New Problem Information Form

Please darken bubbles completely

PATIENT INFORMATION		
Patient Name:	**DOB:**	**Date:**
Height:	**Weight:**	
Referring Physician:	**Primary Care Physician:**	

How long have symptoms been present or date of injury: _____

How did the pain occur?	O	Injury	O	Ongoing Problem	O	Spontaneous
Is this work related?			O	Yes	O	No
Is this the result of a motor vehicle accident?			O	Yes	O	No

What is your occupation? _____

Medications (☐ List Provided) _____

Allergies: _____

Surgeries or Hospitalizations since last seen? _____

Are you? O Right Handed O Left Handed **Pregnant:** O Yes O No

What are you being seen for today?

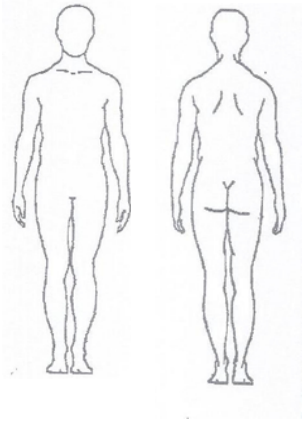
O Neck	O Right Hip	O Left Hip	O Right Thigh	O Left Thigh
O Mid Back	O Right Knee	O Left Knee	O Right Calf	O Left Calf
O Low back	O Right Ankle	O Left Ankle	O Right Foot	O Left Foot
O Ribs	O Right Shoulder	O Left Shoulder	O Right Elbow	O Left Elbow
	O Right Wrist	O Left Wrist	O Right Hand	O Left Hand

Pain Description:

What is the quality of your pain?	O	Mild	O	Moderate	O	Severe
How would you describe your pain?	O	Sharp	O	Dull	O	Burning
Have you had physical/occupational therapy?			O	Yes	O	No
Have you been treated elsewhere for this problem?			O	Yes	O	No

If yes, where and by whom? _____

Mark where your symptoms occur:



Pain Scale: On a scale of 0 to 10 (0 meaning no pain and 10 meaning worst pain), how would you rate the pain you are currently experiencing?

O 0/10	O 1/10	O 2/10	O 3/10	O 4/10	O 5/10
O 6/10	O 7/10	O 8/10	O 9/10	O 10/10	

Are you taking any Medications for this problem?

O Narcotic (Vicodin, Codeine, etc.) O Anti-inflammatory (Advil, Motrin, etc.) O Muscle Relaxer (Flexeril, Soma, etc.)

O Steroid / Steroid Injections

<u>Have you had any of the following diagnostic tests for the problem you are being seen for today</u>?

O X-Ray O MRI O EMG/NCS O Bone Scan O CT Scan O Bone Density Test

I hereby certify to the best of my knowledge that the information stated above is correct.

Patient/Guardian Signature _____ **Date** _____