NEW INJURY/COMPLAINT

Today Date: ________________

Name:____ DOB:__________________

Age:________ Ht:___________ Wt:_______________ ◻ Right-Handed ◻ Left-Handed

Have you had 2 or more *falls* in the past year ◻ Yes ◻ No
Or have you had 1 fall with an injury ◻ Yes ◻ No
Are you Pregnant? ◻ Yes ◻ No

REASON FOR VISIT

- Did you have an injury? ◻ Yes ◻ No If yes, what was the date of injury?___________________
- Brief history of what is bothering you, what body part is injured, and how it happened:

____
____
____
____
____

- If this is a work-related injury, is it under workers compensation? ◻ Yes ◻ No
  - Have you missed work because of this problem? ◻ Yes ◻ No
- If this injury is from an auto accident, is there a legal case? ◻ Yes ◻ No

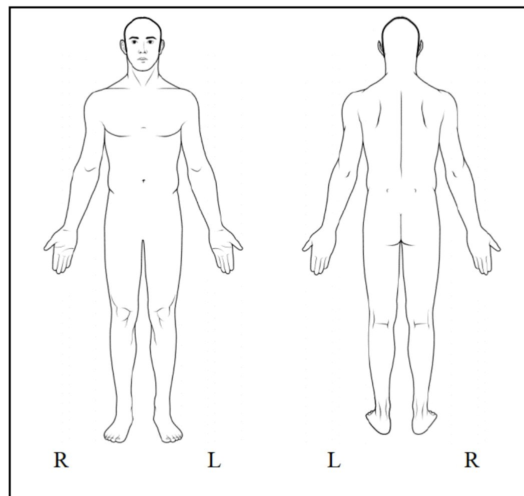
- Please indicate whether you have had any of the following imaging studies and write when/where the most recent was:

	Yes	No	**Body Part** (Ex: Right knee)	**Imaging Location** (Ex: Shields Wellesley)
X-ray	◻	◻		
CT Scan	◻	◻		
EMG	◻	◻		
Bone Scan	◻	◻		
MRI	◻	◻		
Other:	◻	◻		

- Have you seen another doctor for this? ◻ Yes ◻ No
  - If yes please describe? ____
- Have you had Surgery for this before? ◻ Yes ◻ No
  - If yes please describe? ____

LOCATION OF PAIN

- Mark the areas on your body where you feel symptoms.
  Please include all affected areas



Front Back

HOW SEVERE IS YOUR PAIN?

- On a scale of 0-10 how bad is your pain? (Please mark with a vertical line – see example)

Example: Pain 0 ______ 10

Pain on Average 0 ______ 10

Pain at its Worst 0 ______ 10

Pain at its Best (lying down, resting) 0 ______ 10

0 = no pain 10 = worst pain you can imagine

- Describe your pain (check all that apply)

  □ Burning □ Numbness □ Tingling □ Decreased sensation □ Dull
  □ Sharp □ Shooting □ Stabbing □ Throbbing □ Aching

  Other Symptoms: ______

- When do you have pain?

  □ Constant □ Intermittent/Occasional □ During/After activities □ At night

- What activities provoke pain? Describe: ______
- Does the pain limit your activity? Describe: ______
- Have you tried of the following treatments (check all that apply):

  □ Physical therapy

  Location ______

  Dates ______

Of the following list of treatments, please indicate which you have tried and if they helped or not:

	Treatment	Which type	Helpful	No help
□	Anti-inflammatory Medications	□ Ibuprofen	□	□
		□ Advil	□	□
		□ Naproxen	□	□
		□ Celebrex	□	□
		□ Other:	□	□
□	Muscle Relaxants		□	□
□	Narcotic Pain medications	□ Tramadol	□	□
		□ Oxycodone/Hydrocodone	□	□
□	Cortisone Injection	□ Date(s):	□	□
	□ Ultrasound Guided?	□ Date(s):	□	□
□	Physical Therapy		□	□
□	Chiropractor	□ Date(s):	□	□
□	Ice		□	□
□	Hot Packs			
□	Trigger Point Injection	□ Date(s):	□	□
□	Acupuncture	□ Date(s):	□	□
□	Shock wave Therapy	□ Date(s):	□	□
□	PRP/Orthobiologic Injection	□ Date(s):	□	□
□	Other:		□	□

Thank you for taking the time to complete this form

Patient's Signature:____ Date: ___________________