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
- ◯ LEFT SHOULDER
- ◯ LEFT HIP
- ◯ LEFT FOOT
- ◯ LEFT ANKLE
- ◯ LEFT WRIST / HAND
- ◯ BACK
- ◯ RIGHT KNEE
- ◯ RIGHT SHOULDER
- ◯ RIGHT HIP
- ◯ RIGHT FOOT
- ◯ RIGHT ANKLE
- ◯ RIGHT WRIST / HAND
- ◯ 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