Connecticut Valley Orthopaedics & Sports Medicine
Orthopaedic Intake History

Name: _____ **Date of Birth:**_____ **Date:**_____

Height: _____ **Weight:** _____ **Right-handed:** _____ **Left handed:** _____

Occupation: _____ **Is this a work-related injury?** □ Yes □ No Date of Injury: _____

Who requested that you visit this office? □ Doctor: _____ □ Self-referral □ Attorney:_____

What body part(s) is/are involved? (□ Right □ Left □ Both) _____

Please describe the nature of your problem? _____

_____

How long has this problem been present? _____

DESCRIBE YOUR SYMPTOMS

Pain: Where?_____
□ sharp □ dull □ burning □ awakes you at night □ driving a car □ other _____

□ **Weakness:** Describe:_____

□ **Numbness/tingling:** Where: _____

□ **Giving out:** □ at rest □ lifting □ twisting □ running

□ **Grinding/snapping*:*** With what position/motion? _____

□ **Other problems/complaints:** □ headaches □ neck pain □ muscle spasms

Are there <u>associated symptoms</u>? □ swelling □ redness □ other_____

Since your problem started, it is: □ getting better □ getting worse □ unchanged

What makes your symptoms <u>worse</u>? □ activity □ exercise □ work □ sitting □ walking □ other_____

Does anything make you feel <u>better</u>? □ rest □ heat □ ice □ elevation □ other _____

What medications or dietary supplements have you taken or been prescribed for <u>this</u> problem?

_____

Have you tried any of the following: □ injections □ brace □ cane/crutch
□ physical therapy (if yes, where?_____)

Have you had a <u>prior</u> problem with this same orthopaedic condition in the past? □ yes □ no *(*explain below if yes)

Have you had <u>any</u> tests for this problem? □ X-ray □ MRI □ Lab tests □ EMG □ Bone scan

MARK YOUR PAIN LEVEL ON THIS LINE

1----------5----------10
O for LEAST pain **X for WORST pain**

SPORTS PARTICIPATION: