New Patient / Problem Sheet

Name: _____ DOB: _____ Account #: _____

Did you bring x-rays? ____ **Y** ____ **N**

What part of the body is involved? Please mark in the table below. If you have more than one, see receptionist.

Neck	☐	and radiates to	☐ ☐ ☐	R arm L arm Neither	Shoulder	☐	R	☐	L	Elbow	☐	R	☐	L	Hand	☐	R	☐	L	Pelvis	☐	R	☐	L	Knee	☐	R	☐	L	Foot	☐	R	☐	L
Back	☐	and radiates to	☐ ☐ ☐	R leg L leg Neither	Arm	☐	R	☐	L	Wrist	☐	R	☐	L	Finger T 2 3 4 5	☐	R	☐	L	Hip	☐	R	☐	L	Ankle	☐	R	☐	L	Toe	☐	R	☐	L

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

Answer: Comment:

☐ No Injury (Onset was: ☐ Gradual ☐ Sudden)
Why do you think it started?

☐ INJURY (☐ Accident ☐ Sport NOT Auto or Work)
Date _____. Where and how did it happen?
What Sport_____ School_____

☐ INJURY AT WORK Date _____.
From a ___ lift ___ twist ___ fall ___bend ___ pull ___ reach?

☐ WORK RELATED - (BUT NO INJURY)
Date _____. How did your job cause this problem?

☐ AUTO ACCIDENT Date _____
How was your car hit?

On a scale of 0-10 (10 is the worst) how severe is your pain? (Please circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ____ Sharp ____ Dull ____ Stabbing ____ Throbbing ____ Aching ____ Burning _____

The pain is: ____ Constant ____ Comes and goes (intermittent). Does your pain wake you from sleep? ____ Yes ____ No

Do you have: ____ Swelling ____ Bruise ____ Numbness ____ Tingling ____ Weakness ____ Loss of control of bowel or bladder

Since my problem started, it is: ____ Getting better ____ Getting Worse ____ Unchanged

What makes your symptoms worse? ____ Standing ____ Walking ____ Lifting ____ Exercise ____ Twisting ____ Lying in Bed ____ Bending
____ Squatting ____ Kneeling ____ Stairs ____ Sitting ____ Coughing ____ Sneezing

What makes your symptoms better? ____ Rest ____ Heat ____ Ice ____ Elevation ____ Other, explain: _____

Which medications have you been taking now (or previously) for this problem? _____

Have you had any of these treatments? Injection: ____ Y ____ N /Brace: ____ Y ____ N /Physical Therapy: ____ Y ____ N /Cane / Crutch ____ Y ____ N

Were you seen in the E.R. for this problem? ____ Y ____ N Which E.R.? _____ Date _____

Are you here today as a result of the E.R. visit? ____ Y ____ N Who saw you in the E.R. (name)? _____ MD / PA

What tests / scans have you had for this problem? ____ X-Rays ____ MRI ____ CAT scan ____Bone Scan ____ Nerve Test (EMG/NCV)

Have you already had surgery for a problem in this same area either recently or in the past? ____ Y ____ N ; Please list below.

Procedure #1 _____ Surgeon _____ City _____ Date _____

Procedure #2 _____ Surgeon _____ City _____ Date _____

Current work status? ____ Regular ____ Light Duty (How long? _____) ___ Not working due to this problem ____ Retired ____ Disabled ____ Student

When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for : Disability ___ Y ___ N Workman's Comp ___ Y ___ N Unemployment ___ Y ___ N