ATF ORTHOPEDICS
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Name:_____Date:_____Age: _____Sex: M/F Ht:_____Wt:_____

Primary/Family Physician:_____Who referred you to our office?_____Right / Left Handed

What is your primary injury or condition? _____

When did it begin?_____

How did it occur?_____

_____

_____

_____

_____

_____

What makes it worse?_____

(SITTING/STANDING/LYING FLAT/DOING NOTHING)

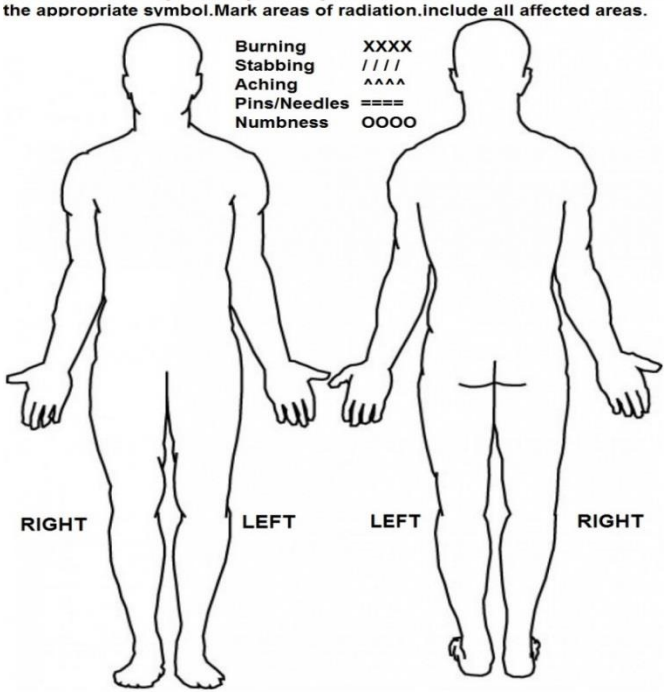
(BENDING/LIFTING/TWISTING/COUGHING/SNEEZING)

What makes it better?

(SITTING/STANDING/LYING FLAT/DOING NOTHING)

(WALKING/EXERCISE/HEAT/COLD)

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol.Mark areas of radiation.include all affected areas.



Circle your pain levels: {Least Pain-----Most Pain}

Worst Level: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Best Level: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Today: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Since the start of the problem are you: IMPROVING / GETTING WORSE / STAYING THE SAME

Who have you seen for this problem?_____

What tests have been done? When?

X-ray:_____ CT Scan:_____ Other:_____

MRI:_____ EMG/NCV:_____

What treatment(s) have you had for this problem?

Medications:_____ Helped? Y / N / Not Sure

Physical Therapy: Y / N When?_____ How many visits?_____ Helped? Y / N / Not Sure

Injections (type/date):_____ Helped? Y / N / Not Sure

Surgery (type/date):_____ Helped? Y / N / Not Sure

Other: _____ Helped? Y / N / Not Sure

Have you ever had the same or a similar problem before? When?_____

Your Past Medical History:

Stroke	Gout	Bleeding Disorders	Phlebitis	AIDS
Heart Trouble	Seizures	Alcoholism	Anemia	Thyroid Problems
High Blood Pressure	Mental Illness	Serious Injuries	Stomach Ulcers	Arthritis
Diabetes	Kidney Trouble	Lung Disease	Liver Trouble	Cancer

Past surgical Procedures:_____

Allergies to Medication(s): NONE or List:_____

Current Medication(s) _____ _____ _____

(Please list doses if available) _____ _____ _____

_____ _____ _____

Marital Status: MARRIED / SINGLE / DIVORCED / WIDOWED

Tobacco use? Y / N _ packs per day for _ years. Year quit?_____Recreational drug use?Y / N

Alcohol use? NEVER / RARE / OCCASSIONAL / MODERATE / HEAVY

Any history of drug / alcohol abuse? Y / N

Regular exercise routine? Y / N Describe:_____Hobbies?_____

Current Job Title:_____Employer:_____How long?_____

Employment status: WORKING FULL DUTY/ WORKING WITH RESTRICTIONS/ OFF WORK/DISABLED / RETIRED

Family medical history includes:

Stroke Diabetes	Seizures	Cancer	Other Illnesses:
Heart Trouble	Arthritis	Bleeding Disorders	Mental Illness
High Blood Pressure	Gout	Kidney Trouble	Alcoholism

Review of Systems: (recent or current conditions)

Weight Change	Hearing Changes	Shortness of Breath	Urinary Burning	
Fever/Chills	Ear Pain / Ringing	Cough	Frequent Headaches	
Night Sweats	Nosebleeds	Nausea/Vomiting	Seizures	
Poor Appetite	Hoarseness	Stomach Pain	Numbness	
Rash	Difficulty Swallowing	Frequent Diarrhea	Weakness	Other Illnesses:
Insomnia	Tooth / Gum Trouble	Frequent Constipation	Backache	
Depression	Chest Pain	Blood in Stool	Joint Pain	
Anxiety	Abnormal Heartbeat	Incontinence	Joint / Limb Swelling	
Visual Changes	Blackouts	Urinary Frequency	Lumps / Masses	

Patient Signature:_____ Date:_____

(Below for physician and office staff only)

Physical Examination: X-Ray / Lab / Test Results:

Imp:
Plan: Medication(s):_____PT / OT / ST:_____
Tests / Treatments: MRI / CT / EMG-NCV / ESI / Other

Special Instructions:
Follow-up visit:_____