# ACADEMY ORTHOPEDICS

## ESTABLISHED PT - NEW PROBLEM HISTORY

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

**Part of the body being seen for today:**

| | | | | | |
|---|---|---|---|---|---|
| ○ Neck: | | **I experience:** | ○ Pain into arm | ○ Tingling above elbow | ○ Tingling below elbow |
| ○ Shoulder: | ○ Right ○ Left | **I experience:** | ○ Pain at neck ○ Pain down arm | ○ Pain with abduction (when I move or raise my arm away from my body) ○ Pain with adduction (when I lower my arm toward my body) ○ Pain above elbow ○ Pain below elbow | |
| ○ Elbow: | ○ Right ○ Left | **I experience:** | ○ Pain into hand | ○ Pain into forearm | ○ Numbness ○ Swelling ○ Tingling ○ Weakness |
| ○ Hand/ Wrist: | ○ Right ○ Left | **I experience:** | ○ Numbness | ○ Tingling ○ Weakness | |
| ○ Knee: | ○ Right ○ Left | **I experience:** | ○ My symptoms are below the knee ○ My symptoms are above the knee | | ○ Swelling ○ Giving way ○ Locking |
| ○ Foot/ Ankle/Leg: | ○ Right ○ Left | **I experience:** | ○ Swelling | ○ Numbness ○ Tingling | |
| ○ Hip/Back: | ○ Right ○ Left | **I experience:** | ○ Numbness ○ Tingling | ○ Pain into left leg ○ Pain into right leg | ○ Pain when cough and/or sneeze |

Select only ONE option which best describes how your problem started. Answer the questions related to the selected option.

○ **NO INJURY** Was the onset ○ Gradual ○ Sudden Onset Date: _____

**OR**

○ **INJURY** ○ Accident ○ Sport Date: _____

**OR**

○ **INJURY AT WORK** Date: _____ ○ Lift ○ Twist ○ Fall ○ Bend ○ Pull ○ Reach ○ Repetitive

**OR**

○ **AUTO ACCIDENT** Date: _____

**Were you seen in the E.R. for this problem?** ○ N ○ Y Which E.R.? _____

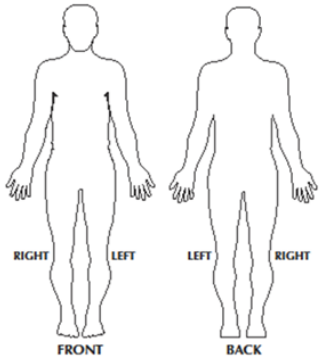
**What test/scans have you had for this problem?** ○ None ○ X-rays ○ MRI ○ CAT Scan ○ Nerve Test (EMG/NCV)

**Does the pain wake you from your sleep?** ○ N ○ Y

**Have you ever had a Bone Density Scan?** ○ No ○ Yes When? _____
*(All female patients or male patient over the age of 75 only)*

**On the drawing below, mark an X where the pain is the worst.**
**Use the symbols below to show where you are having different kinds of pain:**

| | |
|---|---|
| Aching | ^^^^ |
| Numbness | ==== |
| Pins and Needles | oooo |
| Burning | xxxx |
| Stabbing Pain | //// |




_____ _____
**Signature** **Date**