Yes / No

Do you have a home health care provider? Yes / No If yes, who: _____

Do you drink alcohol? Yes / No If yes, how often? _____

Do you currently smoke or use tobacco? Yes / No # ____ packs per day

Any history of drug abuse? Yes / No If yes, what type?

FAMILY HISTORY OF MEDICAL PROBLEMS

Grandparents: _____

Father: _____

Mother: _____

Sisters: _____

Brothers: _____

CURRENT MEDICATIONS (names only)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

DRUG AND METAL ALLERGIES: *(examples: Penicillin, Codeine, Sulfa, Aspirin, Nickel)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

REVIEW OF SYSTEMS: (Do you have....)

◯ Fever
◯ Shortness of Breath
◯ Mental Illness
◯ Blurred Vision
◯ Chest Pain
◯ Nausea / Vomiting
◯ Painful Urination
◯ Rashes
◯ Fainting / Seizures
◯ Bleeding Tendencies
◯ Anemia
◯ Other _____