

Southeastern Orthopaedic Specialists

Date: _____ Chart # _____ Provider _____

Patient Name (Please Print) _____

BP _____ / _____	Pulse _____
Temp. _____ H _____ / _____ W _____	

Patient Signature _____

Age _____ F M Height _____ / _____ Weight _____

Did you bring x-rays? Y N

Who requested that you visit this office? Doctor (Name) _____ Self-Referral Attorney _____

★ What is the main reason for this visit? Pain Numbness Weakness Other _____ (Chief Complaint)

★

What body part is involved?						(Location)
Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L
Back <input type="checkbox"/> Mid <input type="checkbox"/> Lower	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> L

How long has this problem been present? Days Weeks Months

Check the box which best fits how your problem started. Then answer the one question below the box you checked. Use as much space to the right as needed.

NO INJURY (Onset was: Gradual or Sudden) **ANSWER:**

?Why do you think it started? _____

INJURY – (NOT AUTO OR WORK)

Date _____, Where and How did it Happen? _____

INJURY AT WORK

Date _____, Where and How did it Happen? _____

WORK RELATED – (BUT NO INJURY)

Date _____, How did your job cause this problem? _____

AUTO ACCIDENT

Date _____, Where and How was your car hit? _____

Please check the box below which best describes your problem:

★ **The pain is** Constant Comes and goes (Intermittent) (Duration)

★ **Severity** of pain Mild Moderate Severe Extremely severe (Severity)

★ What is the **quality** of the pain? Sharp Dull Stabbing Throbbing Aching Burning Other: _____ (Quality)

Are there **associated symptoms**? Swelling Numbness Weakness (Assoc Symp)

Since my problem started, it is: Getting better Getting worse Unchanged (Context)

Does your pain wake you from sleep? Yes No (Timing)

What makes your symptoms **worse**? Activity Exercise Work Other _____ (Modify)

Which make you feel **better**? Rest Heat Ice Elevation Other _____ (Modify)

What medications have you taken or been prescribed for this problem? _____ (Modify)

Check which treatments you have tried: Injection Y N Brace Y N Therapy Y N Cane/Crutch Y N (Modify)