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

Do you have an Advance Directive? O Yes O No **If yes, please give to front desk to scan or bring to your next visit.**

If No, are you interested in receiving additional information about Advance Directives? 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

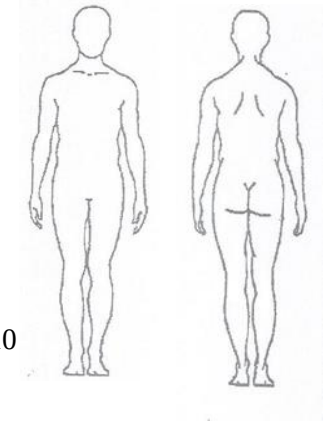
How would you describe your pain? O Sharp O Dull O Burning

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** _____

(Rev. 07/3/2019)