ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

PATIENT INFORMATION

ESTABLISHED PATIENT/NEW PROBLEM ONLY

TODAY'S DATE

FIRST NAME	LAST NAME

REASON FOR TODAY'S VISIT

WHAT IS THE REASON FOR OUR VISIT TODAY?

LOCATION OF PAIN

LEFT KNEE	RIGHT KNEE
LEFT SHOULDER	RIGHT SHOULDER
LEFT HIP	RIGHT HIP
LEFT FOOT	RIGHT FOOT
LEFT ANKLE	RIGHT ANKLE
LEFT WRIST / HAND	RIGHT WRIST / HAND
BACK	OTHER ____________________

HOW LONG HAS IT BEEN PRESENT?

DESCRIBE PAIN

DULL SHARP TINGLING

OTHER ____________________

WHEN DOES PAIN OCCUR?

AT REST WITH ACTIVITY AT NIGHT

OTHER ____________________

ANY OTHER SYMPTOMS ASSOCIATED WITH CURRENT PROBLEM?

SEVERITY: ON A SCALE FROM 1-10, INDICATE HOW SEVERE THE PAIN IS — 1 BEING VERY LITTLE TO 10 BEING EXCRUCIATING/CAN'T FUNCTION.

CIRCLE NUMBER: 1 2 3 4 5 6 7 8 9 10

CONTEXT: HOW DID IT OCCUR?

DATE OF INJURY

INDICATE WHAT MAKES IT BETTER

ICE HEAT REST ELEVATION NONE

HAVE YOU BEEN TREATED BY ANOTHER PHYSICIAN FOR THIS COMPLAINT?

YES NO

HAVE YOU CHANGED ADDRESS? IF "YES", PLEASE INCLUDE:

YES NO

HAVE YOU CHANGED INSURANCE? IF "YES", PLEASE INCLUDE:

YES NO

SIGNATURE (PERSON COMPLETING FORM)	DATE COMPLETED