

CORE ORTHOPEDICS & SPORTS MEDICINE

New Injury Form

PLEASE PRINT USING BLACK OR BLUE PEN ONLY.

Patient's Legal Name: _____ (Last)	_____ (First)	_____ (M.I.)
Patient's Age: _____ Years	Date of Birth: ____/____/____	Height: (Ft) _____ (In) _____ Weight: _____
This form is being completed by: <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other:		
Who is your Medical Doctor or Primary Care Physician? Name: _____ Address: _____ City: _____ State _____ Zip _____ Phone: (_____) _____	Who referred you to Core? <input type="checkbox"/> Friend <input type="checkbox"/> E.R./Hosp. <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Doctor _____ <input type="checkbox"/> Other _____ Occupation: _____ How long have you been doing this work? _____	

HISTORY OF PRESENT ILLNESS (HPI)

Where is your pain located? _____ RIGHT LEFT
(Example: wrist, ankle, low back)

Which is your dominant hand? RIGHT LEFT

Approximate **date** of the onset of the present problem: _____

How did **this** problem occur? _____

Any previous problems to **this** area? No Yes If yes, describe: _____

1. Who have you seen for **this** problem? Not Previously Seen Family Physician
 Emergency Room _____ Other _____
(Hospital)

2. Check off all past tests or treatments for **this** problem: X-ray Splint Medication Physical Therapy
 MRI Surgery Other _____

3. Intensity of pain (circle one): **None** 1 2 3 4 5 6 7 8 9 10 **Severe**

Medications	Dose/Strength	When do you take it?	Reason you take the medication

Allergies to Medicine: _____

CERTIFICATION BY PATIENT OR RESPONSIBLE PARTY:

I have reviewed the information which I have submitted and is contained in this Patient Assessment. I certify that all information given is accurate and complete to the best of my knowledge.

 Patient's Or Responsible Party's Signature Date