

# 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?		Who referred you to Core?		
Name: _____		<input type="checkbox"/> Friend <input type="checkbox"/> E.R./Hosp. <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Doctor _____ <input type="checkbox"/> Other		
Address: _____		Occupation: _____		
City: _____ State                      Zip		How long have you been doing this work? _____		
Phone: ( _____ ) _____				

### 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 \_\_\_\_\_ (Hospital)     Other \_\_\_\_\_

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**

CURRENT MEDICATIONS	<i>Please include prescription drugs, vitamins and drugs you buy over the counter.</i>		
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