

# New Patient Initial Evaluation

Name: \_\_\_\_\_

Age: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Were you referred by another physician? \_Y\_N

(If yes, please provide name and phone number)

Where is your pain/ailment? (circle)

Which side: RIGHT LEFT BOTH

Neck Back Shoulder Elbow Hand/Wrist

Hip Knee Calf Ankle Foot

**Problems** (circle all that apply)

Pain Weakness Instability Locking Swelling  
Stiffness

Date of Injury or onset of symptoms: \_\_\_\_\_

How did problem start: \_\_\_\_\_

Diagnosis if known: \_\_\_\_\_

**Rate your pain** (0=none, 10=worst)

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

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

Pain at night: Yes No

Does the pain wake you from sleep? Yes No

What makes pain better? \_\_\_\_\_

What makes pain worse? \_\_\_\_\_

Is pain getting better, worse, or staying the same?

What does the pain prevent you from doing? \_\_\_\_\_

Date: \_\_\_\_\_

Previous treatments for this problem: (circle)

Physical Therapy Activity Modification Injections

Surgery Medications (please see below)

Other: \_\_\_\_\_

OTC Medications: \_\_\_\_\_

Rx Medications: \_\_\_\_\_

What previous imaging studies have been done:

(please give dates) \_\_\_\_\_

Please list all orthopedic surgeries: \_\_\_\_\_

## **Past Medical History:**

Heart Problems Yes No \_\_\_\_\_

Stomach Problems Yes No \_\_\_\_\_

Diabetes Yes No \_\_\_\_\_

Liver Problems Yes No \_\_\_\_\_

Kidney Disease Yes No \_\_\_\_\_

Blood Clots Yes No \_\_\_\_\_

Other: \_\_\_\_\_

## **Social History:**

Do you drink alcohol? Yes No

If yes, how often? \_\_\_\_\_

Do you smoke/chew tobacco? Yes No

If yes, how often? \_\_\_\_\_

Allergies to medications? Yes No

List: \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_

Who is your primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**REVIEW OF SYSTEMS: (Check all that you have experienced recently)**

General	Pulmonary	Musculoskeletal	Cardiovascular
<input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Poor appetite <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Redness <input type="checkbox"/> Limited motion <input type="checkbox"/> Weakness <input type="checkbox"/> Atrophy <input type="checkbox"/> Cramps <input type="checkbox"/> Popping <input type="checkbox"/> Locking/catching <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Mass <input type="checkbox"/> Deformity	<input type="checkbox"/> Chest pain (angina) <input type="checkbox"/> Palpitations (rapid heartbeat) <input type="checkbox"/> Irregular heartbeat (arrhythmia) <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Swollen ankles (pedal edema) <input type="checkbox"/> Shortness of breath on exertion <input type="checkbox"/> Shortness of breath at night
<b>Skin</b> <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Lesions	<b>Genitourinary</b> <input type="checkbox"/> Frequent urination (frequency) <input type="checkbox"/> Urgent urination (urgency) <input type="checkbox"/> Painful urination (dysuria) <input type="checkbox"/> Need to awaken to urinate <input type="checkbox"/> Blood in urine <input type="checkbox"/> Penile or vaginal discharge <input type="checkbox"/> Kidney stone pain	<b>Lymphatics</b> <input type="checkbox"/> Lymph node swelling <input type="checkbox"/> Node tenderness	<b>Neurological</b> <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures (fits) <input type="checkbox"/> Fainting spells
<b>Head/Eyes/Ears/Nose/Throat</b> <input type="checkbox"/> Hay fever <input type="checkbox"/> Postnasal drip <input type="checkbox"/> Hoarseness <input type="checkbox"/> Visual problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Neck stiffness/pain	<b>Gastrointestinal</b> <input type="checkbox"/> Indigestion <input type="checkbox"/> Gas <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Yellow skin <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Black stools <input type="checkbox"/> Rectal bleeding	<b>Endocrine</b> <input type="checkbox"/> Excessive urination <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Hot intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Easy bleeding	<b>Height</b> _____ <b>Weight</b> _____
<b>Psychiatric</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Other _____ _____ _____			<b>Dominance</b> <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand

**FAMILY HEALTH** Have blood relatives ever had any of the following? If so, indicate their relationship to you (e.g. Diabetes – maternal grandmother)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Liver Trouble       | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Psychiatric Disease            |
| <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Unusual Reaction to Anesthesia |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Any Unusual Disease | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Stroke                         |

If your mother, father or any of your brothers and/or sisters have died, what was the cause of their death and what was the age at the time of death? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I certify that the information provided above is true.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship:  Self  
 Parent or Legal Guardian  
 Other: \_\_\_\_\_  
(Please Specify)

**Physician Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_