

New Patient or New Problem Visit Information

Name: _____ Birth Date: _____ Age: _____

Reason for Today's Visit: _____
(which side? right, left, both) _____

When did the problem begin? _____ Date of Injury: _____

Was it related to an accident? Yes No If yes, describe: _____

Please list anything that aggravates the problem: _____

Type of pain: Ache Stabbing Throbbing Shooting Dull Click/Pop

Circle your pain levels (0= no pain and 10=terrible pain)

At worst 0 • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

Today 0 • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

Since the start of the problem are you: Improving Getting Worse Staying the Same

Please list anything, including treatments, that help relieve the problem:

Whom have you seen for this problem? _____

What test(s) have been done? When? Where? X-Ray _____ MRI _____

CT Scan _____ Bone Scan _____ Other _____

What treatments have you had for this problem? _____

Medications: _____ Helped? Yes No Not Sure

Physical Therapy: Helped? Yes No When? _____ How many visits? _____

Injections (type/date): _____ Helped? Yes No Not Sure

Surgery (type/date): _____ Helped? Yes No Not Sure

Other (type/date): _____ Helped? Yes No Not Sure

Have you ever had the same or similar problem before? Yes No Not Sure _____

Have you ever missed any work due to this injury? Yes No Last date worked? _____

Are you obtaining Worker's Compensation for this injury? Yes No

Is there an attorney involved? Yes No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Legal Guardian: _____ Date: _____

Office Use Only

Physician Reviewed:

Initials: _____ Date: _____